North Tyneside Safeguarding Children Partnership

Serious Case Review

Jasmine

September 2020

Contents

Key:

Jasmine *(not her real name)*	
Mother of Jasmine	MJ
Birth Father of Jasmine	BFJ
Partner of Mother	PM
Maternal Grandmother	MGM
Half sister of Jasmine	HS1
Half sister of Jasmine	HS2

Police	PO1
Children's Social Care	CSC
Social Workers in CSC	CSC 1- 5

(NB: references to CSC2 represents four practitioners who at various times supervised contact arrangements)

Team Managers in CSC	CSC 6-7
Senior Manager in CSC	CSC 8
Independent Reviewing Officer	IRO1
Legal Brief	LB1
Primary School	SCH1
Secondary School Area1	SCH2
Secondary School Area2	SCH3
Cafcass professional	CFSS
Service Provider	SP1
Forensic Psychologist	FP1
Primary Care GP	GP1, GP2

1. Local Safeguarding Children Boards and Serious Case Reviews

1.1. The main responsibilities of Local Safeguarding Children Boards (LSCBs)[1] at the time this SCR was commissioned were to co-ordinate and quality assure the work of member agencies to safeguard children. The statutory guidance, which accompanied legislation and underpinned the work of LSCBs, set out its expectation that LSCBs should maintain a local learning and improvement framework so good practice could be identified and shared.

1.2. In situations where abuse or neglect of the child is known or suspected and children die or are seriously harmed, LSCBs were required to undertake a rigorous, objective analysis of what happened and why, to see if there were any lessons to be learnt which could be used to improve services in order to reduce any future risk of harm to children. There was an expectation that these processes known at the time, as Serious Case Reviews (SCRs) were transparent, with the findings shared publicly.

1.3. North Tyneside Safeguarding Children Board[2] (NTSCB) commissioned this SCR in July 2019 in line with statutory guidance in place at the time.[3] This guidance has now been updated and with effect from September 2019, arrangements for undertaking local reviews where a child has died or been seriously injured have been amended. Local reviews are now referred to as Child Safeguarding Practice Reviews.

2. The circumstances which led to this SCR

2.1. Agency records indicate that Jasmine's birth father (BFJ) and her mother (MJ) separated for a second time in 2013, when Jasmine was about eight years old. MJ met PM, in the local area sometime in 2015, and he moved into the family home with MJ, Jasmine and the maternal grandmother (MGM). Jasmine continued to have regular contact, including overnight stays, with BFJ and her eight half siblings, including HS1 and HS2.

2.2. In December 2016, BFJ was arrested following allegations of rape and sexual abuse of HS1 and HS2 over a number of years. He was charged, alongside another adult female known to the family, and was given a lengthy prison sentence in July 2017. Initial police enquiries indicated that MJ was implicated in, and had known about, BFJ's abuse of HS1 and HS2. MJ was arrested but released on bail the following day and at the request of the local authority she and PM moved out of the family home whilst further investigations were undertaken by

[1] *Children Act 2004, s14*
[2] *Now North Tyneside Safeguarding Children Partnership (NTSCB)*
[3] *Working Together to Safeguard Children 2015 HMSO,*

Police and CSC1. Jasmine remained in the care of MGM under a voluntary accommodation order[4] and was made subject to an Interim Care Order[5].

2.3. MJ was not charged with any offences but concerns about her relationship with BFJ and her parenting required her to undergo two parenting assessments and attend a Capacity to Protect programme. In October 2017, Jasmine was made subject to a 12-month Supervision Order and MJ and PM moved back into the family home.

2.4. In late March 2018, Jasmine wrote in a school book, shared with SCH2, that PM had started to touch her '*above and below the waist*', but she did not want her mother to leave home again. Statutory agencies were informed in line with procedures. PM denied the abuse, but the family agreed a safety plan with CSC and PM moved out of the home while further enquiries were made. The following day Jasmine told Police that she did not want to go to court or help Police with their investigation, but she signed a statement confirming that abuse as she had described, had taken place. Police took no further action against PM, but agencies remained concerned about MJ's capacity to protect her daughter and following a multi-agency strategy discussion, agreement was reached that a child protection investigation should be undertaken.

2.5. Whilst on holiday with PM in May 2018, MJ contacted the local authority to advise that she, MGM and Jasmine wanted PM to move back into the family home. In response to this information, a multi-agency strategy meeting took place and the local authority later advised MJ of their intention to consider care proceedings in respect of Jasmine, if PM returned to the family before the child protection investigation was complete.

2.6. In early June 2018, Jasmine sent a letter to CSC4 saying she had made up the allegation against PM and had acted in a '*rage*'. In response to this letter, senior managers in CSC reviewed the case and a decision was taken not to commence legal proceedings which would have enabled the local authority to remove Jasmine from the care of MJ or exclude PM from the home. In the view of the local authority, there was insufficient evidence to successfully apply for a Care Order from the court.

2.7. The family, including PM, relocated a few weeks later to another local authority area, (Area2) some 12 miles away. Jasmine, still subject to a Supervision Order, was enrolled in a new school (SCH3) under a different surname and attended from September 2018. There was no contact between CSC and professionals in Area2 and the Supervision Order expired in October 2018.

[4] *Section 20 of the Children Act 1989 provides the local authority with the power to provide accommodation for children without a court order when they do not have somewhere suitable to live. It is widely known as voluntary accommodation because the parents must agree to the child being accommodated.*

[5] *An Interim Care Order is an Order made by the Court, which means that the Local Authority shares parental responsibility with the parent. The Local Authority can make appropriate provisions for the child even if these are contrary to the parent's wishes.*

2.8. In June 2019, Jasmine told a teacher in SCH3 that she had been sexually abused by PM, the previous evening and this had been happening '*for some time'*. PM was arrested and placed on police bail and Jasmine was accommodated by the local authority, where she remains.

2.9. Police referred the case to the Rapid Review Team and a decision was taken on 4.7.2019 that the criteria for undertaking a SCR were met. This decision was endorsed by the National Child Safeguarding Practice Review Panel. The SCR process was delayed due to Covid19, but work, albeit at a slower pace, continued during the lockdown period, but without the benefit of face to face learning events with practitioners.

3. The approach used

3.1. The Board appointed an independent reviewer to lead the review process and to produce the SCR report in collaboration with a review team. The Review Team consisted of senior professionals, representing the agencies that had been involved with the family. Their role was to provide strategic information about their agencies' involvement; to identify learning for their agency through the submission of an Agency Learning Report and to assist the independent reviewer's understanding of what happened and why. Membership of the team is listed in Appendix 1.

3.2. Members of the Review Team identified frontline practitioners and first line managers who had known, or had worked with, Jasmine and some members of her extended family. These professionals formed the 'Practitioner's Group' and offered useful insights to support learning. This group met on one occasion and conversations also took place with some individual practitioners.

3.3. At the start of the review, a timeline of agency interventions was collated to illustrate multi-agency activity and who knew what and when. Each member of the Review Team completed an Agency Learning Report, the aim of which was to provide a description and analysis of practice within their own agency. Additional information was accessed through scrutiny of various assessments and agency records by the independent reviewer and the Review Team.

3.4. This report has been produced in consultation and collaboration with the Review Team. The independent reviewer had oversight of the process, identified single and multi-agency learning points and produced this report, which includes recommendations for consideration by North Tyneside Safeguarding Children Partnership.

4. Key Lines of Enquiry

4.1. The Review Team agreed that the period under review would be from **January 2017** when BFJ was under investigation to **June 2019** when Jasmine alleged, for a second time, sexual abuse by PM.

4.2. The report is structured around four key lines of enquiry (KLEs).

KLE 1: The response of agencies to allegations against BFJ in January 2017.
KLE 2: The response of agencies to Jasmine's allegation in May 2018,
KLE 3: How well agencies communicated with each other and worked collaboratively.
KLE 4: The work undertaken with Jasmine and the extent to which professionals understood the dynamics of sexual abuse in families

5. Family Involvement

5.1. MJ, MGM, and Jasmine are aware that this review is taking place. The Review Team have been advised by Police that conversations with Jasmine and family members should not take place until criminal proceedings in respect of PM and court proceedings in respect of Jasmine are concluded.

6. Parallel Proceedings

6.1. At the time of writing this report, the charges against PM are still with the Crown Prosecution Service, awaiting a decision. Jasmine remains subject to care proceedings in Area2 with a date for a final hearing yet to be agreed.

6.2. A Fact Finding hearing, undertaken as part of these proceedings, found sufficient evidence to conclude that Jasmine had been sexually abused by PM.

7. Background Information.

7.1. Working Together to Safeguarding Children 2018, defines child sexual abuse (CSA) as

'forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.'

7.2. The Children's Commissioner for England's Inquiry (2015) defined CSA in the family environment as: '…. *sexual abuse perpetrated or facilitated in or out of the home, against a child under the age of 18, by a family member, or someone otherwise linked to the family context or environment, whether or not they are a family member*.' A key consideration is that the child sees the abuser as a trusted and familiar adult and part of their family's social

network. Around two-thirds of all child sexual abuse allegations reported to the police are perpetrated by a family member or someone close to the child and family.[6]

7.3. Police and CSC investigations into the allegations made against BFJ in 2017, uncovered a complex web of sexual relationships and alleged sexual abuse in five interconnected local families known to BFJ and MJ over a number of years. Some of the children and young adults from those families were already known to agencies and others were later referred to the local authority for support and protection.

7.4. The Review Team had access to an initial assessment undertaken by CSC in 2011, when Jasmine was five years old, and in response to some highly concerning sexualised behaviours reported by SCH1. Records of Jasmine's language, drawings and behaviour at that time suggested knowledge about oral and anal sex, highly unusual in a child so young and indicative of, at the very least an absence of family boundaries or worryingly, sexual abuse. The assessment undertaken concluded that there were '*no safeguarding concerns'* and the case was closed with parents, BFJ and MJ, at the time being provided with 'Keep Safe' information.

8. Appraisal of Practice

8.1. The purpose of SCRs is to support improvements in safeguarding practice. This means it is not enough just to describe professional activity in a case or to identify elements of practice that were problematic without seeking to understand why they occurred. The analysis needs to explore what systems were in place to support practice and what might have made it difficult for professionals to do their job as well as they might have done. The review also considers what may have influenced professional activity and decision-making at key points in work with the family.

8.2. It is important to be aware how much hindsight can distort judgment about the predictability of an adverse outcome. Once serious injury or harm to a child is known or, as in this case, suspected, it can become easy to look back and conclude that certain assessments or actions were critical in leading to that outcome. The Review Team was mindful of the dangers of hindsight bias but wanted to understand why certain actions and decisions would have made sense at the time and importantly, what systemic factors in place then, might still be negatively impacting upon practice in North Tyneside in 2020.

8.3. The analysis is structured around four key lines of enquiry (KLEs), which lead to findings, learning points and recommendations. The KLEs are headlined below and an appraisal of practice under each key line of enquiry follows.

[6] *Centre of Expertise on Child Sexual Abuse. Key Messages DMSS Research June 2018.*

8.4. KLE 1: The response of agencies to allegations against BFJ in January 2017

8.4.1. The response of CSC and Police to the allegations made against BFJ in December 2016 by Jasmine's two half-sisters, HS1 and HS2 was swift, proportionate and in line with expected practice. Jasmine gave no indication at that time or, it would seem at any time since, that she had been sexually abused by BFJ.

8.4.2. Following her arrest, both MJ and PM were asked to move of out of the family home whilst further enquiries were made. Jasmine remained in the care of MGM under a voluntary accommodation order[7] agreed with MJ. These actions and the decisions taken were appropriate and in line with procedures and expected practice.

8.4.3. There is much to evidence that Jasmine was well supported by key agencies at this time; pastoral support was provided by SCH2, and opportunities, although never taken up, were apparently made available for Jasmine to discuss her well-being with the school nurse, home visits were made by CSC1 and contact visits for Jasmine with MJ and PM were facilitated and supervised by CSC2 and later by MGM.

Assessments of MJ to determine risk

8.4.4. MJ holds a professional nursing qualification, works in a hospital and told professionals that knowledge about safeguarding was an important aspect of her role. Following her arrest, MJ was suspended from her post. The Review Team was advised that the relevant Health Trust had, in line with local and national procedures, contacted the Local Authority Designated Officer[8] for support and advice about MJ's future employment with Trust. The Review Team was informed by the Trust that MJ had been subject to disciplinary proceedings and was reinstated in July 2017, following a police decision to take no further action.

8.4.5. The circumstances surrounding MJ's arrest and the background information gathered from the police investigation raised two significant concerns about MJ:

i. whether she posed a sexual risk to Jasmine and,
ii. the extent to which she would protect Jasmine from sexual harms in the future.

8.4.6. These two concerns led the local authority to commence care proceedings[9] in respect of Jasmine and, in March 2017, Jasmine was made subject of an Interim Care Order.[10] The

[7] *Section 20 of the Children Act 1989 provides the local authority with the power to provide accommodation for children without a court order when they do not have somewhere suitable to live. It is widely known as voluntary accommodation because the parents must agree to the child being accommodated*

[8] *The Local Authority has a designated officer (LADO) who provides advice and guidance to employers and voluntary organisations. Liaises with the police and other agencies and monitors the progress of cases to ensure that they are dealt with as quickly as possible consistent with a thorough and fair process*

[9] *The Local Authority has a duty to intervene and start care proceedings if there are concerns that a child is at risk of significant harm because of the care, or lack of care, by their parents*

[10] *An Interim Care Order is an order made by the Court during the course of care proceedings and means that the Local Authority shares parental responsibility with the parent. The Local Authority can make appropriate provisions for the child even if these are contrary to the parent's wishes.*

court, Cafcass[11] and the local authority agreed that a Parenting Assessment should be undertaken to ascertain whether MJ posed a risk to her daughter and was able, in future, to keep her safe.

8.4.7. A Parenting Assessment of MJ was promptly undertaken by CSC3. According to agency records, MJ engaged well, was reflective and fully cooperated with the assessment which addressed a number of pertinent issues. However, CSC3 concluded the assessment by questioning the '*authenticity of [MJ's] presentation'* and expressed *'serious doubts…. relating to [MJ's] ability to protect [Jasmine]*'. The assessment concluded with an acknowledgment, and a recommendation, that a more comprehensive psychological assessment was required.

8.4.8. The recommendation to require MJ to undergo a forensic psychological parenting assessment was agreed by the court and in May 2017, FP1 was instructed by Cafcass via a Letter of Instruction (LOI) to explore, in greater depth, the risks that MJ posed or could pose to Jasmine, the possible rationale for her behaviour when she was in a relationship with BFJ and how, going forward, this might impact on her ability to keep Jasmine safe from any future abuse. The use of specialist and forensic assessments is not uncommon especially in cases where legal proceedings are underway or are being challenged. They can be used effectively to support professional decision-making around risk and can be extremely helpful in contributing to a complex process to support professional judgment. Given the nature of concerns requiring MJ to undertake a clinical psychological assessment was appropriate and in line with best practice.

8.4.9. FP1 reported that MJ cooperated fully with the assessment process; she was prompt for both appointments, completing two psychometric tests and was reported to engage well with FP1. MJ was described as an articulate woman who, although appeared upset at having to undergo another assessment, understood the need to do so.

8.4.10. Whilst MJ admitted to FP1 she had used graphic language about the abuse of HS1 and HS2, for the sexual gratification of BFJ, she told FP1, that this was because she believed that this was the only way to maintain her relationship with her husband, BFJ and to satisfy his sexual demands. FP1 stated that MJ expressed a view that whilst she had been naive and had been manipulated by BFJ, she had never believed that he would actually abuse, or was abusing, his daughters.

8.4.11. The professional opinion of FP1, summarised in her report to the court in June 2017, indicated that MJ had a positive attachment to Jasmine and a strong desire to look after and protect her and that the risk of MJ sexually harming Jasmine or any other child was low, *i.e. unlikely*. FP1 expressed concern however, that MJ '*struggled to perceive possible*

[11] *The Children and Family Court Advisory and Support Service (Cafcass) is a non-departmental public body in England set up to promote the welfare of children and families involved in family court proceedings*

risk factors' and had evidenced '*biased and distorted'* thinking about what kind of people sexually abuse children and how they manage to do so.

8.4.12. It is important to acknowledge the distinction that FP1 made in her report, that in respect of these two strands, the risk that MJ would physically and of her own volition sexually abuse her daughter was low, but there was a much clearer risk that she would continue to miss signs of risk in others. CSC records later referred to MJ having been assessed as being a 'low risk' but FP1 confirmed that this 'low risk' rating did not equate with safe parenting in terms of future partners. Regarding this latter point, FP1 recommended that more work was needed to help MJ develop a better understanding of CSA and how perpetrators operate as MJ could become involved with another partner who actually posed a sexual risk to Jasmine.

8.4.13. Given the concerns about MJ, her past history and research[12] about how perpetrators target children and groom families, this information, contained in FP1's report did not lead, as it should have done, to a risk assessment on PM, as MJ's current partner. In the absence of any information to the contrary, FP1 assumed, incorrectly, that any risks PM might pose were being, or had been, assessed by the local authority. CSC records described the findings from FP1's assessment report as 'positive' and noted that MJ had been assessed as '*low risk*, although some concerns remained about MJ's parenting and her ability to protect Jasmine. It is important that findings and recommendations from externally commissioned specialist reports are well understood and always considered alongside emerging concerns and in subsequent assessments. There is, however, little to indicate that the findings from FP1's report and their implications were kept under review as would be expected, especially when Jasmine retracted her allegation against PM in June 2018.

8.4.14. In communication with the Review Team, FP1 has reflected on some personal learning emerging from this review and intends to ensure that going forward, any assumptions about risk assessments of other family members are clarified and conclusions drawn from future assessments are made more explicit than was evident in this case.

The alleged conversation between MJ and HS1

8.4.15. In July 2017, CSC records note that HS1 told her social worker, whilst undergoing her own parenting assessment, that in April 2016, when she was 15, she told MJ about the abuse by her father, BFJ. HS1 alleged that MJ had said she believed her but asked her to think for 24 hours as [the allegation] could have '*repercussions for the family*'. HS1 also alleged that MJ asked whether BFJ '*had any images' of herself'.* This information was shared promptly and appropriately with CSC3 and was discussed with CSC6 that day, and with a senior manager CSC8 and LB1, in the legal team, the following day.

[12] *Stages of Sexual Grooming: Winters and Jeglic. (2016); NSPCC Protecting Children from Grooming, (2018)*

8.4.16. The implications of this information were clearly well understood, especially given that MJ's account of that conversation recorded in the parenting assessment by CSC3 in May and in FP1's report in June, was at variance with the detailed information provided by HS1. MJ said in both her assessments that HS1 had only said '*stuff*' was happening, but she did not suspect that it was of a sexual nature.

8.4.17. There were several emails between frontline practitioners and senior staff in CSC, expressing concern about the detail of this information and it clearly raised further doubts in the minds of professionals as to whether MJ would, going forward, be able to protect Jasmine from abuse. A decision was taken by CSC8 that FP1 should be asked her view about this new information in light of her report which had been completed a few weeks earlier. FP1 was approached, and produced in August 2017, an addendum to her original report. FP1 advised that if HS1's version of the conversation was accepted then it demonstrated a gross failure on the part of MJ to protect a vulnerable teenager. It also called into question MJ's capacity for honesty with professionals, it being a significant variant of what she had told FP1 and CSC2.

8.4.18. In terms of MJ being a risk to Jasmine, FP1 confirmed that the additional information, did not, change her original view that MJ, herself, did not pose '*a sexual risk to Jasmine*' as all of the factors identified within the first assessment remained the same. FP1 did however again highlight her concern about MJ's ability to recognise and respond to risk by others and reiterated that MJ needed further specialist input to help her understand child sexual abuse and how perpetrators operated.

8.4.19. The minutes from the LAC review held in September 2017 refer briefly to the fact that MJ had denied the context and content of the conversation as described by HS1. There are however no case notes which provide detail or analysis about the conversation that took place between CSC3 and MJ. There was however an agency record in which MGM inferred to CSC3 on a home visit, that MJ had refused to lend HS1 money and this may have led to HS1 wanting to '*cause trouble'* for MJ. Without access to any records, it is difficult to ascertain to what extent the significant disparities between the account by MJ and that of HS1 were explored. The alleged wording to HS1 by MJ to '*think about the repercussions for the family'* carries a particular significance when considered alongside Jasmine's allegation made a few months later that she '*did not want her mum to leave the home again'* and her refusal to help Police with their investigation into her allegation.

8.4.20. MJ successfully completed a 'Capacity to Protect' assessment, which covered a range of areas linked to the sexual abuse of children, from understanding how perpetrators work to responding sensitively to children when they tell what has happened to them. MJ had attended all four sessions, completing all the required tasks and exercises. The report written by SP1 described MJ as open and straightforward and willing to discuss some very personal aspects of her life. SP1 concluded with a recommendation that MJ be allowed to care for Jasmine especially given that MGM was to continue to live with the family and would offer an extra layer of protection.

8.4.21. SP1's report, produced in October 2017, highlighted discrepancies between what MJ told SP1 and what she had told CSC2 in the parenting assessment in May, namely that she actually believed that HS1 was about to make a sexual allegation against BFJ. This information does not appear to have prompted a conversation between CSC3 and MJ and was a missed opportunity to try and gather more detailed information about what MJ knew and what she suspected about BFJ.

8.4.22. MJ was subjected to two assessments and completed an intensive programme to educate her about child sexual abuse. She and PM remained in contact with Jasmine throughout most of 2017, with supervised contact visits initially taking place about three or four times each week and later contact visits 'supervised' only by MGM. Jasmine also had occasional contact with her half siblings. Jasmine was in receipt of regular support sessions from school and although some concerns emerged about her emotional well-being, she was described as coping well and just wanting her mum and PM to return home. Multi-disciplinary LAC reviews and care team meetings took place regularly and no additional concerns were raised about Jasmine's safety or welfare during that time.

The 'invisible' male

8.4.23. Men play a very important role in children's lives and have a great influence on the children they care for or with whom they are in regular contact. Despite this, research and SCRs[13] suggest men are too often ignored by professionals who sometimes focus almost exclusively on the quality of care children receive from their mothers and female carers. The focus of work between March and October 2017 centered only on MJ. There was very little professional curiosity about PM despite FP1's assessment which indicated that MJ seemed to develop intense relationships and be overly positive about these.

8.4.24. A repeated finding in case reviews is how often fathers and male figures are absent in records, assessments and care plans. When protecting and supporting children, practitioners need to proactively assess and where possible engage with all significant men in a child's life, understanding that some may pose risks, some may be assets to the family, and some may incorporate aspects of both. Whilst PM was not entirely 'invisible' in this family, in contrast to the work undertaken with MJ, and MGM, there was a lack of sustained professional curiosity about him in terms of his background which suggested he was not actively considered as a safety risk to Jasmine.

8.4.25. Some information was shared between agencies about PM, either verbally or in report form. It was known that PM had been convicted of an indecent assault in 1992, when he was a teenager although he insisted the offence was because he had been reported by a '*lady for urinating in a public place'*. It was also known that in response to a number of domestic abuse incidents he had been referred to MARAC in 2013 but had since been deregistered. CSC3 was able to determine, as part of MJ's parenting assessment that PM had received a 12-month conditional discharge for the disputed offence. Police, were

[13] *https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/hidden-men*

clear however, that although no other details were on their system, PM had been convicted for an indecent assualt on a female over the age of 16.

8.4.26. The LAC review in July 2017 did not pick up that a risk assessment for PM had not been undertaken. Neither was it noted that the references to PM in the parenting assessment were brief and without any analysis of the fact that PM's account of his sexual offence differed significantly from that provided by the Police. Notes from the meeting did however refer to some disparity in police information about him, which needed '*to be followed through*'.

8.4.27. There is however no evidence that this action was ever completed and it seems that it was not until the strategy meeting in May 2018 that information about MARAC and allegations about PM's propensity to expose his genitals to family members and friends was discussed in a multi-agency meeting. Had this information been shared earlier, and the source of this detail is unknown, it may well have heightened concerns about possible future risks to Jasmine from PM.

8.4.28. Research studies[14] and file audits have repeatedly shown that historical information is not always given the attention that it should be given in assessing risk and the needs of children. Whilst evidence that PM had a 'history' did not automatically confirm the existence of any current risk, it did require professionals to be curious enough to explore and understand PM's past behaviours and to consider how and if these had changed over time. PM was clearly not seen as posing any significant risk to Jasmine; concerns centered only on MJ's ability to protect, yet there was evidence in both the parenting assessment and in the forensic psychological assessment that suggested MJ did not appear to fully understand how perpetrators of sexual abuse operate and her '*distorted and biased thinking*' about who would abuse children had implications for her choice of partners.

8.4.29. Whilst the lack of any dogged persistence in following up background information about PM suggests a lack of professional curiosity about a significant member of the family, it is important to understand why this was so. Whilst some parents or carers are openly resistant to the involvement of statutory agencies and will argue and dispute plans to make changes, PM was seen as cooperative and understanding and importantly, was viewed as a supportive and caring figure by all family members. Descriptions of his relationship with Jasmine were also positive and encouraging and CSC records note how pleased Jasmine was to see both PM and MJ when they arrived for their contact sessions.

8.4.30. PM's contact with Jasmine was noted to be appropriate and welcoming and there was a sense that professionals understood that he had a key role within the family. The focus only on MJ as 'the parent' however meant that any potential risk PM may have posed went unassessed. When professionals are working with families where concerns have

[14] *The Munro Review of Child Protection: Final Report 2011*

been raised, all those living in the household and any 'significant other' in a child's life, should be subject to robust and ongoing assessments, including partners of parents, both to determine risk and to confirm and assess their ability to protect children within the family.

Finding 1: *Despite multi-agency concerns about MJ's perception and distorted thinking about the kinds of people who abuse children, PM, as MJ'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.*

MGM as a protective factor

8.4.31. The Review Team was curious about the role of MGM and the responsibilities she was given to protect Jasmine and ensure that any safety plans were followed through. CSC were clearly mindful of the need to plan for permanency for Jasmine if, after legal proceedings, she would not be able to return to her mother's care. Consequently, MGM was subject to a robust assessment which would have allowed her to become a Special Guardian[15] for Jasmine, if MJ at a future date, had not been able to care for her daughter.

8.4.32. The Special Guardianship Order (SGO) Regulations 2005 provide a lengthy list of matters which the local authority is required to report on before a SGO can be made. These assessments are known to be detailed and extensive and include an exploration of the applicant's ability to safeguard the child from risks, there understanding of what the risks are and how, going forward, they will manage these.

8.4.33. An SGO assessment also supports the local authority to approve a Connected Person[16] as a temporary foster carer until any legal proceedings have concluded. Although some concerns were noted in relation to MGM's understanding of sexual abuse and how it can impact on children and their families, the fostering panel considered that on balance, MGM had much to offer Jasmine. MGM was therefore provisionally approved as a Family and Friends Foster Carer in June 2017 and according to agency records the panel's recommendation was endorsed by the Agency Decision Maker[17] the day after the panel had met.

8.4.34. Unlike PM, MGM's lifestyle, background, and views were subject to extensive scrutiny during early 2017 and her presence in the home offered a reassurance to professionals that Jasmine would be well protected.

Jasmine as a Looked after Child (LAC)

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[15] *A Special Guardianship Order (often known as an SGO) is a legal order where the court appoints a carer – usually a relative – as the 'Special Guardian' of a child until they turn 18 or when a parent can resume parental responsibility.*

[16] *Connected Person fostering is a legal arrangement where a child who cannot be cared for by their parents, is looked after by a relative, family friend or any other person with a connection to the child in a personal or professional capacity*

[17] *The Agency Decision Maker is the person in a local authority who makes* ***decisions*** *on all adoption and key fostering matters.*

8.4.35. As a Looked after Child, Jasmine's needs and well-being were under continual review and there was ongoing contact with MJ and MGM by SCH2 and CSC3. There is evidence of timely LAC reviews[18], chaired by an Independent Reviewing Officer (IRO1) and Care Team meetings, which took place regularly to ensure that Jasmine's care plan was being implemented and the local authority was discharging its responsibilities appropriately.

8.4.36. Whilst MJ was seen as cooperative and had engaged with professionals, multi-agency concerns about her ability to protect her daughter remained. The local authority's final care plan, agreed at a LAC review meeting chaired by IRO1 and attended by SCH2 in September 2017, was that Jasmine should be made subject to a 12-month Supervision Order. This recommendation was supported by Cafcass and agreed by the court in October 2017. At this point MJ and PM moved back into the family home.

The use of Supervision Orders

8.4.37. Being the subject of a Supervision Order meant that Jasmine was no longer a Looked after Child but, in line with local procedures, would be supported under the Child in Need (CIN) framework.[19]

8.4.38. Jasmine's care plan presented to the court by CSC3 indicated that from October 2017, home visits to Jasmine would initially be made every two weeks, multi-disciplinary CIN meetings would take place six weekly and a '*long term safety plan'* for Jasmine would also be agreed and implemented. The Supervision Order gave the local authority the legal power to visit Jasmine and her family and ensure the plan presented to the court was being implemented as agreed.

8.4.39. The making of a Supervision Order is granted under an s.31 Children Act 1989 by a court and only on the basis that actual and likely significant harm by parents has been evidenced. This is the same threshold, which is applied when a child is made subject to a Care Order and becomes 'looked after' by the local authority.

8.4.40. Views on the value of Supervision Orders are highly contested and whilst some argue there are advantages in terms of legal oversight which places duties on local authorities to '*advise, assist and befriend*' supervised children, other views highlight that these orders do not provide any 'teeth' to hold parents to account and do not carry the same 'statutory weight' as Care Orders or Child Protection Plans. In addition, critics argue that Supervision Orders do not ensure any additional automatic benefits in terms of the services provided, mandatory home visits or expectations that formal reviews will take place on a regular basis.

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[18] LAC Reviews are a statutory requirement. They are the mechanism whereby the local authority ensures that they are fulfilling their obligations to care and plan for the child.

*[19] A **child in need** is defined under the **Children** Act 1989 as a **child** who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services or a **child** who is disabled.*

8.4.41. Managing Supervision Orders under a Child in Need framework is common to many other local authorities. Research[20] suggests however that in general, partner agencies are not as well informed about Supervision Orders as they are about Child in Need and Child Protection processes and this can lead to some professionals regarding Supervision Orders as sitting only under the auspices of CSC rather than within a multi-agency framework. This view was confirmed by some agencies, including SCH2, who were asked as part of this review, how well they understood these and other court orders.

8.4.42. There is no explicit duty in legislation which stipulates that the local authority should 'monitor' children on Supervision Orders, the legislation states only that services should be provided which '*advise, assist and befriend*' children and their families. The review found evidence that although professionals in CSC saw Jasmine's Supervision Order as a necessary protective measure, it nevertheless, sat beneath more urgent child protection cases, with home visits and reviews being required only to check up that all was well. Yet, by granting a Supervision Order, a court had already determined that Jasmine was at risk of significant harm, the same threshold used for child protection.

8.4.43. There have been other national reviews[21] and various studies[22], which suggest that children placed on Supervision Orders should, given the high threshold for their application, be managed under Child Protection procedures rather than as Child in Need, which tends to be regarded as a less serious category, carrying fewer risks. Other suggestions have been to just strengthen the regulatory framework for these orders to ensure that reviews have independent oversight to avoid the dangers of drift which can happen more often in CIN cases, than in those which are held under the auspices of child protection

8.4.44. The Review Team was informed that previously there was no system in North Tyneside to quality assure work with children subject to Supervision Orders. However, in response to the learning that has emerged from this SCR as it progressed, CSC reflected on its practice is now revising its procedures. These changes are to be welcomed and will ensure that work with children subject to Supervision Orders is more clearly defined and purposefully monitored both by the agency and by multi-agency partners. The Review Team were informed that CSC is to ensure that:

- A Service Manager provides independent oversight of all casework for children subject to Supervision Orders
- Detailed Child in Need Plans are established within 10 working days of the making of the Supervision Order
- Senior managers provide managerial oversight of progress throughout the duration of the order and ensure contact and liaison with 'new' professionals if the family move local authority areas
- Cases are held by qualified social workers with not less than 12 months experience

[20] *National study of Supervision Orders and special guardianship (May 2015–July 2017*
[21] *See Derbyshire LSCB Serious Case Review 'Polly' 2017*
[22] The contribution of Supervision Orders and special guardianship to children's lives and family justice. Centre for Child and Family Justice Research Lancaster University 2019.

- All cases where Supervision Orders are in place are subject to monthly reviews under current supervision arrangements.

***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.*

Supervision and managerial oversight

8.4.45. As a Child in Need on a Supervision Order and in line with the care plan presented to the court in the October, it would be expected that at least six or seven visits with Jasmine and her family would have been made, and at least two multi-agency CIN meetings to have taken place between then and March 2018. There are however no case records which refer to work undertaken with Jasmine and her family during that period.

8.4.46. Social work home visiting and reviews are important aspects of case management and were in effect the only means to establish whether the Supervision Order for Jasmine was delivering fully on its support functions and importantly, whether, in this case the family were following through on the commitments that had been made at the final court hearing. Home visits and reviews are important ways of actually carrying out the duty to '*advise, assist and befriend*', but there is little to evidence this work was undertaken as expected or given the priority it required.

8.4.47. Following Jasmine's allegation in March 2018, MJ told CSC5 that the family had received no help from CSC and although the independent reviewer was assured that visits had taken place and no concerns had emerged, there are no records available to refute MJ's assertion. A member of the Review Team told the independent reviewer that there was confidence in both the integrity and expertise of the professionals involved in this case and, based on '*knowledge about the professionals' wider practice, did not doubt*' that visits to the family had been made. There was however an acknowledgment that the lack of records in this case, the absence of a detailed CIN plan and the agreed long term safety plan did not meet expected standards and this should have been picked up and challenged in supervision and through managerial oversight.

8.4.48. Accurate, accessible and detailed recordings are essential in Child Protection and Child in Need cases and especially so when a child is subject to a court order; they are vital tools for ensuring accuracy of information, accountability, and continuity in work with families. Case records are not just a repository of information; they are the tools which assist social workers in planning and making the best decision for the children and young people with whom they work. The absence of detailed records and case notes from October 17 when Jasmine was allocated to the social work team until the family moved to Area2 in July 2018 was accepted by the agency as a serious failing, and one which the Review Team was told

had been taken seriously by senior managers in the agency and appropriately addressed with the professionals concerned.

8.4.49. The independent reviewer was told by a senior manager in CSC that agency expectations around recording practice for social workers were very clear in North Tyneside at that time and remain so. Case records of any activity related to a child or young person are expected to be completed within 72 hours of the event/visit. Where children have CIN status, visits are expected to be made not less than six weekly and multi-agency CIN meetings to review progress against the child's plan should also be not less than six-weekly. All CIN cases are expected to be discussed in supervision at least on a monthly basis. CSC was also subject to a systematic, comprehensive, and regulatory inspection of casework in March 2020 and no issues regarding recording were noted and casework was deemed outstanding, requiring then a better understanding of why practice in this case did not meet expected standards.

8.4.50. The independent reviewer spoke with both CSC4 and CSC6 and appreciated their willingness to share and reflect on their practice. CSC4 indicated that as no concerns emerged in relation to Jasmine, school were actively involved and the authority and legal processes had deemed it safe to reunite the family, the issue of recording the contacts with the family was not prioritised and focus was placed on more pressing cases considered to be of higher risk. CSC6 also attributed the lack of managerial oversight in this case to focusing more on the perceived higher risk child protection cases held at that time by CSC4. CSC6 also reflected that because there were no reported concerns, and assessments had indicated the risk from MJ were low, the case was not seen as a high priority, and supervision and managerial oversight on this case, was not as robust as it should have been.

8.4.51. Professional supervision is central to effective work with children and families. The supervisory environment should provide practitioners with the opportunity to critically analyse their work and provide a safe place for them to reflect on their practice, decisions and interventions. It is in part, through robust supervisory practices, that professionals, including managers themselves are supported in organisations. [23]

8.4.52. The Review Team had sight of some case discussions/supervision notes made by CSC6 and CSC7 following sessions with social workers, but these did not meet expected standards and were not of high quality. It is of course possible that these sessions or supervisory conversations were in line with best practice but without records it is difficult to see how supervisory practices are quality assured.

[23] *SCIE: The foundations of effective supervision practice (2017)*

8.4.53. Supervision records should evidence support and challenge to ensure the best possible interventions for families whilst also providing a place for professional dialogue and debate. The independent reviewer was also unable to access any notes from supervision sessions led by senior managers in relation to this case. Frontline professionals and their managers have to deal with multiple demands in sometimes-stressful work environments. Consequently, they need access to regular, focused support and challenge from their line managers. Where the quality of practice falls below expected standards, steps should be taken to identify the reasons for this and appropriate mitigation plans, regularly monitored, put in place.

Finding 3*: 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.*

8.4.54. Feedback from health colleagues about supervisory practices present varied and robust systems to support both frontline practitioners and managers. School staff do not generally have the same protocols or opportunities for supervision as their colleagues in health and social care and with respect to their work with Jasmine there was no external support who offered support or challenge to SCH2.

8.4.55. Since Sept 2018, SCH2 indicated that they now have weekly allocation and supervision meetings and have increased the size of the team to ensure that cases can be evaluated, and staff supported in their decision-making and practice. CSC has also put in place a helpline which allow schools to check and challenge and question decision-making of others outside the organisation. This is a good example of partnership working, which is clearly valued and seems to be working well.

8.5. **KLE 2: The response of agencies to Jasmine's allegation in March 2018,**

The initial response by agencies

8.5.1. SCH2 acted swiftly when, in March 2018, Jasmine showed a member of staff a notebook in which she had written that she was being hurt by PM '*like [BFJ] did to my sisters'* and the response by Police and CSC was equally prompt. MJ could not be contacted and after a number of failed attempts, PO1 and CSC5 in line with expected practice went ahead and spoke with Jasmine at school. Jasmine told PO1 and CSC5 that PM had touched her above and beneath her clothing and this had happened before, sometimes after school either in her bedroom or when MGM was upstairs in her own room. Jasmine indicated that she did not want to go home that day if PM was there. She did however agree to talk again with PO1 the following day.

8.5.2. PO1 spoke with PM and he denied the allegation but agreed to move out of the family home whilst further enquiries were made. CSC took appropriate measures to ensure Jasmine's safety and PM, MJ and MGM were asked to agree and sign a safety plan, which they did. The plan was produced as a written agreement detailing six conditions agreed with by MGM, PM and MJ. Signed also by CSC5, the agreement stipulated that no pressure would be placed on Jasmine by any family member to talk about what she had told police and PM would have 'no contact with Jasmine' and '*no face to face or phone contact'* with any family member, including MJ.

8.5.3. The purpose of securing this agreement with family members was to ensure that they were clear about what they had to do, until informed otherwise, to keep Jasmine safe. The use of the safety agreement at that time was both appropriate and timely. CSC5 recorded that when dropping off a copy of the safety plan later that evening, she saw MJ and Jasmine and observed things seemed '*a little tense'*. No other details or reflections were provided about this observation.

8.5.4. Jasmine met with PO1 the following day as agreed but refused to take part in an ABE[24] interview, saying that she did not want to go to court and did not want her mum to leave again. Jasmine was provided with assurances about the support measures that would be put in place but refused to assist police with their enquiries. Jasmine did insist however that the abuse by PM happened as she had described and in line with police procedures, signed a statement to this effect.

8.5.5. In line with expected practice, a multi-agency strategy discussion took place the following day between Police and CSC. According to records, consultations were also held with health colleagues and SCH2, and an agreement was reached that s47[25] enquiries should be undertaken. This was appropriate even though Jasmine was subject to a Supervision Order in line with child protection procedures.

8.5.6. Concerns were shared that despite MJ and MGM both attending [different] programmes about child sexual abuse, their response to Jasmine's allegation had not been as supportive to Jasmine as would be expected and this could leave Jasmine vulnerable, should PM return to the family. When a child makes an allegation against a family member, denial and disbelief are deeply worrying responses and the impact on non-offending family members learning of the abuse should not be underestimated. Whilst the background and context of these responses needs to be understood, and often-family members will need time to digest what has been said, these responses from MJ and MGM were nevertheless

[24] *Achieving Best Evidence (ABE) interviews with children are undertaken by police and social workers where allegations of abuse are being investigated.*

[25] *A Section 47 enquiry means that CSC must carry out an investigation when they have 'reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm'. The aim is to decide whether any action should be taken to safeguard the child.*

important factors in considering the crucial role MJ and MGM had to play in the future protection of Jasmine.

8.5.7. According to agency records, the strategy discussion concluded with a reference to the safety plan already in place and notes from the meeting indicated that, going forward, the family needed to come up with a more detailed safety plan, to keep Jasmine safe. As CSC4 was on leave, CSC5 was asked to progress the s47 enquiries work in the interim and follow up the agreed actions from the meeting, which included a case discussion with CSC8 as to whether a child protection conference was required. Legal advice was that the local authority was doing all that they could and s47 enquiries should continue.

8.5.8. Section 47 enquiries involve an assessment of a child's needs and the ability of those caring for the child to meet them. The aim is to decide whether any action should be taken to safeguard the child. The child's parents/carers are interviewed, as well as the child, depending on their age. The assessment also includes information from the child's school, GP, and any other key professionals involved with the child and the family. The multi-agency decision to undertake a s47 investigation, notwithstanding Jasmine's decision not to cooperate with police, was appropriate and in line with child protection procedures.

The use of safety plans or written agreements

8.5.9. The local authority Care Plan for Jasmine, presented to the court and agreed with Cafcass five months earlier, had included an assurance that a '*long term safety plan'* would be developed and implemented to assist MGM and the family and to support Jasmine given ongoing concerns about her safety. However, in the absence of any CIN meetings and without any lead from CSC, this '*long-term'* safety plan was never produced.

8.5.10. Safety planning is a complex and dynamic child protection process that focuses on building enough safety for children to remain within the care of their families. The safety planning process involves professionals working collaboratively with parents, children and an informed family network to develop and implement a detailed plan that leaves everyone confident that, going forward, the child will be safe in the parent's care.

8.5.11. Given the findings from Police and CSC enquiries in early 2017, which had identified complex family networks where sexual abuse of children had happened and, given the concerns about MJ's capacity to protect her daughter, a safety plan for Jasmine was clearly considered by CSC, the court and Cafcass to be in Jasmine's best interests, in that it would identify what steps were needed by family members to keep Jasmine safe.

8.5.12. That the safety plan was never produced and the need for it never queried by any agency would suggest that the purpose and value of these plans are not as well understood by professionals as they should be. Were this not the case, it is fair to assume that developing a robust safety plan with this family, after October 2017, and after March 2018 would have

been given a much higher priority both by CSC and SCH2. Safety plans differ from care plans and Child in Need plans in that they are designed to control safety threats and have an immediate effect, while care plans seek to create change over time to reduce risk and increase a parent's capacity to protect their child. The safety plan is meant to stay in effect for as long as the threats to the child exist and the family remain unable to ensure or provide for the child's safety.

8.5.13. After Jasmine made the allegation against PM in March 2018, the safety plan agreement put in place was helpful as an emergency response. It was not however useful as a longer-term safety measure. It was unrealistic over a longer period, impossible to monitor but more importantly, had not involved Jasmine. The safety agreement drawn up by CSC5 had apparently not been seen by CSC6, which calls into question not only its value and effectiveness, but also how duty information is shared with, or picked up by, professionals and their managers working with families. There is no evidence to suggest the plan drawn up at that time, was shared with any other agencies. The Review Team understand that safety plans in North Tyneside are rarely produced as multi-agency documents and very often are not shared with the appropriate partner agencies.

8.5.14. The use of 'safety plans or written agreements' to seek assurances from parents is common practice and research[26, 27] suggests they can be of value but, unless they are well designed in partnership with family members - including the child - and shared with other agencies, they are little more than a paper exercise. In minutes from Legal Gateway meetings[28] (LGM) seen by the Review Team, MJ and PM were reported, in July 2018, as respecting the '*safety plan'*, yet in May 2018, only a few weeks after the plan was agreed, the couple went on holiday, clearly in breach of the said agreement. Agency case notes also refer to PM sharing information that he had spoken with Jasmine and she was missing him. There is no evidence to suggest that the breach of the safety plan was challenged, by the caseworker or through managerial oversight.

8.5.15. Safety plans rely upon a parent's awareness and acknowledgement of risks and their acceptance and willingness for the plan to be implemented. Despite attending the four week Capacity to Protect programme in September 2017, aimed at increasing MJ's awareness around child sexual abuse, there was no evidence that MJ demonstrated concern for Jasmine, in fact by going on holiday with PM there was a clear message to her daughter that she did not believe her allegation, a view that Jasmine shared with SCH2.

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[26] *NSPCC Children and Families experiencing Domestic Abuse (2010)*

[27] *Working with 'Denied' Child Abuse, Turnell and Essex Open University Press 2006*

[28] *A Legal Gateway Meeting is called to consult with colleagues to ensure that children are the subject of active case management and effective child protection planning and that appropriate legal action is taken when required to promote and safeguard the welfare of the child.*

8.5.16. The use of the original safety agreement when Jasmine first made her allegation was a helpful and necessary response to an emergency situation. The strategy meeting in March 2018 confirmed that the safety plan in place should continue but there is little to evidence the document had been seen by any of the agencies at the meeting. The legal advice given to CSC a few days later was that because Jasmine was subject to a s31 Supervision Order and a safety plan was in place, the local authority had no need to issue public law care proceedings at that stage. The quality focus and content of the safety plan was taken for granted and clearly provided professionals with a degree of assurance that Jasmine's safety and welfare would be safeguarded by those around her.

8.5.17. The reality of a creating an effective family-owned safety plan in high-risk cases is that it is very, very hard work for families and the professionals working with them. The detail and extent to which family members are asked to monitor an adult family member who could be suspected of abuse is extremely challenging for all concerned. For safety plans to be as effective as research suggests they can be decisions to *'put a safety plan in place'* need to be made within a multi-agency context by professionals who understand their purpose, are clear about their own shared responsibilities to ensure that any plans are purposefully created and continually monitored.

Finding 4: *Safety plans can be valid tools for removing or managing risks that would otherwise make the children unsafe at home. Jasmine's safety plan was not fit for purpose as a longer-term measure. Without a process by which safety agreements are created, 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.*

The missing assessments

8.5.18. A multi-agency strategy meeting was held in early May chaired by CSC6 and triggered by MJ wanting PM to return to the family home. It was noted in the minutes that the situation concerning the initial s47 was 'unclear', but no action was identified to determine why this was so and why this work had not been progressed as agreed. There was no reference made to the safety plan; this was a missed opportunity to explore in a multi-agency setting, the extent to which the adults in the family had adhered to the safety agreement and fully understood professional concerns. The meeting concluded with an agreement that care proceedings would be sought to remove Jasmine if MJ and PM reunited in the family home.

8.5.19. At a Legal Gateway meeting two weeks later, there was no reference to the s47 enquiry and notes indicated that a '*focused risk assessment is being undertaken in respect of PM'*, although who was undertaking this work is unclear. Neither this risk assessment nor the s47 enquiry was progressed and once Jasmine's letter of retraction arrived in early June, the missing s47 assessment and the risk assessment pertaining to PM appears to have been considered immaterial. Rather than ensuring, in line with procedures, that the s47

assessment was completed to inform any multi-agency decision-making, Jasmine was apparently spoken to on '*2 or 3 occasions*' by CSC4 and said she had not been pressurised into sending the letter but had lied about PM. After taking legal advice CSC made a decision not to commence care proceedings in respect of Jasmine.

8.5.20. Given the research and all that was known about Jasmine's lived experiences, together with the concerns expressed by professionals in partner agencies that Jasmine would be pressurised into retracting her allegation, expected practice would have been for CSC to have reconvened the multi-agency strategy meeting to consider next steps. The outstanding s47 enquiry and PM's risk assessment should certainly have been addressed as a matter of some urgency. Being subject to a Supervision Order does not preclude a parallel process of child protection taking place and the implications of Jasmine's 'retraction' should have been discussed within a multi-agency framework in the light of what was known about the family and PM. The issue of Jasmine's letter of retraction is further explored in KLE4.

Information shared at the Legal Gateway meeting (LGM)

8.5.21. The information recorded in the Legal Briefing and Legal Gateway meeting documentation, dated May 2018, states that MGM and MJ were '*not convinced*' about Jasmine's allegation and that despite '*lots of work*' the family were showing '*no insight*'. The document was however amended in July 2018 - it is not clear by whom - and refers to Jasmine's letter of retraction and states, incorrectly, that the family have '*stuck to the safety plan*'. It is assumed that these additional comments were made at the Legal Gateway meeting chaired by CSC8, at the end of July 2018.

8.5.22. The notes also state that the decision to issue legal proceedings had taken place with '*senior management and legal*' but that the case should be reviewed again at panel to record a decision not to issue proceedings. The retraction by Jasmine did have an impact on the evidential threshold for issuing care proceedings and this was reflected in the legal advice given.

8.5.23. The Review Team was told by CSC8, the chair of the LGM, that the complete set of Legal Gateway documents forwarded to the Review Team, not all of which had been fully completed, had not been seen as a full set. The decision not to commence care proceedings was therefore based on only limited information and without the benefit of s47 enquiries and the outstanding risk assessment on PM. It is not insignificant that additional information was added to the document bundle and again it is not clear by whom, at the end of July, which states that. '*Nothing happened… Jasmine does not understand the gravity of what she accused mother's partner of and*… '*PM is devastated' but has behaved sensibly*'. From these records it is clear that Jasmine's allegation was not believed to be true. Significantly, the safety scaling for Jasmine on that note had increased

to 7. It was unclear to the Review Team who had revised this, when several weeks earlier at a multi-agency strategy meeting, the safety scale had been 2/3. The only difference was that Jasmine had sent a letter retracting her original allegation.

8.5.24. The process which led to the decision not to commence legal proceedings in this case was not robust, based on sound evidence or subject to the expected level of management scrutiny. The Review Team has been told that significant changes have since been introduced and the process is now more robust and there is evidence of defensible decision-making, which is more supportive of both the child/family and also the social workers who express a view and offer their professional judgment. The Review Team was informed that the Legal Gateway meeting process has been subject to an external peer review which commended and validated the process. It would appear that, in this case, the Legal Gateway process fell below usual standards of decision-making, but this was not representative of wider practice.

8.6. KLE 3: The extent to which agencies worked together and collaborated

Information Sharing

8.6.1. Multi-agency meetings remain the key mechanism for implementing and progressing plans to promote a child's well-being, safety, and welfare. When these meetings work well, they ensure that everyone works collaboratively towards agreed goals so the very best outcomes for a child can be secured. There was evidence of good collaboration between agencies when the allegations against BFJ emerged in December 2017 and after MJ was arrested in January 2017. Key agencies were represented at the strategy meeting and at the Initial Child Protection Conference (ICPC) held a few days later, also attended by MJ, PM and MGM.

8.6.2. At the ICPC meeting in February 2017, Jasmine's looked after status was confirmed and a Care Team was established comprising of MJ, MGM, CSC3, and SCH2, its function being to support and monitor Jasmine's care and well-being. PHSN1 was also identified as a key member of the care team but as there were no identified health needs for Jasmine, and in line with agency policy, this professional did not attend any future LAC or CIN meetings during the period under review. As PHSN1 did not attend these meetings, the only agencies involved were, in effect, SCH2 and CSC. Minutes from the multi-agency meetings were however copied to PHSN1 until September 2017 after which time there would appear to have been no further communication from other agencies until Jasmine made the allegation against PM in March 2018.

8.6.3. The GP practice where Jasmine and MJ were registered was not invited to the ICPC meeting in February 2017. This appears to have been an oversight and although invitations to

subsequent LAC meetings were extended, the practice was not represented at any multi-agency meetings.

8.6.4. Jasmine's medical records held safeguarding information, noted as cause for concern, from 2011 and safeguarding information from 2017 which included correspondence about MARAC and BFJ. There was also a 'pop-up' indicating that Jasmine became a Looked After child in February 2017. There was however no other safeguarding information on file after then. There was no detail in Jasmine's medical records relating to her allegation against PM, the subsequent strategy meetings or any indication that the GP practice was approached to contribute to the planned s47 investigation, as would be expected.

8.6.5. Medical records for MJ indicated that she attended the GP surgery in early April 2018 and was seen by GP1. Although records indicated she was a parent of a Looked After Child, there was no other safeguarding information on her file relating to BFJ. MJ reported to GP1 that Jasmine had made an allegation of sexual abuse against her partner the previous day and she had been contacted whilst at work and told that PM had been asked to leave the family home. MJ said she was worried about what would happen. According to notes provided to the independent reviewer, MJ was advised to seek further support from Police and CSC. GP1 did not however confirm any of this information to CSC in line with expected practice and child protection procedures.

8.6.6. GP1 saw MJ in early May 2018, when she stated that CSC had not been in touch for three weeks, and her impression was that CSC and the police did not believe Jasmine. She was provided with a further sick note. There was a further telephone appointment with MJ and GP2 on 18th May 2018 requesting an extension of the sick note. On this occasion, MJ mentioned that many meetings with CSC were pending and that her partner was still out of the house. GP2 did not confirm this account with CSC.

8.6.7. Jasmine was seen by GP2 in June 2018, when she attended the surgery with MJ, who described Jasmine's low mood, crying and poor sleep. According to records, both Jasmine and MJ told GP2 about the stresses involving BFJ and Jasmine's allegations against PM and said although CSC had been involved, everything was now sorted. Again, there is no evidence that GP2 consulted with CSC both to acquire and share information – Jasmine's presentation in June 2018 was particularly significant - and to confirm CSC's involvement. The information from MJ, as the parent, was accepted without question and the GP clearly saw no need to seek corroboration of what had been shared.

8.6.8. Information about the alleged sexual abuse of Jasmine by PM was not referred by either GP1 or GP2 to, or confirmed with, CSC to determine their involvement and safeguarding information held in Jasmine's medical records was not included in her mother's medical records leaving open the possibility that important information about Jasmine's welfare and safety could be overlooked. When information about child sexual abuse is shared by a

patient or parent of a patient and there is no reference to this already on the GP system, the GP concerned should seek clarification of this information by consulting with CSC. Assumptions should not be made that other services are aware of the current situation. This is to ensure that the information or allegation is known to statutory agencies and that the GP is involved in any assessment and is kept updated of progress.

8.6.9. Expected practice would be that where safeguarding information is held on a child's records, systems should be in place to ensure that relevant information is also logged onto their parent's medical record. A cross check should also be undertaken of whether the information should be documented in other family member's records too.

Finding 5*: Neither GP1 nor GP2 confirmed with CSC what MJ had said about the alleged sexual abuse of Jasmine by PM and some important safeguarding information held in Jasmine's records was not included in MJ's medical records.*

Child In Need arrangements

8.6.10. When a child has been identified as needing services from the local authority, expected practice is that a multi-agency Child in Need plan sets out how agencies will work together and what services will be required to assist the child and family. Best practice suggests that to be effective, these plans, indeed any children's plans, should set clear measurable outcomes for the child and expectations for the parents and reflect the positive aspects of the family situation as well as the areas of concern. Although the elements of Jasmine's CIN plan were noted in the September LAC meeting and outlined in the report to the court, the detail of the plan, going forward, in terms agreed goals, expected outcomes and the means by which progress could be monitored and measured had not been agreed.

8.6.11. Professionals from SCH2 and the 0-19 PHSN team[29] informed the independent reviewer that in North Tyneside, CIN plans are usually agreed at the first CIN meeting and this arrangement usually works well. According to SCH2 records, a CIN meeting was held in October 2017 during which they were informed that MJ had completed the Capacity to Protect programme and MGM was undertaking a fostering course. It would seem there was no discussion about the need to produce a CIN plan or a safety plan for Jasmine and as this meeting is not referenced in CSC records there are no minutes to indicate what additional information was shared or what actions were agreed.

8.6.12. What is clear is that work to develop a CIN plan or the 'long term safety plan' referred to in papers presented by the local authority to the Court and confirmed in an email to Cafcass, prior to the October court hearing, did not progress. The views recorded in CSC case notes that professionals needed to be 'hyper-vigilant to [Jasmine's] situation' so potential future risks could be managed do not appear to have been shared with SCH2 so there was no

[29] *Public Health School Nursing service.*

challenge when the next CIN meeting did not take place until seven months later in May 2018, two months after Jasmine made her first allegation against PM.

8.6.13. Even if risks to Jasmine were considered minimal - and the fact that Jasmine was subject to a Supervision Order would suggest otherwise - it is important to understand why SCH2 did not query why formal meetings to develop and implement a CIN plan with family members were not happening. There is evidence that SCH2 was an active partner in work with Jasmine and her family. There was evidence of challenge when SCH2 questioned the local authority, with IRO1 about their plan to allow MJ to return home to care for Jasmine before she had completed the Capacity to Protect programme. This challenge was evidence of best practice and led to further discussions and an agreement that MJ should complete the programme before Jasmine could be returned to her care. The risks to Jasmine and the need for protective action were clearly understood by SCH2

8.6.14. SCH2 were aware that court proceedings had been concluded and that Jasmine was subject to a Supervision Order, which allowed MJ to return home to care for her. They had also been informed that the case was to be transferred to the social work team in October 2017 and a new social worker CSC4 would be working with the family. SCH2 said they were never consulted about a revised plan for Jasmine but as they remained in contact with MJ and continued to offer support to Jasmine, as a Child in Need, the absence of any formal 'multi-agency meetings' did not trigger any concern or challenge. The existence of a Supervision Order also left SCH2 reassured that any concerns would be picked by the allocated social worker.

8.6.15. Soon after Jasmine made the allegation about PM, school broke up for Easter and when Jasmine did not return after the holiday SCH2 contacted CSC4 for an update. Information was shared to the effect that Police were taking no further action against PM, but s47 enquiries were being undertaken and PM had left the family home. The multi-agency strategy meeting held in May 2018 and chaired by CSC6 in response to MJ stating that she wanted PM to return to the family was attended by SCH2, CSC4, Police and the Safeguarding Nurse Advisor from the MASH team.[30] The notes indicate that the s47 assessment agreed in March had commenced but the situation in terms of its progress was 'unclear.' This was a statement of fact, unusual in that it was made by the agency representative who had responsibility for ensuring the assessment was undertaken but, according to the notes provided to the Review Team, there were no questions or challenges by any of those present. The meeting used the Signs of Safety approach to map out strengths, concerns and challenges before making a scaling decision about Jasmine's safety.

[30] MASH (Multi-Agency Safeguarding Hub) is a team of co-located multi agency safeguarding partners, operating in a secure environment with access to their agency's electronic data, who research, interpret and determine appropriate information sharing in relation to children, young people (and vulnerable adults) at risk of immediate and / or serious harm

This was good practice offering opportunities for professionals to discuss and debate different perspectives about risk and safety within a shared framework.

8.6.16. Examining the notes provided from that meeting, the strengths identified related primarily to Jasmine's own resilience and the support she was receiving from school rather than any strength within the family and their ability to keep her safe. Conversely, the list of factors that professionals were worried about was extensive and included views that Jasmine would be coerced into retracting her statement and also that MJ had asked CSC4 what would happen if Jasmine retracted her allegation. These points and others, including that fact that Jasmine had remained consistent in stating that inappropriate touching had occurred, led to the safety scale for Jasmine's being rated very low – 2/3, suggesting a high-level concern about Jasmine's safety. There was agreement that MJ would be advised that should PM return to the family home, the local authority would instigate legal proceedings.

8.6.17. Two weeks later, Jasmine sent the letter to CSC4 stating that what she had told police and social workers about PM was not true. From SCH2 records it appears that CSC4 had already spoken with Jasmine when she attended a Care Team a few days later, and Jasmine had also talked with CSC4 about what SCH2 described as low level 'falling-out'. This meeting was an important opportunity to discuss concerns that Jasmine may have been coerced into sending the letter, but there is no evidence to suggest such a discussion took place, if it did then the review team have not had sight of any relevant notes or minutes. According to SCH 2, CSC4 said she was to speak to Jasmine again to further 'unpick' what Jasmine had said.

8.6.18. Expected practice would have been, on receipt of Jasmine's letter, for the strategy meeting to have been reconvened so Jasmine's retraction, the legal situation and concerns about Jasmine's safety could be discussed within a multi-agency setting and a way forward agreed.

8.6.19. SCH2 was informed at a Care Team meeting in early July that the family were moving, and Jasmine would be attending SCH3. The family indicated this was because Jasmine had been bullied at school, although SCH2 found no evidence of this. Although there was agreement that there should be a joint meeting between the schools and with CSC4, this meeting never took place and SCH2 did not query its absence. According to SCH2, they were unaware at this stage that PM had resumed contact and was living again living with Jasmine and her family. There was clearly some communication between CSC4 and SCH2 but the absence of any formal meetings or agreed plans meant that work with Jasmine and the family at this stage was ad hoc and not well coordinated.

The family and professional interactions

8.6.20. During a practitioner's meeting, professionals reflected on their engagement with MJ. Described at times as articulate, accommodating and cooperative, several practitioners

acknowledged a sense of unease working with MJ. Encouraged to explore this further, comments emerged from some practitioners that MJ was often overly keen to impress with her knowledge about safeguarding but was also overly familiar and seemed to view herself as more of a colleague than as parent about whom there were some concerns. It was suggested that this may have been a way to keep professionals at a distance, but some found her intensity and familiarity uncomfortable at times.

8.6.21. The possibility that professionals were discomforted because MJ was different from some other parents with whom they worked - she was challenging, articulate, held a professional position and claimed to know about child protection procedures - was readily acknowledged by practitioners who knew her. It was however pointed out that both FP1 and MW1 found MJ to be responsive and engaging, although FP1 shared her view about an 'intensity' in MJ, which she acknowledged could be off- putting to some professionals.

8.6.22. An additional factor highlighted in the practitioner's group was the extent to which MJ was viewed by professionals as a victim of abuse who had been manipulated and coerced by BFJ into meeting his sexual demands and humiliated by him when she tried to refuse. As a result, professionals reflected that perhaps they did not think critically enough about some of the information that came to light and consequently MJ was given the benefit of the doubt about her ability and willingness to protect Jasmine. There is little to evidence for example, that MJ was directly challenged or questioned ***in any depth*** by social workers at times when it would have been appropriate to do so: when incriminating material emerged which suggested she was implicated in the abuse of HS1 and HS2; when conflicting information about HS1's allegations came to light (July/October 2016); when despite the completion of the Capacity to Protect programme, MJ continued to cast doubt on what her daughter was saying about PM (March 2018); and when she went on holiday with PM despite the safety plan agreement (May 2018).

8.6.23. Practitioners discussed the possibility that there may have been elements of disguised compliance in the responses of MJ and PM, who presented as cooperative and responsive to professionals although this was not an issue which had previously been explored by any agency.

8.6.24. It came as something of a surprise to the professionals who had worked with and met MJ that other colleagues felt the same 'discomfort' with MJ's disconcerting familiarity and the ensuing discussion centered on the importance of professionals having opportunities to reflect not only in supervision but also with other professionals about how they 'feel' working with some families, as feelings invariably influence actions that are taken and decisions that are made. This conversation led to a helpful discussion around the benefits and challenges of professionals being able to meet in certain circumstances without the

presence of parents to make sense of their experiences in trying to help some families and to discuss how or if their own interventions are making a difference.

8.6.25. Feedback from practitioners who attended the practitioner's meeting and those who responded, amid lockdown regulations to draft 2 of this report, welcomed the idea of being able to explore how best to work collaboratively with some complex and challenging families. It was acknowledged that such meetings should only be held in certain circumstances and in response to clearly defined challenges, but the consensus was that this would be a welcome move to enhance multi-agency working. Not all members of the Review Team agreed with this view.

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

The family's move to Area2

8.6.26. The family moved to Area2 at the end of the school term in July 2018. Jasmine was still subject to a Supervision Order and would continue to be so for another three months. When children about whom there are concerns move with their families to another local authority, their safety and welfare can be compromised so liaison and appropriate information -sharing between agencies and authorities is crucial.

8.6.27. There is no statutory requirement for CSC to have notified the local authority in Area2 but best practice would have been for CSC to have made contact with the key professionals in Area2 and notify them that there was North Tyneside Social Care involvement, an allocated Social Worker, a CIN Plan and that Jasmine had been subject to care proceedings and was subject to a Supervision Order. This did not happen. Neither were school records transferred to Jasmine's new school and when health records were eventually transferred to the new GP practice, they did not contain some important safeguarding information.

8.6.28. SCH2 acknowledged that they had a responsibility to make contact with SCH3 and should have done so. They have now changed their system for the transfer of safeguarding information when children move schools and are confident that their revised processes and procedures will strengthen existing practice.

8.6.29. It is worthy of note that the Children, Education and Skills Sub-committee in North Tyneside reviewed in July 2018 the collaborative working practices of the authority to ensure they were improving outcomes for children and their families with a focus on the most vulnerable and those in need. The findings from that multi-agency exercise found evidence of good collaborative working relationships with its statutory partners, its neighbouring local authorities and internally. This would suggest the issues identified in this case are not

systematic of any wider issues, but are a reminder that without timely, constructive, and relevant information sharing between different agencies and local authorities, children can be left vulnerable.

8.7. **KLE 4: To what extent were the issues and complexities responding to familial child sexual abuse understood by professionals**

The challenges of working with Child Sexual Abuse

8.7.1. Current research[31] [32] about familial child sexual abuse suggests that around 1.3 million children living in England today will have been sexually abused by the age of 18. Around one third of reported cases will have been perpetrated by a family member or an adult known to the family network. Sexual abuse in the family has become the most common type of abuse counselled by Childline in recent years; it was also the most commonly reported type of abuse by adults calling the National Association for People Abused in Childhood's (NAPAC's) helpline in the year ending March 2019.

8.7.2. Responding to child sexual abuse in the family environment is complex. Research by the Centre of Expertise for Child Sexual Abuse highlights significant challenges for agencies, and professionals and suggests that it is important for professionals working in this area to be well trained and appropriately resourced in order not only to prevent abuse happening but also to identify, protect and support children who are have been or are at risk of subject sexual abuse.

8.7.3. There was recognition by all agencies from the outset that whilst Jasmine never alleged abuse by her birth father, she had nevertheless, grown up in the company and sometimes the care of adults whose sexually boundaries were blurred and who were later found to have sexually abused children. The concerns about MJ were appropriate as were the questions as to whether she could or would keep Jasmine safe from future sexual harms.

8.7.4. The practitioners who contributed to this review demonstrated knowledge and understanding about familial sexual abuse both in terms of its indicators and impact. Although they were clear about the practice and procedures of working with families where child sexual abuse was known or suspected, it was acknowledged that the work around familial child sexual abuse had to some extent been eclipsed over the years by the growing focus on child sexual exploitation. Views were however firmly expressed by some that Jasmine's refusal to cooperate with the police and the letter she sent retracting her allegation against PM should have been explored and discussed within a multi-agency context in the same way that initial concerns related to her safety and care were addressed.

[31] *Protecting Children from Harm Children's Commissioner 2015*

[32] *Key messages from research on intra familial sexual abuse. Centre of expertise on Child Sexual Abuse 2018*

8.7.5. There is a wealth of research which stresses the importance of listening to children and taking into account their wishes and feelings. However numerous SCRs highlight that professionals do not always listen well enough to children and can focus too much on the needs and viewpoints of the parents. In January 2020, a serious case review was published by North Tyneside Safeguarding Children Board [33] in which one finding, highlighted that in that case, professionals had not listened as well as they might have done, to what they were being told by children or took pains to 'hear ' what the children were trying to say. The Review Team was reminded by CSC of the 'difficulties' [for the agency] following Jasmine's clearly written retraction and her insistence to CSC4 that she had lied to police and social workers and having 'listened' respected what they were told, namely that the abuse did not happen.

8.7.6. Listening to children and taking into account their views and wishes, cannot be overestimated, but professionals do need to interpret what they are told by children and take into account a wide range of factors which then need to be balanced against the need to safeguard their welfare. At times this may mean overriding the wishes of the child and young person and not accepting what they say at face value.

Understanding why children retract

8.7.7. Whilst holding in mind the need to be balanced and to give sufficient weight to all possible hypotheses, there is a need to apply current knowledge and existing theory about sexual abuse in the family to practice. This requires professionals and their managers to use their judgment and manage uncertainty so children are supported and can, when needed, be protected from sexual harm.

8.7.8. When a child retracts an allegation of sexual abuse, it can pose problems for both civil and criminal proceedings. Research[34] suggests however, that the examination of retraction statements do not often receive the same careful attention, as the investigation of the original allegation. There is certainly little to evidence that Jasmine's responses both in terms of what she told PO1 the day after she made her allegation and the letter she later wrote retracting what she had said, were well considered from a multi-agency perspective or carefully evaluated. Had they been so, it may well have added to the concern about Jasmine's allegation rather than casting doubt upon it.

8.7.9. Doing justice by and for children, and keeping them safe, requires professionals to acknowledge that not everything that every child says will necessarily be 'the truth', just like adults, children can be mistaken, confused or dishonest. The message and evidence of children is of central importance to the work of child protection professionals, but the task

[33] *NTSCB. Serious Case Review Claire and Anne, January 2020*
[34] *The evaluation of retractions in child sexual abuse cases. Tulley (2002*

of protecting children who make or retract allegations of abuse is more complicated than simply accepting their accounts at face value.

8.7.10. Social workers face significant obstacles in trying to evidence concerns about a child being sexually abused but decisions on whether to act or not, need to rest upon one central question - 'on the balance of probabilities, is the evidence enough to intervene?' These are complex decisions, whatever the nature of the suspected abuse; however, when it comes to child sexual abuse, a 'secret' crime for which there is often very little medical or forensic evidence, the challenge for professionals is even more complicated.

8.7.11. In Jasmine's case, she was subject to a Supervision Order, which meant she was already recognised through a court process, as being a vulnerable child who met the threshold for the highest level of concern. Jasmine's insistence that she had made up lies about PM, together with the lack of any medical or forensic evidence may well have weakened any case for public law care proceedings, whatever the reason for her retraction. Nevertheless, it remains puzzling as to why, given documented concerns that Jasmine would be pressurised into retracting her allegations which until then she had consistently claimed to be true and, importantly, what is known from research about why children retract allegations, actions agreed at the Legal Gateway meeting in July without reference to any agency partners, were based on a view that Jasmine had lied about PM.

8.7.12. In all the key decisions that need to be made in child protection work, it is not a matter of choosing between one view and another, it involves weighing up on the balance of probabilities what might be happening or what might have happened to a child and taking action accordingly based on careful consideration of a different hypotheses. These challenges are well researched and are further compounded when there is no forensic or medical evidence to support the view that sexual abuse has or may have occurred. However, the civil threshold of '*on the balance of probabilities*' does not appear to have been well considered in Jasmine's case.

8.7.13. Jasmine's letter did not spark enough healthy scepticism by CSC professionals, as might be expected, evidenced by the decision not to seek the views of other professionals but to speak only with Jasmine about her letter. The independent lead reviewer was told that Jasmine insisted 'several times' to CSC4 that she had lied about PM and had not been pressured into withdrawing her allegation. However agency records also evidence a degree of bias in agency records which describe PM as being '*devastated*' [by the allegation] but was nevertheless '*being sensible'* Records also refer to there being 'no evidence' to suggest that what Jasmine had alleged, had happened. This may have been the case or not; what was missing was any evidence that the content, context and circumstances of Jasmine's retraction had been as carefully and well considered by CSC and agency partners as was her initial allegation.

8.7.14. Upon receipt of Jasmine's letter and information from CSC4, the agency sought legal advice and were advised that the evidential threshold for care proceedings was no longer met. CSC consequently made a decision not to commence legal proceedings in respect of Jasmine as planned, but did not consider any other option including resorting to child protection procedures and pursuing the missing s47 enquiry which had already been commissioned as a response to an acknowledged and accepted risk. This would have provided additional information taking into account all that was known about Jasmine's background and her family and, regardless of what she said, would have supported a well-considered decision as to whether Jasmine was more than likely than not have been abused by PM.

8.7.15. CSC4 said that Jasmine was adamant that she had made up the allegation and stuck to her story that she was angry at PM for taking her phone. CSC4 said Jasmine's sincerity and that of PM who continued to state that nothing had happened convinced CSC4 that Jasmine had indeed acted '*in a rage*' when she made the allegation. The family also told CSC4 that they were moving to Area2 because Jasmine had been bullied at SCH2 but would still cooperate with any outstanding work in respect of PM's assessment. This information was conveyed to the Legal Gateway meeting.

8.7.16. In this case there was an over-reliance on the views of only one practitioner and this was influential in maintaining the status quo, i.e. that Jasmine's safety would be assured through the continuation of the Supervision Order and PM's contact with the family could be resumed. This 'single' agency approach to managing Jasmine's letter of retraction inhibited alternative views being shared and debated and it remains unclear why this course of action was pursued rather than re-convening the strategy meeting. With a degree of healthy scepticism, it is noted that by the time this decision was taken, the family had already moved out of the area and into another local authority, which, it could be argued, may have impacted on decision-making.

8.7.17. Every day, social work practitioners make decisions about the wellbeing of thousands of vulnerable children and families. These decisions are often complex, concerning emotive issues in conditions of uncertainty. They are often made under both time and resource pressure. Statutory children and family social work is all about managing risks and making good-quality decisions. To do this successfully, professional judgment and information about risks and how they are managed and addressed needs to be shared between professionals and managers at all levels. The independent reviewer was however left with a view that in this case, without the support of agency partners or robust managerial oversight, CSC4 alone was left with the brunt of the responsibility for determining whether or not Jasmine was being truthful about the abuse.

Finding 7: *Jasmine's allegation against PM 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 agency 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.*

8.7.18. Research[35] highlights clear evidence of the powerful and central role that relationships play in adolescent's well-being and the importance of a trusted relationship between vulnerable or abused children and practitioners was highlighted in four major multi-method qualitative reviews of child sexual abuse and child sexual exploitation in the UK. It has not been possible to appraise the work that was reportedly undertaken with Jasmine or comment on its effectiveness. Without access to Jasmine's views and insights it is difficult to glean whether a trusting relationship had developed with CSC4 which allowed Jasmine to talk freely and with confidence not only about her life at home but also about the circumstances that led to the allegation and those which led to it being withdrawn.

9. Concluding Comments

9.1. Child sexual abuse in the family environment is complex area and presents significant challenges for professionals who have a responsibility to prevent abuse happening and to protect children where the risk of sexual abuse is known or suspected.

9.2. The number of children on Child Protection plans because of sexual abuse has fallen over the past two decades; it is now the lowest category for Child Protection plans, far below those for neglect and emotional abuse. Research[36] suggests that these statistics may reflect changing trends in priorities, with some forms of CSA slipping down the agenda as local authorities and partner agencies have focused specifically on child sexual exploitation and prioritised other issues such as the impact of domestic violence on children. It may also reflect professional and organisational challenges, about how best to respond to sexual abuse in the family: the challenges of obtaining evidence of a hidden crime, working with denial and disbelief and, as in this case, managing retractions and finding ways of protecting children in a complex and emotionally charged family context.

9.3. Overcoming these challenges requires confident professionals in all agencies who fully understand the complexities of working with children who have been or who may have been sexually abused in the family environment. It also means understanding the importance of effective safety measures designed to keep children safe, such as

[35] *World Health Organisation (2014) Health and Well-being of Young People*
[36] *Multi-Agency response to Child Sexual Abuse in the Family (JTAIs) 2020*

Supervision Orders and safety plans and knowing when and how to challenge if these are not working or not in place. It is equally important that professionals in all agencies understand that although there may not be evidence to secure a conviction, or an allegation of sexual abuse is withdrawn, this does not mean that agencies should retreat or that the alleged abuse did not take place.

9.4. This review found evidence of some good practice when sexual risks around Jasmine's safety emerged; the response by agencies, and CSC specifically, was prompt and focused and Jasmine's interests were well served. SCH2 was consistent in their support for Jasmine. The review has highlighted the importance of multi-agency working, managerial oversight and good supervision and importantly, the need for professionals not only to understand the impact on children when sexual abuse in the family occurs but the importance of them remain open-minded about what they are told whilst remaining persistent and curious about the child's lived experience.

10. Summary of Findings

Finding 1: *Despite multi-agency concerns about MJ's perception and distorted thinking about the kinds of people who abuse children, PM, as MJ'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.*

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.*

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.*

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.*

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

Finding 6: *Some warm, responsive, or challenging parents have the capacity to disarm professionals and deflect their concerns. In this case, professionals who knew MJ and PM 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.*

Finding 7: *Jasmine's allegation against PM 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.*

END/

Appendix 1

Agencies involved in the Serious Case Review

Role	Organisation
Business Manager	North Tyneside Safeguarding Children Board (NTSCB)
Administrator	(NTSCB)
Independent Reviewer	Linda Richardson
Designated Nurse Safeguarding Children & Chair of the Review Team	North Tyneside Clinical Commissioning Group (NTCCG)
Designated Doctor Safeguarding Children	Northumbria Healthcare NHS Foundation Trust (NHCFT)
Named GP Safeguarding Children	North Tyneside Clinical Commissioning Group
Senior Manager Quality Assurance	North Tyneside Children's Social Care
Safeguarding and Public Protection Manager / Named Nurse	Northumbria Healthcare NHS Foundation Trust (NHCFT)
Safeguarding Lead	NTC 0-19 Service
Det Chief Inspector - Safeguarding	Police
Acting Named Nurse - Safeguarding	NHCFT
Head Teacher	Sch2
Head of Student Welfare	Sch3