Key Learning: Amara

What is a Rapid Review?

A Rapid Review must take place when a child has suffered a serious incident or death, and it is known or suspected that they may have been abused or neglected. The review helps us to identify learning and consider what went well and what needs to be improved. It seeks to understand what this means for practice and how multi-agency systems and practice can help children and keep them safe.

This Rapid Review was held in January 2025 in response to a young person in our care, who sadly died. The Rapid Review group were in full agreement that all relevant learning has been considered, and a Child Safeguarding Practice Review would not identify any further learning.

Understanding the young person and what happened

Amara was a female of mixed Indian and Caribbean heritage. Amara and her sisters became looked after two months after moving to Durham due to increasing concerns about their care, mum's drug and alcohol use and worries that Amara had been sexually abused by a family member. Sadly, Amara was found hanging at the home of her foster carer in December 2024 and she died a week later in hospital. Amara was 12 years old at the time.

Prior to moving to Durham, the family was known to both children's and adult's services in another local authority. There were worries about domestic abuse, honour-based violence, mum's drug and alcohol use and mum's mental health (including PTSD).

This rapid review has focused on the involvement, support and actions of services that supported Amara and her family from their arrival in County Durham up until Amara passed away, to identify key messages, any good practice and future learning.

Key messages

- Offering the right support at the right time
- Collaborating and sharing information between agencies and across boundaries
- Trauma informed practice and seeing behaviour as communication
- Strengthening professional curiosity and creating opportunities to slow down our thinking and reflect
- Developing confidence and knowledge across agencies about anti-racist and culturally sensitive practice
- Reviewing and simplifying systems and processes to reduce barriers to assessment

What worked well

Information sharing – There were many good examples of multi-agency information sharing such as:

- Way Through sharing information with children's services about the children and family when mum's care was transferred to them from their previous local authority
- Mum self-referred to TEWV mental health services and following an initial assessment TEWV shared their worries with children's social care and a TAF was planned.
- Both schools for the children shared information with each other, allowing them to clarify and verify information and understand the situation. School kept the social worker and the foster carer up to date with information about the sisters.

Relationship building - The school nurse met with mum early on, offered advice and guidance and built a relationship with her.

Culturally sensitive care – The foster carer showed respect for Amara and her sister's culture, for example by doing hair braiding with them.

Involving Amara in her health assessment – although there was a delay in the assessment being completed, the quality of the assessment itself was of a high standard and Amara was involved throughout. The assessment identified that Amara needed emotional support for the trauma she had experienced. Discussions took place with Amara about whether she had ever felt suicidal or had self-harmed. A referral was made to Full Circle, and information was shared about the 24-hour crisis team in the interim.

What did we learn?

Theme	What does this mean for our practice?
Sharing information and professional collaboration **Incomplete information** • Information which could have been known was not initially available from the family's previous local authority • This impacted on services in Durham having a full understanding of the family's background, risks and trauma **Missed Intelligence from Police National Database** • Information about sexual abuse linked to wider family members was available but not identified early enough **Delayed multi-agency strategy discussions** • Opportunities to intervene earlier were missed due to delays in convening strategy discussions and not involving all relevant services **Delayed support for Amara** • Despite Amara speaking about being sexually abused and there being a family history of domestic abuse, no referrals for support were made until her delayed Child in Care assessment	***Seeking and sharing information*** Issues with information sharing is a recurring theme in Rapid Reviews and in national reviews. It is important that all services supporting children and families communicate clearly with each other at the earliest opportunity. This includes: • **Sharing information in a timely way** when families move from one local authority to another • **Inviting all relevant agencies to strategy discussions** so that practitioners have a better shared understanding of the situation • **Practitioners having access to key contact details** and duty numbers for teams, so information doesn't get lost when the named worker is unavailable or has moved on • **Involving all practitioners who know the child and family in assessments and plans** so that information they hold can be triangulated with what children and families are telling us and any difference is explored • **Discussing additional support with children and their parents/carers at the time worries are identified**, to avoid unnecessary delay in accessing support.

Theme	What does this mean for our practice?
Multi-agency working There were delays in Amara receiving her health assessment when she became a child in care, due to: • delays in the referral being received • errors in the paperwork being submitted • a delay in being offered an appointment This delay was missed despite there being an escalation policy in place. This has highlighted issues with Child Health Assessment systems and processes that can get in the way of practitioners being able to book an initial assessment.	***Simplifying systems and processes*** It is important that systems and processes for statutory assessments: • help children to be seen in a timely way • overcome barriers, for example around consent and providing proportionate information at key points in the process Plans are in place to better explore what caused the delay for Amara and consider how processes can be streamlined.
Professional Curiosity **Cumulative harm** • Amara and her family had been subjected to various traumas such as domestic abuse, sexual abuse and honour-based violence • There were worries identified around mum's drug and alcohol use and mental health • Agency records didn't fully reflect the worries, needs and impact • Some worries and needs were missing from the children's plan • There was a lack of curiosity about gaps in information, including past harm and the impact of this on mum and the children • The family's reason for moving was not actively explored	***Staying curious*** • All practitioners need to **pay attention to the wider needs/complicating factors** affecting children and families • Assessing risk of harm is an inexact science. **Past behaviour is the best predictor of future behaviour** however this can and does change (*Eileen Munro*) • **Understand what has happened in the past and the impact of this on the children and family over time** so that any current needs can be identified, and support offered to reduce the worries • **Asking curious questions** to the children, family and practitioners who know them about what has happened to them is particularly important when a family has moved from out of area, and we don't hold this history on our files

Theme	What does this mean for our practice?
Race, Ethnicity and Culture (intersectionality) **Identity** • Some attempts had been made to better understand Amara however we did not have a clear picture of how Amara viewed her place in the world or as a child in care **Racism and trauma** • Amara felt that she was being racially abused and her heightened reaction to a professional moving past her that made her feel dirty suggests past trauma **Behaviour as communication** • Amara's behaviour had started to change and become more worrying. This occurred at the same time as the issues around racist language and comments • There was a missed opportunity to explore Amara's behaviour in this context: *'if the behaviour could talk, what might it say?'*	***Culturally sensitive practice*** This is a recurring practice theme that has been highlighted in previous Child Safeguarding Practice Review Panel's annual reports. • **Intersectionality** means considering how multiple forms of disadvantage and inequality linked to race, class, gender, culture (*social GRACES, Burnham)* can overlap and create difficulties for children, families and the practitioners supporting them • **Inequality** can make it harder for children and families to be understood and access the help and support they need • We need to **explore and name differences in power and privilege** in our relationships, services and systems • Although the population of Durham is still predominately White British, **the demographics of Durham are starting to change** • **Practitioners often feel uncomfortable talking about race and culture** for fear of getting it wrong • **Children and families are the experts in their own lives** and are best placed to tell us about their experiences, what this means for them and the language they prefer • This can help practitioners to make sense of children and families' presentation in culturally sensitive ways and **create plans that are unique to them**

What is the DSCP doing?

- The DSCP updated the Information Sharing Agreement Guidance in 2024, and full training is available on the DSCP website.
- The DSCP will look at how guidance from 'How we Practice in Durham' (Children's Social Care) can be used for all partner agencies to highlight the importance of communicating and involving all practitioners in assessments and plans.
- The DSCP's Clarify, Verify and Reflect briefing is available to help practitioners stay curious in their approach.
- The DSCP has updated the Cumulative Harm guidance, and this has been re-circulated to partners.
- A review of the Child Health Assessment process will be undertaken to check policies and procedures against systems and practice so that these are aligned.
- The DSCP has developed an action plan to cover all multi-agency and single agency actions which will be monitored and reviewed in the Performance and Learning Group (PLG).

What can you do?

- Discuss this key learning briefing in team meetings and in supervision.
- Create a safe, reflective space in your agency to think about what racism is, the impact it has and what is within your own and your agency's ability to challenge and change. It is okay to ask for support and help in developing an understanding of race, ethnicity, religion and culture and what this means for children and families.
- Access training on anti-racist and culturally sensitive practice to improve your confidence and knowledge when working with global majority heritage families.
- Ask curious questions, observe and share information so you can identify intersectionality and its impact on children and families.
- Reflect on the importance of communicating and collaborating with all practitioners who know the child and family. Involve all key practitioners who know the child and family in strategy discussions and assessments and include them in planning.
- Consider the child and family's history and how this could still be relevant and impacting on them currently.

Useful links

- A Practitioner's Quick Guide to Cumulative Harm
- Durham Harm/Worry Matrix
- DSCP Training Programme Please use this link to book onto the DSCP's anti-racism training offer and 'Information Sharing to Safeguard Children' training
- Safeguarding Practice Reviews Silent on Black Asian and Mixed Heritage Children Press release (March 2025)
- North-East Anti-Racism Coalition
- DSCP - Clarify, Verify and Reflect
- DSCP Multi-agency Reflective Group Supervision Guidance