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| **Meeting:** | Children, Education and Skills Sub-Committee |
| **Date:** | 8 July 2021 |
| **Title:** | Serious Case Review, Jasmine |

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| **Service:** | North Tyneside Safeguarding Children's Partnership |
| **Wards affected:** | All |

**1. Purpose of Report**

To update the Committee on the learning from Serious Case Review (SCR) Jasmine, published on 12 April 2021

**2. Introduction**

The SCR was commissioned in July 2019 by North Tyneside Safeguarding Board (NTSCB) in line with statutory guidance at that time. An Independent Reviewer was commissioned to facilitate the review process and complete the report. The Review was completed in September 2020 but could not be published until criminal proceedings had concluded.

The purpose of a SCR is to undertake a rigorous analysis of the contact Jasmine and her family had with services to try and understand what happened and why. The organisations responsible for services can then identify any lessons to be learnt which could be used to improve services and reduce any future risk of harm to children and young people.

3. **Details**

In June 2019 Jasmine, age 14 disclosed to school staff that her mother's partner (referred to as P) had sexually abused her the previous evening whilst her mother was at work, and this had been happening for some time. She had previously made a disclosure of sexual harm by P in March 2018 whilst living in North Tyneside.

The case was referred due to concern that after a short period of time the perpetrator returned to the family home where he is alleged to have continued to commit further and more serious sexual offences against Jasmine. The abuse took place against a significant background history of inter familial abuse within the extended family,

### *Brief History to the Case*

Jasmine's parents separated when she was eight years old and she lived with her mother, grandmother, and mothers' partner, P. In 2016 her father was arrested for the sexual abuse of Jasmine's two half siblings. Mother was implicated and also arrested. Safeguarding procedures were promptly initiated, and Jasmine was cared for by grandmother, mother and P moving out of the home. An Interim Care Order was granted.
Mother was not charged with any offence. A parenting assessment and 'capacity to protect' assessment was completed and in October 2017 Jasmine was made subject to a 12-month Supervision Order and mother and P returned home

In March 2018 Jasmine told school that P had touched her sexually and safeguarding procedures were initiated. A safety plan put in place with mother and P moving out of the home and grandmother caring for Jasmine. During interview Jasmine told police the abuse had happened, but she did not want to assist with their enquiries or go to court. There was no further police action against P and when mother advised they were going to move back into the home, she was informed care proceedings would be considered.

Jasmine wrote to the social worker and said she had made the allegation up as she had been in a 'rage'. The Local Authority felt there was insufficient grounds to pursue legal proceeding and mother and P returned home. In the summer of 2019, the family relocated to a neighbouring LA area and Jasmine (still subject to a supervision Order until Oct 2018) was enrolled at a new school. In June 2019 Jasmine told school staff that she had been sexually abused by P and it had been happening for some time

### *The Findings*

The Review Report identifies 7 findings, two of which relate specifically to Children's Social Care: -

**Finding 1:** *Despite multi-agency concerns about mother's perception and distorted thinking about the kinds of people who abuse children, P, as mother's partner and a significant male in the family, was not viewed as a potential risk to Jasmine and consequently was never subject to a risk assessment or any other assessment.*

There was little professional curiosity about P and his background who was seen as a supportive and caring figure by all family members. As in other national reviews, learning suggest men are too often ignored by professionals despite playing a very important role in children's lives.
In response CSC have shared the learning point with teams and discussions are held in case discussion and supervision sessions in respect of individual cases. They have reviewed quality assurance processes for assessments to consider the inclusion of significant males.

**Finding 2***: Agencies need to improve their knowledge and understanding about the threshold criteria for granting Supervision Orders and their associate responsibilities to ensure these orders are well executed in the child's best interests. Without this, the needs of some highly vulnerable children may be overlooked and not addressed.*

The Review identified the Supervision Order (the legal power to visit Jasmine and her family to 'advise, assist and be friend') was not appropriately prioritised by Children's Social Care (CSC) or fully understood by other agencies.

In response to the finding, CSC have introduced a review process at team manager level, of those children and young people subject to Supervision Orders. This will provide strengthened oversight of this cohort of children. Cases are reviewed by Legal Gateway prior to expiry to determine if an extension is necessary. To develop wider awareness, a briefing note in relation to the role of supervision Orders has been shared across agencies.

**Finding 3***: (Single Agency: CSC) The system for providing quality, reflective supervision sessions to practitioners and first tier managers in CSC should be reviewed to ensure that managers at all levels comply with supervisory standards in relation to work with children, young people and their families.*

Actions by CSC include,

- Supervision training has taken place with all team managers in relation to the principles of quality, effective and reflective supervision.
- Workshop for managers in relation to group supervision using the Signs of safety methodology have taken place
- Supervision audit carried out, and a task and finish group have implemented the recommendations, including changes to the supervision policy.

**Finding 4***: (Single Agency: CSC) Safety plans can be valid tools for removing or managing risks that would otherwise make the children unsafe at home. Jasmines safety plan was not fit for purpose as a longer-term measure. Without a process by which safety agreements are monitored and reviewed as part of a multi-agency plan, they will not keep children safe, although they may give the impression to some professionals of doing so.*

Since the safety plan that was put in place for Jasmine (March 2018) significant work has been completed by CSC to refine and develop their use. This is line with the continuing journey to strengthen and embed the wider signs of Safety model in North Tyneside.
LCS, the electronic case file record has been updated to include a safety plan template which details how the risks are managed and reviewed

**Finding 5***: (Single Agency: GP Practice) Neither GP1 nor GP2 confirmed with CSC what mother had said about the alleged sexual abuse of Jasmine by P and some important safeguarding information held in Jasmine's records was not included in mother's medical records.*

Jasmine was seen by the GP and mother described Jasmine's low mood, crying and poor sleep. Both explained the stresses involved with the allegations. The GP did not corroborate this information with Children's Social Care. In response the CCG have organised specific training sessions for G. P's to share the learning.

**Finding 6***: Some warm, responsive, or challenging parents have the capacity to disarm professionals and deflect their concerns. In this case, professionals who knew mother and P did not have opportunities to reflect and explore what interventions were working well and what professional barriers, including their own feelings, could impact on their judgment.*

Mother was described by practitioners as overly familiar, intense, articulate; she had a knowledge of safeguarding and a professional role. Practitioners reflected this may have made it difficult to challenge her, for example there was little evidence of challenge when she cast doubt on Jasmine's disclosure of abuse by P and went on holiday with him.
Practitioner Briefings and online sessions to share the learning have highlighted the need to be aware of the possibility of elements of disguised compliance in the responses of some parents/carers.

**Finding 7:** *Jasmine's allegation against P was taken seriously, discussed with agency partners and actions taken in line with child protection procedures. However, Jasmine's retraction of her allegation and the response to it was not discussed by agency partners and was not subject to the same degree of scrutiny. This allowed a single agency view to prevail without debate. There is evidence to suggest that some professionals in North Tyneside would benefit from an improved understanding of why children retract statements of sexual abuse and how they can best be supported when they do so.*

The Review found that Jasmine's allegation against P was taken seriously, discussed with agency partners and actions taken in line with child protection procedures. However, Jasmine's retraction of her allegation and the response to it was not discussed with agency partners and was not subject to the same degree of scrutiny. Her refusal to cooperate and the letter she sent stating she had made up the abuse did not spark healthy skepticism and was not sufficiently explored with her. The important role of trusted relationships with vulnerable children and young people to enable them to talk about their experiences was highlighted.

To support practitioners in this complex area of work the Safeguarding Partnership has developed training which considers child sexual abuse from the child's perspective and includes why children may retract statements of sexual abuse and how they can be best supported when they do so. Feedback in relation to the value and relevance of the training has been excellent.

## 4. Background Information

From September 2019, the new Multi-Agency Safeguarding Arrangements, came into operation and are known as the North Tyneside Safeguarding Children Partnership. These new arrangements have replaced the role of the Local Safeguarding Children Board. The Safeguarding Partners are resolved to act on the learning and a detailed action plan is in place which identifies achievable and measurable actions to act on the learning identified in the Review.

The following documents have been used in the compilation of this report and may be inspected at the offices of the author.

You can access a copy of the full SCR report **here**

## 5. Appendices

None.