Ulric June 2021
The Report
From Tunnel to Swamp

Purpose: to drain the swamp not swat individual mosquitoes

- Systems' Analysis of Practice
- Findings reflect the explanations for professional practice that the analysis has evidenced-not always know why
- To support improvement work, not blame

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"It was like walking on eggshells"

Practitioners

Appraise and explain

Wandsworth- CSC, Community Midwives, Police, SWLStG, Kingston –ASC, AfC, Hospital maternity & mental health, (Mother & Baby Unit) MBU

Virtual day October 2020- 23 practitioners & additional interviews

Parents' voices

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Ulric's Story

- **Family known before & in pregnancy in Kingston – good practice counselling – pre-birth multi-agency risk assessment?**
- **Ulric is born Jan 2019- 5 days on ward- anxieties re discharge**
- **Mother unwell, threatening to kill baby-A&E-frightening experience**
- **Mother & Baby Unit-2 hours away-information sharing**
- **Confusions over Wandsworth or Kingston**
- **Discharged MBU Feb 2019- no multi-agency plan**
- **Trigger injury May 2019 – stronger practice – CP planning**

Findings:

1 There is some inconsistent understanding re statutory guidance in the LCPP about pre-birth assessments related to mental health risk factors. (p20)

2 Coordinated work, robust information sharing & effective strategic oversight will better ensure all children are safeguarded. Our local information sharing between agencies can be strengthened. (p23)

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Findings:

3 Children are best protected when the local system of management oversight in supervision & meetings is strong. (p26)

4 Professional curiosity is best supported when working with families & professionals if there is a local culture of collaboration & professional challenge (p26)

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Findings:

5 Transparency is key. Confident & open practitioners work better if their views are challenged- all struggle at times to communicate. Families do well when they have a good understanding & can make informed choices. (p28)

- Baby D Report

https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/retrieve2?SetID=CA93B1D9-97B8-4118-A752-FB4ACEA537FF&SearchTerm0=Baby%20D&SearchPrecision=20&SortOrder=Y1&Offset=1&Direction=.&Dispfmt=F&Dispfmt_b=B27&Dispfmt_f=F13&DataSetName=LIVEDATA

- THINK FAMILY
  https://kingstonandrichmondsafeguardingchildrenpartnership.org.uk/think-family.php

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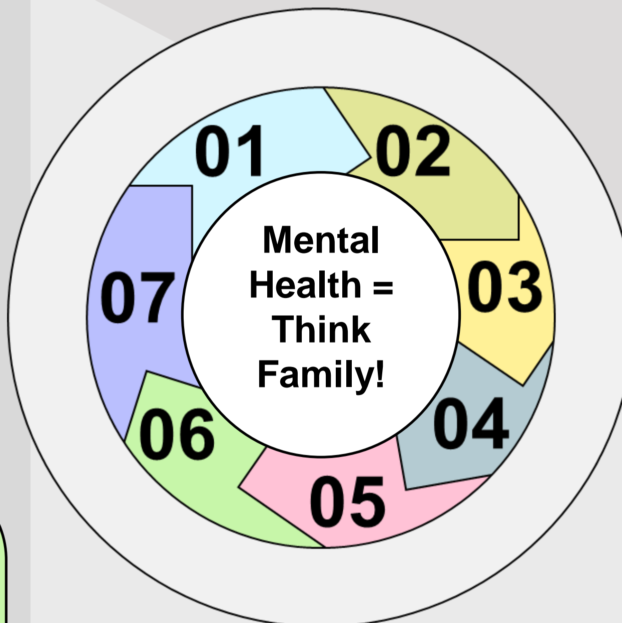
Official

1.Mental Health = Think Family!
We carried out a multi-agency audit in July 2019 looking at 9 local children and young people, who were receiving services for mental health, neurodevelopmental, and emotional wellbeing concerns. We also looked at 3 adults known to local mental health and offender management services. Here are our findings:

2. Outstanding work was taking place with some very complex cases, achieved through good working together- best practice was seen when **regular updates** were shared between professionals, including to therapeutic services and care placements. CAMHS provision for children with complex behavioural needs should be reviewed. We should consider a **multi-agency approach** at the earliest possible opportunity. Some agencies had chronologies which were very helpful, and there was a recommendation for all agencies to use these.



3. Learning Passport meetings in schools could discuss whether need has increased, and then could lead to actions.

All children had their **Views, Wishes and feelings** included. Good News! This had been achieved through observations in some cases. And please remember to offer advocacy too.

Communication and Information Sharing: All Adult Services need to demonstrate that they have enquired whether children are present in a family and what the potential / actual risks parents or other adults visiting or in the home may pose. These risks need to be communicated to CSC as appropriate. Watch out about duplicating information between IT systems.

4. The regularity of **Child in Need meetings** for all children in the family, and all involved agencies, including the Voluntary Sector is vital. And be sure to identify the **Lead Professional**, so that we all know, especially when the case closes to CSC. Don't forget to invite CAMHS to Children Looked After reviews too.

Let's think together if A&E psycho-social meetings could include complex presentations.

5.Support to Carers: In some cases parental support was not clear or discussed between professionals and parents. Remember to carry out PCNAs (Parent Carer Needs Assessments) or Carer's Assessments. Consider Young Carers for siblings or in some cases for children, whose parents also have health concerns.

6. We noted the **Vulnerability of adoptive placements** as children grow older.

Ethnicity and Diversity: consider issues of ethnicity, culture, and gain a detailed background in assessments, in order to look at the impact of diversity issues in keeping children and adults safe.

Transitions: from primary to secondary school and from CAMHS to Adult Mental Health Services can be tricky times. Remember to share information in good time and make contingency plans.

Grab packages should be available in acute settings, in case children go missing.

7. Try our **multi-agency training** here, which is mostly free: https://kingstonandrichmondsafeguardingchildrenpartnership.org.uk/training.php

And our Think Family **See the Adult, See the Child** guide to working together in Kingston and Richmond here: https://kingstonandrichmondsafeguardingchildrenpartnership.org.uk/news-resources/policies-and-procedures-87/see-the-adult-see-the-child-protocol-171.php

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