7 Minute Briefing- Emma Rapid Review

Resources

Safeguarding Partnership Board Website
http://www.safeguardingcambspeterborough.org.uk/children-board/
Safeguarding Training: Virtual Briefings (Microsoft Sways), Online Training and Training Resources
http://www.safeguardingcambspeterborough.org.uk/availabletraining/

Good Practice

•**A Trusted Professional**. It was good practice that Emma had a teacher with whom she could share her feelings and concerns.

•**Tailored medication**. Even though Emma was on a waiting list to see the ADHD CAMHS team, the GP continually liaised with the team in relation to her ADHD medication. This ensured that Emma's medication was tailored to her health needs illustrating good communication and working together between health agencies.

•**Memory box**. The creation of a memory box by the hospital was a thoughtful and helpful way of supporting those close family members to have something of Emma to hold onto and to remember her.

Being Curious

All professionals could have been **curious** about Emma's lived situation with a view to supporting her needs and keeping her safe from harm.

- Professionals could have asked Emma's mother, or other professionals working with the family, why they were living in a women's refuge and about other factors such as "maternal mental health, maternal relationships and domestic abuse".
- Health agencies tried to find out what was "wrong with Emma", in terms of her behaviours but should have considered instead what might be behind those behaviours.
- Professionals should have asked foster carers how they were coping with Emma's dysregulation and what they were doing to support Emma.
- Social cares files noted that Emma had been bullied. However, there was no follow up recorded as to what the bullying involved nor what this meant for Emma.

Working Together

Within the chronologies there was good practice noted in terms of effective information sharing and agencies working together to support both Emma and her sister. However, there was also evidence noted that **communication** between health, social care and education could have been better.

Background

Peterborough Children Social Care were notified by Peterborough City Hospital that Emma, a thirteen-year-old child in care had tragically taken her own life. Emma had been accommodated as a child in care along with her older sister since 2012. In her early years she had experienced being neglected and exposed to unsafe situations. In February 2023 Emma and her sister experienced changes to their main carers. This was a difficult time for Emma moving from carers whom she regarded as her 'Mum and Dad'.

Transitional Changes

Professionals felt that Emma being moved away from her foster carers without prior warning and the time given to understand and prepare for coming to terms with such a significant change must have impacted on her greatly. A strong learning point would be to give consideration to the right support for other children in care with the transitions that they might encounter within their lives. It was recognised that **multi-agency child in care review meetings** would be the best place to have those discussions for making plans and exploring supportive interventions. **All relevant professionals in a child life should attend these meetings** to support any changes and identified risks for the child.

Voice of the Child

All agencies' professionals have recorded the perceptions of others in relation to Emma for example what the foster carers, health, social care and educational professionals thought. However, there was little evidence of **Emma's voice** or what she thought about what the other people/professionals were saying about her, her behaviours and her lived situation. https://www.safeguardingcambspeterborough.org.uk/download/lived-experience-of-the-child-practice-guidance/