Emma Learning Review Report

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children.

Locally, safeguarding partners must make arrangements to identify and review serious child safeguarding cases which, in their view, raise issues of importance in relation to their area. They must commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken. [1]

This review was co-authored by representatives from Children Social Care and Hampshire Constabulary who had no involvement in the case.

The Safeguarding Partnership formed a case review group to oversee the review process. In selecting the reviewers for this case, the review group was cognisant of the requirements of Working Together 2018, that they possessed: -

- Professional knowledge, understanding and practice relevant to local child safeguarding practice reviews, including the ability to engage both with practitioners and children and families.
- Knowledge and understanding of research relevant to children's safeguarding issues.
- Ability to recognise the complex circumstances in which practitioners work together to safeguard children.
- Ability to understand practice from the viewpoint of the individuals, organisations or agencies involved at the time rather than using hindsight.

In order that the review maintained an independent focus the safeguarding partnership commissioned an independent review author to have oversight over the review process.

I Independently chair a review group in another area, and I have undertaken previous safeguarding reviews for children and adults, as well as Domestic Homicide and Multi Agency Public Protection Arrangements (MAPPA) reviews.

As the independent reviewer I have in this case: -

- Been involved in the review set up and formation of the terms of reference.
- Had access to the various agencies review information and reports as requested.
- Been involved in the case review group meetings.
- Been involved in the reviewer's discussions and development of the report.

[1] Working Together 2018 - HMG

I have been able to provide oversight, scrutiny and challenge to the reviewers.
I have found that the process was approached by the case review group and in particular the reviewers with transparency and a desire to achieve child centred learning and improvement for the partnership.

Jon Chapman

Independent Scrutineer

Emma was 16yrs and 9 months when she died. She lived primarily with her mother but also at times, particularly in her teenage years, stayed with other adults, family members or close friends. She was staying with a relative at the time of her death. The relative's partner was charged and convicted of Emma's murder in 2020 and was subsequently sentenced to imprisonment for life.

The community in which Emma lived, is one in which many of her extended family members lived and the practice in this community, as in many others, is for people to 'take in' and offer support to extended family and friends. It is very common for 16/17 year olds to be staying with people other than their immediate parent/s.

Emma was known to both universal and statutory services throughout her life with periods of concern relating to domestic abuse and neglect. At the time of her death a Children and Families Assessment was being undertaken as Emma had moved from one extended family member's home to another and was considered at risk of homelessness.

The perpetrator has been described as having learning difficulties. He had apparently not been in employment for some time. His partner/wife seemed to be a support/carer to him.

There were no known or previous concerns relating to the perpetrator.

To identify learning from this case the Local Child Safeguarding Practice Review (LCSPR) was tasked to consider the following areas of focus.

1. The voice of the child – what was life like for Emma over the last 18 months of her life? Were her voice and views clearly articulated and captured in agency records and by those who worked with her?
2. The transition from school to college and in particular the significant drop in her attendance after starting college.
3. The impact of the reported rape by a peer the previous summer, and the news that no further action was going to be taken by the Police.

4. What was professionals understanding of the cumulative impact of her earlier life experiences and prior events on the current risks to Emma?
5. Was anything known about the alleged perpetrator that may have indicated a risk?
6. Learning identified from any of the areas highlighted above that may benefit other young people in a similar position or at a similar transition point in their life.

Individual agency reports and chronologies were provided to inform the LCSPR and supported the identification of the below findings and recommendations.

Finding 1:

The Hampshire Safeguarding Children Partnership Escalation Policy was not used effectively. Schools and other partners should have the confidence to utilise the policy to ensure that any concerns are robustly addressed enabling the effective safeguarding of a child. In order to do this, there needs to be an understanding of the potential barriers that prohibit the effective use of this policy.

Recommendation 1:

Hampshire Safeguarding Children Partnership develop guidance and an associated training package for the HSCP Escalation Policy and process and ensure it is widely promulgated across all agencies.

Finding 2:

The positive description of Emma by professionals does present a potential dichotomy; whilst it is acknowledged that Emma presented in such a positive way during this time, it is plausible that this was creating over optimism and disguised Emma's ongoing vulnerability or her ability to effectively utilise the support put in place.

Recommendation 2:

The Hampshire Safeguarding Children Partnership via their current extensive training programme, proactively encourage practitioners to operate a reflective mind-set with their case work and via supervision, being cognisant of professional over optimism and ensuring continuing practice of professional curiosity.

Finding 3:

a) For adolescents on a Child in Need Plan, thorough consideration by the supporting professional network needs to be given to the parent's ability to consistently support the child. Where applicable professionals working with the family need to understand the details of the parenting capacity assessment and what this means in practice.

b) For cases of children linked to exploitation this information should be utilised to establish if the parent is able to understand the risk posed by contextual safeguarding

issues, has the ability or emotional resource to put in place protective measures suggested for their child, and is empowered to access the relevant pathway of support should they struggle to sustain being a protective parent.

Recommendation 3:

a) The respective partners of the Hampshire Safeguarding Children Partnership to remind practitioners of their role in contributing towards assessments of parenting, that no one agency will have all of the information and that by contributing, all partners will have a better understanding of the assessed needs.

b) The Hampshire Safeguarding Partnership exploitation sub-group to scope what pathways of support are available for parents of children at risk of harm due to exploitation and consider whether engagement with parents and carers is sufficiently reflected in the HIPs Exploitation Strategy and its work streams.

Finding 4:

Practitioners outside of children's social care do not always clearly record the voice of the child or differentiate the child's voice from the parent's. There are strengths in the CSD 'voice of the child' approach that could be utilised by other agencies.

Recommendation 4:

Hampshire Safeguarding Children Partnership ask the respective partner agencies to review their recording standards and ensure that expectations regarding the quality of recording, including how the 'child's voice' is recorded, is made clear to practitioners.
Each agency should ensure that it is meaningful, understood and embedded within training and practice.

Finding 5:

Disengagement with (professionals and) education increases vulnerability. The college applied its standard procedures in relation to deteriorating attendance and non-engagement. Adjustments to the standard procedure in acknowledgement of the safeguarding context and additional vulnerabilities may have been beneficial and led to more frequent contact with education professionals. Additionally, the timely transfer of child protection records across education settings is imperative in order that education professionals swiftly have a full picture and history of child protection issues and concerns; this was not the case.

Recommendation 5:

a) Standard operating procedures – for example the procedure for non-attendance in an education setting – should acknowledge and respond to contextual safeguarding, recognising that variation in procedure may be needed to address increased levels of vulnerability for some children

b) Education settings should ensure that child protection records are transferred in a timely fashion at points of transition, in accordance with Keeping Children Safe in Education (KCSiE) statutory guidance.

Finding 6:

The transition from school to college was a very challenging period in Emma's life and could even be described as a 'critical moment'. Emma had gone from a child who would readily engage with professionals, to disengaging at college and no longer accessing the support offered. With the Child in Need plan drawing to an end, there is limited information to suggest that there was a continued strong collaborative multi-agency approach and her prior network of support had dissipated.

Recommendation 6:

Partner agencies of the Hampshire Safeguarding Childrens Partnership should be reminded of the existing guidance which explains when it is appropriate to convene a professionals meeting. This should reflect a commitment to ensuring a co-ordinated approach to children that are not in receipt of statutory support.

Finding 7:

The impact of a 'no further action' decision cannot be underestimated, therefore when a victim of rape or serious sexual assault is given details of the investigation outcome, wherever feasible, and in agreement with the victim, this would be better done in a supportive, face to face environment with the relevant supporting professional present. Other relevant agencies involved with the young person should also be appropriately informed, in order that the necessary support can be given. The impact of Covid on this case should be acknowledged.

Recommendation 7:

Hampshire Constabulary review its process when providing victims of rape and serious sexual assault with an investigative outcome and put in place a mechanism to ensure that wherever possible this is done so in conjunction with a supporting person or professional present.

Finding 8:

Professionals must be mindful of the language they use when recording interactions with children. The way in which professionals quantify and record these statements is essential to get right to ensure that the next professional has a good understanding of the provenance. Conversations should take place with individual practitioners in safeguarding supervision, as well as agencies being encouraged to question each other in multi-agency settings, so that assumptions can be questioned, and clarity reached as to what commonly used terms really mean.

Recommendation 8:

Partners should emphasise that it is incumbent upon practitioners in all agencies to question the language that is used to describe a child, their presentation and context in assessments, reports, plans and general recording.

Finding 9:

When domestic abuse is not being reported to the police it is important that other supporting agencies, where possible, undertake the relevant domestic abuse (DA) risk assessments. This should be combined with a good understanding of the impact of domestic abuse on children, including older (teenage) children, ensuring that DA is routinely considered though the lens of child protection and the S47 threshold of 'risk of significant harm'.

Recommendation 9:

Partner agencies of the Hampshire Safeguarding Children Partnership to ensure practitioners know how to respond when unreported domestic abuse is raised by a child service user or by a parent of a child service user. Practitioners should be encouraged to proactively ask about the presence of domestic abuse in a safe and supportive way. Agencies should encourage a multi-agency approach to the management of risk.

Recommendation 10:

Hampshire Safeguarding Childrens Partnership conduct a multi-agency audit of a cohort of adolescents known to children's social care, police and health due to risk of harm following neglect. This audit should enable the HSCP to identify any continued learning for professionals and identify positive practice.