Norfolk Safeguarding Children Partnership

Child Safeguarding Practice Review

Case AO – Jasmine

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Case AO – Jasmine

This is a safeguarding practice review (SPR) that draws upon the experiences of Case AO. SPRs are often known by their case designation, in this instance it is Case AO; this is to preserve anonymity and confidentiality. However, as a review group, we have chosen to give Case AO a name – Jasmine. By using a name this reminds all of us that behind words and numbers there was a young person with thoughts, emotions and experiences.

1. Jasmine - The vibrant young person

The family and the professionals that worked with Jasmine, without exception, all expressed immense respect, warmth and love towards her. Jasmine[1] was described as a vibrant, charismatic girl/young person who would leave you in no doubt as to how she felt about you. Jasmine was funny, smart, likeable and independent. She took great care of her appearance, always trying to look her best and was proficient at doing hair and make-up on herself and others. She liked going to parties and raves. She was well liked by her peers, offering support and guidance to people she attended school and college with. She could sometimes be feisty or aggressive which did get her into trouble. However, as she got older, she would listen and reflect on her conversations with professionals and look to learn from them. It was recognised by Jasmine and others that she had challenges in managing her emotions, and this impacted her responses and behaviours. Jasmine was fiercely protective of those she loved and also recognised how much she was loved by people around her, especially her father and paternal grandmother, with whom she had close relationships. Jasmine's mother lived out of area, and although Jasmine did spend time with her mum, this was on a sporadic rather than regular basis. During her teenage years, Jasmine had built some strong and meaningful relationships with key professionals, and she came to learn that these key people really did want to support and safeguard her.

The Jasmine described is evident in her very last Looked After Child Review just three days before her death. At this review Jasmine was described by professionals as positive (despite some setbacks) and looking forward to her future as she neared her 18th birthday, however, her paternal grandmother had concerns about her at the time and thought she presented as 'very low'. Despite these differing views, Jasmine engaged in the care review and the person that comes through is a young person able to express her wishes, feelings and choices whilst acknowledging the concerns that people expressed in wanting to keep her safe.

This safeguarding review will highlight that Jasmine's (earlier) life was characterised by instability, unsettled care, and having to negotiate a myriad of professional relationships. Through it all she was described as a 'light' in people's lives.

Jasmine died in November 2024 at 17 years old.

[1] Jasmine's heritage was white British

2. Review Process

2.1 Why was this review commissioned?

A Local Safeguarding Children Practice Review (LSCPR) is undertaken when a child dies or is seriously harmed as a result of abuse or neglect and there is learning that may lead to a change in practice within the safeguarding system (Child Safeguarding Practice Review Panel, 2025). This review was commissioned by the Norfolk Safeguarding Children Partnership following a Rapid Review process in which the statutory partners decided Jasmine's death met the criteria and this decision was ratified by the national Child Safeguarding Practice Review Panel (CSPRP).

2.2 Purpose of review

The purpose of a review is not to seek blame but to identify learning for agencies and practitioners involved in safeguarding by considering the system as whole through the practice that took place. Since 2018 the emphasis has been on the 'why' rather than the 'what' (Dickens et al, 2023) which means a move away from a description of what happened to an analysis of events, therefore this review does not give a detailed breakdown of events. One of the critiques of reviews has been that they churn out the same lessons, what Wood (2016, p.8) called "predictable, banal and repetitive"; whilst this may be true, it is worth emphasising that identification of novel learning does not necessarily mean that previous learning has been embedded and no longer needed. It is, also worth noting that learning should not only account for where the system needs to improve, but also for where the system is doing well, and this case presents some novelty in terms of the good practice employed. Therefore, this review has remained open to all learning, mindful that the only way to know how the system is functioning is through feedback (Munro, 2011).

2.3 Methodology

2.3.1 Who has been involved

This review has been led by the lead reviewer, the author of this report. The author is an independent reviewer with no connections to Jasmine or the professionals and organisations involved. The process has been supported by a panel of agency representatives from across the partnership. The panel members hold senior positions in their own organisations but have not had any previous line management involvement with the practice, oversight or decision-making regarding Jasmine.

The lead reviewer did have the privilege of meeting with Jasmine's paternal grandmother and her partner who kindly shared their thoughts and feelings with regards to the agencies and the people who worked with Jasmine. These reflections are referenced, where relevant, within the analysis and we thank the family for meeting with us. There were approaches made to Jasmine's father and mother, through members of the partnership, but Jasmine's parents either declined to meet with the lead reviewer or did not respond to the invitation to participate.

Unusually for a LSCPR, because Jasmine was a 'Looked After Child', there have been many examples of where we have been able to 'see' and 'hear' Jasmine's own words. As you will see through the review, professionals actively sought Jasmine's thoughts and feelings, and she would share these with others. Consequently, there are records of how she felt about her experiences (including video) and these have been drawn upon in writing this.

A Learning Day was held with professionals, managers and agency representatives who had direct experience of working with or management knowledge of Jasmine. The learning was explored via two approaches: the first was through the work of the partnership with Jasmine; and the second was a broader look at transitional safeguarding with the 15–18-year-old cohort in Local Authority (LA) care. The learning day is drawn upon more extensively within the analysis.

2.3.2 Note on Language

Jasmine was seen as an independent and resourceful young person. In some instances, people called her resilient while others highlighted that her outward appearance of resilience hid her vulnerable circumstances, contributing to the adultification of Jasmine by those who engaged with her. Adultification refers to the perception and treatment of children as more adult than they are, placing more responsibility and expectations on the young person particularly within the youth justice framework (Davis & Marsh, 2020; Goldson, 2013). There is a danger, that in writing about Jasmine, this report perpetuates the adultification, but it should also be acknowledged that while Jasmine was still a child according to safeguarding legislation, she was nearing her eighteenth birthday.

There has been a concerted effort across the safeguarding system, in response to learning from where children have been exploited, to emphasise that all under 18's are children. This is to recognise that what professionals may view as a 'choice' is in fact influenced by the vulnerabilities experienced by the child. It is also in law that people aged 16 and over have the assumed capacity to make decisions as it relates to their life, unless assessed as otherwise under the Mental Capacity Act 2005. Recognising capacity is about accepting individual rights and agency which must also be balanced with safeguarding requirements. The decision to refer to Jasmine as a child or young person has been a difficult one given the context; however, this review will follow the convention used in recent research that acknowledges the voices of young people this age and will therefore predominantly refer to Jasmine and her cohort as a young person/young people throughout the report.

Adultification can also lead to inappropriate language used to describe the activities and experiences of young people such as when professionals discuss child sexual or criminal exploitation. It is important to recognise how the context, such as the element of coercion or wider systemic issues, relate to the young person experiencing vulnerability and risk, therefore, it is sought to frame exploitation within these conditions. It should, however, be noted that there may be examples of language used either by professionals or Jasmine herself that may not do the same.

Finally, whilst reviews tend to use the formal monikers of 'father', 'mother', 'grandmother' and so on, in this review, reflecting how Jasmine spoke of her parents and paternal grandmother, the terms 'dad', 'mum' and 'granny' will also be used.

2.3.2 Parallel proceedings

Two separate proceedings took place in conjunction with this review. (1) The Norfolk and Suffolk Foundation Trust conducted a Patient Safety Incident Investigation (PSII) Report following Jasmine's death which was shared with the lead reviewer. (2) An inquest took place in autumn 2025, which found that the cause of death was drug related.

2.4 Key Lines of Enquiry

This review was commissioned to understand what learning could be taken from the last two years in Jasmine's life: November 2022 – November 2024. The keys lines of enquiry agreed by the panel were:

- What evidence is there of the impact of the joined up multi-agency response to Jasmine, including understanding her lived experience, consistent child-focused practice and the importance of building trusting relationships?
- How well do we support our adolescent LAC as they mature and explore their independence? What do we do to help support their resilience, risk awareness and risk management in the context of historical adversity and trauma?
- What did agencies understand of the relationship that Jasmine had with her father and the implications this had for her relationships with others? How did this impact the implementation of safety planning? How well did we understand father's parenting capacity?
- How do professionals know, understand and manage agency and risk when working with adolescents using alcohol and drugs? How does this inform our assessment of risk of exploitation? How effectively were any potential risks communicated across the multi-agency professional network?
- How are developmental, transitional and mental health issues understood and supported within this? What consideration and understanding is there to mental capacity within this cohort and how adolescents' exercise agency?

3. Key people and events

Jasmine's life was complex and there was a wealth of information provided to the review group regarding her experiences. In line with moving away from description to analysis, the snapshots offered here are merely that – snapshots, an approach that illustrate Jasmine's experiences for analysis rather than giving a detailed breakdown. There are periods of Jasmine's life that have not been included, not because they are not important, but because Jasmine still has a right to privacy.

Although the review period is November 2022 to November 2024 in which Jasmine was 15 – 17 years old, Jasmine had been known to Children's Services (CS) since she was two years old. Therefore, whilst out of scope, it is relevant to understand what happened to Jasmine as the context of her early experiences will undoubtedly have influenced her experiences and her actions during the later stages of her life.

3.1 Key events pre-November 2022

Jasmine's life was characterised by uncertainty and instability. Having been the subject of Child in Need and Child Protection interventions from a very young age, Jasmine would not have consciously known a time when there was not professional involvement in her life. The concerns for Jasmine related to her parents' drug use and domestic abuse within the family. In addition, both parents spent time in prison. After the parents' relationship broke down, Jasmine spent time living in various family homes including with each parent separately and the homes of paternal and maternal grandparents. In November 2016 a Care Order was granted with a plan for long term fostering. Jasmine lived with several different foster carers but none of them lasted any significant time.

Paternal grandmother's reflection was that she advocated for Jasmine to be in a placement where she was the sole child, but this never happened. Granny also raised the frequent changes in social worker and said Jasmine was assigned to over 20 different social workers in her lifetime. The timeline of Children's Services involvement from November 2018 to November 2022 details five changes in social workers. As Jasmine got older, she made it clear she wanted to live with her dad, and at one point this was pursued through a parent capacity assessment. Although the Care Order was not discharged, in June 2020 dad's address was agreed as a place that Jasmine could stay. In January 2022 Jasmine and her dad moved into social housing provision. A number of complaints regarding noise, parties and drug usage were received by the district council's (DC) Anti-Social Behaviour (ASB) team and responses to these complaints were gradually escalated.

With all the address changes, it meant that Jasmine attended six different primary schools. An Education, Health and Care Plan (EHCP), completed in July 2019, details staff members remembering Jasmine's intelligence, thoughtfulness, empathy and describing her as "*very special*". The EHCP recognised that Jasmine struggled to maintain friendships as she tended to want to control situations and could be intimidating to others. But she could process information quickly and liked problem-solving, and when not feeling threatened was "*quick-of-mind, articulate, funny, caring and compassionate"*. Although Jasmine started at a high school, by the end of Year 7, she was placed in alternative education provision. Paternal grandmother reflected that she had suggested on a number of occasions that Jasmine be enrolled in mainstream education on a part time basis with one-to-one support. Because this did not happen, it left Jasmine "*to her own devices during the daytime*". In October 2021, Jasmine had an Education Other Than At School (EOTAS) package in place that continued into the review period and she was able to able to build some good relationships with the staff across the two provisions she attended in a shared timetable between the two provisions – Education1 and Education2.

As a teenager she was arrested several times and participated in informal Youth Justice interventions. From 2018, she came to the attention of the Multi-Agency Child Exploitation (MACE) team and this is where she was first referred to work with MACE1, a staff member employed by the police to support young people at risk of exploitation. MACE1 became an enduring constant, providing challenge and support for Jasmine. From 2018 to 2024, Jasmine was regularly discussed at the Child Planning Meeting (CPM), which are held depending on the risk for a child, so a high risk equates to weekly meetings. Jasmine fluctuated between high, medium, and standard risk, and at times being stepped down from needing MACE support. In June 2021, Jasmine was referred to the Targeted Youth Support Service (TYSS) and here she met YW1. YW1 came to be a very important person in Jasmine's life, which Jasmine expressed her gratitude for:

"*I would always give [YW1] a 10 - she has been with [me] for the longest, she gives me her time and isn't scared to tell me as it is, which in a funny way I kinda respect!"*

There is little detail of health services engagement with Jasmine prior to the review period. However, the records show a police referral that meant Jasmine was placed on a waiting list for review within the Looked After Child Healthy Child Programme. The EHCP refers to a social worker referring Jasmine to a Looked After Child health intervention for emotional support but there is no evidence that this support ever started. Jasmine was admitted to hospital in June 2022 following a

paracetamol overdose. Information recorded at later date details that a follow up appointment with CAMHS was recommended but there is no evidence that this happened.

Reflection - What might have Jasmine's experience been like?

The information provided illustrate a childhood for Jasmine characterised by instability and intermittent care. She came to the knowledge of Children's Social Care from the age of two but continued to live in a household where substance misuse and domestic abuse were known. This must have been bewildering, noisy, lonely and scary, requiring Jasmine to find coping mechanisms to soothe herself. The possible impact of her earlier childhood was not explicitly recognised until later in her life and she never received any therapeutic intervention for her experiences. Even though she did well and was recognised as a bright child, each school move would have necessitated the need to build new relationships with peers and teaching staff. Jasmine learned to be self-sufficient and hypervigilant because she never knew how long someone would be in her life and what safety they may offer. Jasmine had to build relationships with many professionals, none of which lasted for long periods of time, yet despite this, she showed hopeful patterns of behaviour as she continued to try and build relationships with the adults she liked. The institutionalisation of Jasmine meant she had learned to curate what she said to avoid problems or unwanted change and learned to put barriers up with people she was not interested in getting to know. It must have been upsetting/disconcerting/worrying for her when she had emotional outbursts, lashing out to others without knowing why this happened and yet there were no prolonged interventions to help her manage her emotions or to understand her own experiences. She always returned to her father and their bond was evident to others. However, whilst there is evidence that this bond was recognised, paternal grandmother reflected that dad had never been offered specialist parenting support, and records also show that professionals found him to be aggressive, unresponsive and intimidating. It must have been hard for Jasmine knowing the one person she wanted to live with was unable to provide her the support she needed and despite all the professionals involved, that never changed. Her eventual ennui about all the temporary relationships she had in her life were evidenced in December 2023 when she first met her new Youth Justice case managers following a court ordered Referral Order for drug supply. Jasmine said to her workers:

> *"No offence, cos I'm sure you're both lovely, but I don't want to have to get to know you, I just want to start the work."*

3.2 Key Events November 2022 – November 2024

There is extensive information provided in the rapid review of the review period, including a detailed chronology of key events which was compiled for the whole review period. It is not the purpose of this review to provide the full detail, instead, discrete episodes of time will be presented that illustrate what Jasmine experienced and offer anchor points for the analysis that follows.

3.2.1 November/December 2022

Jasmine was 15 years old in November 2022 and the care plan for her was working towards discharging Jasmine's Care Order in favour of a 12-month Supervision Order with her dad. In November 2022 Jasmine was closed to TYSS and deemed to be no longer at considerable risk of exploitation, however, she was aware that she could contact YW1 (and did do on occasions) even when closed to TYSS. Her school attendance dropped significantly from October onwards and SW1

notes at a later point that Jasmine had stopped "*engagement with other professionals*" following the TYSS closure. In December, multi-agency meetings and communication between professionals expressed growing concerns about dad, the problems at the address they were living at and Jasmine not meeting with her social worker or attending school. As a result, the pursuit of the discharge order was stopped. Jasmine's social worker at this point had been with her since March 2021.

Education 2 followed up non-attendance with Jasmine's social worker and with family members. Jasmine had said she had a cold, but also a few days later told her social worker that she was feeling too low to attend Education 2. Jasmine had a few missed opportunities to engage with universal healthcare during these months including not wanting to wait at the walk-in health centre and a missed dental appointment. In addition, both the Looked After Child health team and Neurodevelopmental Service (NDS) had been trying to contact Jasmine for a health check and for an assessment regarding ADHD. Following advice from the social worker on how to engage with Jasmine, the NDS team were then able to reach her and Jasmine confirmed she would like to go ahead with the NDS assessment.

Despite the move away from the planned Supervision Order, the care plan allowed Jasmine to remain with dad with support until her 16th birthday in March. However, further concerns emerged regarding dad and his activities. Just before Christmas, dad's Probation Officer contacted Children's Service to raise safeguarding concerns and notify them that dad was being recalled to prison due to breaching his release conditions. Jasmine was very upset at dad's arrest and his recall. In a reflection with YW1 she wrote "*Dad is back in prison and I feel alone and abandoned*".

During this period, the district council issued Jasmine and her dad a Stage 1 ASB Warning Letter due to the "*excessive noise, parties and general anti-social behaviour*" and with further complaints, the ASB team looked to serve Jasmine's dad a Community Protection Warning. This did not happen once dad was recalled to prison as it did not then meet the enforcement threshold.

In December 2022, Jasmine was referred back to the TYSS and assessed as medium risk of exploitation. There were concerns regarding three young males, known for drug involvement and county lines activity, seen at dad's flat with Jasmine and she was often at the flat without adult supervision. The later period of December, Jasmine moved between (or said she was at) a few different addresses and was reported as missing when she failed to turn up for a meeting with YW1. Twice the police found her at her dad's flat and each time she was returned to granny's care. Late December, police notified partners that Jasmine was in a relationship with someone who had known gang association. There was, also, an incident in which the police firearms team were deployed to the area following a call from a male on Jasmine's phone saying there were masked men with knives around the area. At this point, the police requested an urgent lock change at dad's flat and locks were changed on the home at the end of December. A social care assessment was planned to commence on a family friend identified by Jasmine to offer a safe base for her in Norwich after three other people were deemed not safe.

Reflection – what does this highlight?

This period was not unusual when looking through the timeline of Jasmine's life and it highlights several significant areas to consider:

- Jasmine loved her dad and wanted to be with him, but it was a complex relationship.

- In any one month, there was a lot happening for Jasmine. Her life was disordered, and she was regularly missing, being contacted or sought after by a number of professionals.
- There were a lot of professional concerns regarding her peers who were known to both the police and the youth justice team; at times this included concerns about Jasmine's partners and the risks of exploitation and domestic abuse.
- Jasmine's interactions with professionals were not consistent; with some agencies she had patterns of engaging and then withdrawing – this was similar to her dad's pattern of working with professionals. The case notes discussed Jasmine's attachment style but this was never formally assessed.
- The network of professionals did meet regularly and tried to share up to date information – during November and December alone, Jasmine was discussed at five different multi-agency meetings. There was a trail of updates and notifications through email and phone calls between different parts of the network.
- Paternal grandmother was seen as a safe adult however granny was unable to stop Jasmine from going back to Norwich, and there is little evidence of how professionals explored this with granny.

3.2.2 May/June/July 2023

These three months marked the lead up to Jasmine's dad being released from prison.

Prior to May, Jasmine had moved into her Semi-Independent Accommodation (SIA) and had a new social worker – SW1 (both events happened in March 2023). At first, Jasmine refused to meet SW1 but a meeting was mediated by YW1. A referral to the Child and Adolescent Mental Health (CAMHS) had been made by the GP and the referral was declined – the interviews and learning day discussion highlight differences in opinion as to whether this was due to insufficient information or not considered to have met the threshold. Jasmine's attendance at her education provision had fallen significantly, and she was often not present at her SIA and reported as missing. Her risk of exploitation had gone from high to standard by the end of April.

At the beginning of May 2023, a meeting for Jasmine's Personal Education Plan (PEP), was held but Jasmine did not attend. Her overall education attendance was recorded at 16% and although her input was limited, Jasmine had shared that her low mood made it difficult to attend. She also agreed that YW1 could share with SW1 and the education providers that "*Coming to school is not on my list of priorities at all*". It was agreed that she would have a phased return. Between July 2023 and September 2024, Jasmine was out of education and therefore an opportunity to provide stability and further supportive relationships was missed. During this period, in key meetings such as the CPM, education representation is missing and there was no record of her education being discussed.

Two days later Jasmine was seen by SW1 and tells SW1 that she was going to London to stay with friends in a hotel overnight. They had a conversation about how Jasmine would keep herself safe and she also agreed to provide the address of the hotel and to keep in touch with her placement. Jasmine and SW1 had an open discussion about Jasmine taking drugs, although Jasmine said often she did not have the money to pay for them. The next day, she called the SIA twice; the first time she was worried that she had lost her friends and was stranded in London but later in the day, she called to say she was with her friend, and they were getting the train back to London. Jasmine arrived back safe and well. During May, the Education safeguarding team received seven notifications of Jasmine

being missing from care/home. However, Jasmine also had other periods away from home, not recorded as missing as she stayed in touch with key people such as YW1, SW1 and MACE1. Whoever she called, they would have a conversation about how Jasmine was keeping herself safe and whether Jasmine needed help getting home. In June she moved into a SIA closer to the city centre.

During May, Jasmine was suspected of assaulting another young person and in June she was arrested several times. These arrests included possession of drugs and a serious assault on another young person. Following an arrest for drugs possession in which she was found with six small bags of suspected ketamine, it was noted that she was arrested alongside two males who were suspects in an armed robbery. Jasmine was seen by the mental health Liaison and Diversion Service while in custody but she gave minimal responses to the worker. Children's Services (CS) note a contact made by the mental health service to discuss referrals for Jasmine. The notes recorded do not specify what the referrals were or whether this was actioned or followed up. The only record of possible follow up is a referral received by mental health in June 2023 which resulted in an assessment in January 2024. She was also given a Referral Order for intent to supply Cocaine and Ketamine.

Dad was due to be released from prison in July. In conversations with YW1, Jasmine talked of her anger and shame about her dad and his relationship with someone who was one of Jasmine's peers and a former friend. When Jasmine committed the serious assault, it was because a young person had said something about Jasmine's dad, and this had been the catalyst for losing control. As often happened in their conversations, Jasmine was reflective and thoughtful and would look to learn from YW1. This aspect of Jasmine was identified in the 2019 EHCP. As a testament to the relationship between Jasmine and YW1, Jasmine said the following:

"I am so glad you have been my youth worker, and that you have stuck with me for so long - you have helped me and we have had some really good conversations - thank you for being there for me even when I thought I didn't need anyone"

The SIA placement had raised concerns about Jasmine's behaviour and that they were struggling with managing it. There was an incident in which Jasmine was intoxicated, arrested for assault and when in custody found unresponsive. She was taken to the ED at the local hospital. This was followed by a period of eight days in which Jasmine does not return to her placement. During this time she was seen by SW1, YW1 and MACE1 on different occasions and told each of them that she was staying with friends with the plan to return to dad's care when he was released. Following the hospitalisation, there was an email exchange between a Clinical Psychologist from the children and young person's Looked After mental health team and SW1 noting the increased drug taking and risks. Two weeks later there was another exchange in which SW1 requested an update with regards to the mental health assessment. The week following, Jasmine was discussed at the mental health team 'huddle' and the team offer an initial assessment at the end of July (which takes place in January 2024).

Reflection – what does this highlight?

These three months highlight behaviours and practice that are present across the whole review period:

- Jasmine was regularly using Class A and Class B substances; this resulted in being hospitalised on more than one occasion. Her behaviours and peer group at this point

increased risk and unpredictability. This is indicative of the reasons for the risk categorisation in MACE moving frequently.

- Jasmine's continued struggling with her emotions particularly concerning her dad: when she felt threatened, she was unable to manage her emotions in a safe way but when she felt secure, she could reflect on what was happening for her. This pattern was first recorded formally in 2019 in her EHCP.
- Jasmine built some strong, enduring and respectful relationships that included her youth worker – YW1, her social worker – SW1, the safeguarding lead at Education 1 – DSL1, and her police MACE worker – MACE1. The professionals that worked with Jasmine did have frank, honest and challenging conversations with her and when in a positive emotional state, she was able to listen and reflect. The identified professionals and her Youth Justice worker talked about how they recognised that Jasmine had not had a typical childhood, meaning she acted older than her years. To address this, they spoke of doing other activities with her, for instance, YW1 gave lovely examples of doing "*childish*" things with her like playing on the swings in the park
- Despite verbally disclosing issues with her mental health and wanting support, there is a lack of clarity over communication and intervention between mental health services and the wider network.

3.2.3 July-September 2024

By July 2024, Jasmine had been in a relationship with a new boyfriend Matthew[2] for a few months. Jasmine would stay with Matthew and his family, experiencing what she called a "normal" family life. Professionals working with Jasmine noted the stability that she was experiencing although she was still using drugs and alcohol. She had visited her mum in London for a few days. Her work with YW1 had come to a positive close in April 2024. She had her mental health assessment in January 2024 and she commented:

"*I am looking forward to finally getting therapy and being supported by CAMHS, I'm glad that you [YW1] and [SW1] were doing all these bits in the background for me because I need this help, because I am so low and I recognise that I need this"*

In July 2024, following a period of living with dad, Jasmine moved into a new SIA. The mental health team had been trying to contact her to arrange an appointment for her first therapeutic session following her assessment in January 2024. The trainee Clinical Psychologist (tCP) assigned did try and contact Jasmine several times and set an appointment asking for SW1 to support Jasmine's attendance. On the day of the appointment, Jasmine did not feel able to attend and in a phone call with the trainee psychologist said "*she wasn't having a good day and didn't feel able to come*". A second appointment was arranged for the following week and Jasmine attended with SW1. Jasmine talked openly with the tCP, and SW1 and YW1 both reflected that Jasmine felt uneasy after the appointment and perhaps had not been comfortable with the level of detail she had shared with a new person. An appointment was arranged for the next week, but it is not clear from the records whether this took place. However, in an appointment scheduled for two weeks later, Jasmine did not attend as she felt it was "*not a good fit for her*". After reallocation in August, there was a period where SW1 was not well, meaning the mental health team did not speak to SW1 until October 2024.

[2] Name changed to protect identity

Therefore, Jasmine's next mental health appointment was scheduled for November 2024. In the intervening period Jasmine had expressed she was happy to meet a new clinician.

In August, Jasmine reached out to YW1 to talk about her struggles with alcohol and drugs. YW1 supported Jasmine in accessing a local voluntary organisation mental health drop-in for young people but Jasmine did not wait to see someone. It is not clear how this was followed up. Also, during this month, Jasmine had several unauthorised absences from the SIA but she remained in contact with support staff and there were no concerns raised. When seen by SW1 early in September 2024, Jasmine was excited to start college and reported safe relationships and social interactions. She started college and the interviews with college staff indicate that she attended well during the first half term. She was liked by her fellow students and being a year older than most of them, Jasmine took on a familiar role of nurturing and supporting them.

Whilst Jasmine experienced more stability than she had previously, Jasmine's dad was still presenting with drug issues, and his home had become unsafe. A condition of dad's probation licence was to address his substance misuse and he was assigned a Recovery Worker (RW) from a commissioned voluntary sector service provider. His relationship with the RW was ambivalent: he openly told her that he thought she was too young for him to engage with. The RW noted that dad said Jasmine was not living with him but case notes also indicate that he had told someone else at the agency that his daughter lived with him two days a week. The RW did have some contact with SW1 in July 2024, but it is not clear what communications happened after this and what information was shared and when.

Reflection – what does this highlight?

- The way organisations operate are not always conducive to the lives of young people with funding, structures and processes providing barriers to young people accessing and receiving support.
- Whilst there were some very good examples of information sharing across the period, there was also a reliance on both SW1 and YW1. This becomes more problematic when staff are absent and/or are on leave - an issue raised by Jasmine's paternal grandmother. This is also problematic when the services working with parents are not fully aligned within the partnership communication network.
- Jasmine had a period of relative stability and had started to see what her future could look; she had aspirations, and she was developing an alternative sense of self and life experiences. However, even in this period of stability there were still many issues she was trying to deal with.

3.2.4 November 2024

At the end of October, Jasmine and Matthew were no longer in a relationship. Although Jasmine had finished the relationship, she was remorseful about her actions. Jasmine's attendance at college had fallen significantly and both case notes and interviews highlighted that concerns for Jasmine were increasing. At the end of October, Jasmine met with SW1 who expressed concern about Jasmine's increasing drug use and her seeing old acquaintances. Jasmine acknowledged the concern and shared that she had a physical fight with her dad. SW1 reminded Jasmine of all the progress she had made, and Jasmine agreed that she needed help from the mental health team.

The ASB team received reports of parties at dad's flat going on into the early hours of the morning. By this point, Jasmine's dad had been issued a Community Protection Notice (CPN), the further ASB complaints meant the CPN had been breached. The ASB team started the process for a partial closure of the property. It should be noted that throughout their dealing with dad and the property, they were mindful of the impact this would have on Jasmine, and they would pass information onto Children's Services and had a good relationship with police colleagues.

Jasmine's risk of exploitation was raised to medium which did frustrate Jasmine, as she shared in 2023:

> *"I know all the stuff around exploitation, and to be honest I'll probably be high, standard, then medium then high and it will repeat itself, but that isn't because I am being exploited - it's because certain people don't trust the friends I have, then add boys in the mix and it doesn't look great, but I think people forget these are my people"*

Her emotions during this month were up and down, there were points where she presented as "*happy and well*" and other incidents where she is noted as being "*low in mood*". An ADHD assessment had been agreed but the NDS team was not clear what professionals were working with her and where she was living. When arranging the assessment appointment, contact was made directly by email with Jasmine. The conversation between CAMHS and SW1 continued by email to facilitate attendance for Jasmine. During this month, Jasmine stated both that she did and did not want to engage with CAMHS. As mentioned previously, she did engage with her Looked After Child Review and, although she expressed low mood, she did identify her hopes and aspirations moving forward. The day after the review, Jasmine said she wanted to drop hair and beauty at college and a PEP meeting noted this. There are conflicting reflections on Jasmine's experiences at college; the college tutors noted how she was liked by her fellow students, but Jasmine had told SW1 that she had struggled to make friends on the course.

Jasmine died the following day, and the death has been ruled as drug related at the inquest held in autumn 2025.

Reflection – what did this highlight?

- Jasmine was struggling with her emotions and there was a rapid increase in concerning patterns of behaviour.
- The concerns in the escalating risks she was exposed to were evidenced by the partnership, and individuals were doing what they could to support Jasmine through this time.
- Supporting someone aged 15-17 years is challenging: no one professional can be with the young person all day every day.

4 Findings and Analysis

The key lines of enquiry will be answered using a transitional safeguarding framework for analysis. The analysis addresses the key points from Jasmine's experience but also draws upon the discussion at the Learning Day in which the group reflected on how the system works with young people in LA care who are 15-18 years old. A transitional safeguarding lens has been applied to the analysis to support learning that can be applied to the specific needs of the cohort under examination.

4.1 What is Transitional Safeguarding?

The period for young people between the ages of 15 and 24 years has become increasingly recognised as a distinct development period in which they are both navigating the transition from childhood to adulthood and doing so whilst their brain goes through a developmental change. The ways in which young people experience this are dependent on context and biology, therefore it is not experienced in the same way at the same time for each young person. Research and practice have shown that the organisation of statutory services is not conducive to supporting young people as they move through this development stage, as the provision of services change significantly once the arbitrary age of 18 is reached.

Transitional Safeguarding is an approach to working with young people aged 15 – 24 years old that recognises safeguarding should be an active and collective response to the harms that they may face, it is not about reaching thresholds or the delivery of specific services (Cocker et al, 2024). As an emerging approach, it offers a useful way to think about how best to meet the needs of young people that is flexible, personal and appropriate to the needs of each young person. As such, it is not about using a defined toolkit, instead, it offers six principles to consider how services are being offered, these can be seen in Figure 1:

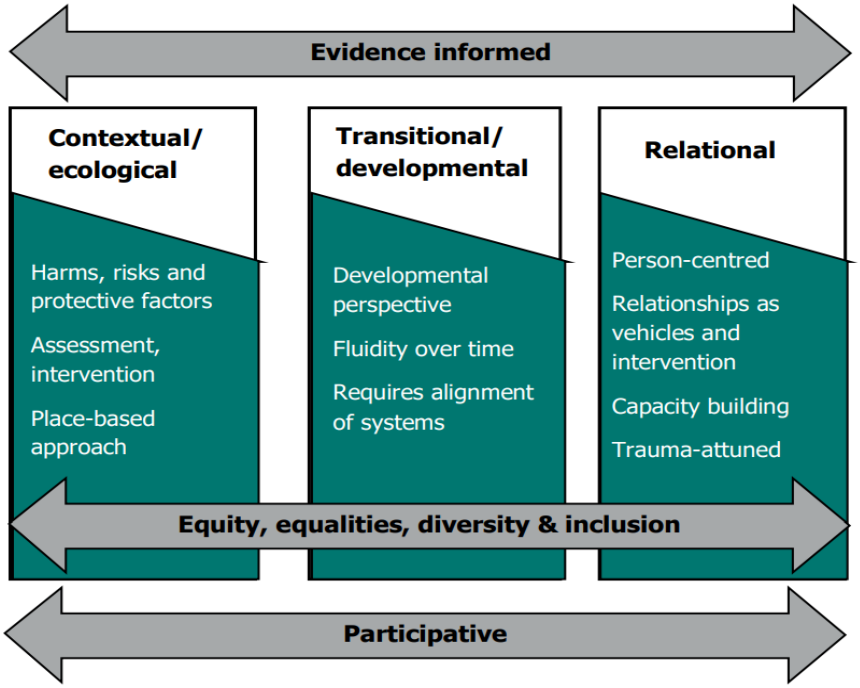

Figure 1: Six principles of Transitional Safeguarding taken from Cocker et al (2024, p.55)

This review does not have the space to offer a comprehensive description of each of the principles, please see Cocker et al (2024) for a full exploration of the approach. The following sections will offer a brief introduction of each principle before examining this through the experiences of Jasmine and the discussions from the learning day. The principles are not discrete categories but should cut across any work being undertaken. In order to organise the information, each principle here will focus on one aspect of Jasmine's life.

4.2 Evidence-informed

Effective safeguarding requires use of evidence-based models and interventions. An evidence-informed approach recognises the importance of using research alongside professional expertise and triangulating this with the lived experience of the cohort or individual you are working with.

There were many examples of thoughtful evidenced-informed practice that recognised Jasmine's developmental stage and her context. This was illustrated with the use of language as it offers an insight into practice, for example, how we talk about responsibility, actions, perceived choices etc. In reading the case notes and talking to people, the language very much reflected an understanding of Jasmine that recognised her vulnerabilities as well as her strengths. For instance, while the word 'resilient' was used to describe Jasmine, there were several professionals that recognised this was not helpful for Jasmine in keeping her safe. The use of 'resilience' holds societal assumptions that the young person is managing well and coping. Resilience can be defined in different ways, but research has challenged the concept of resilience as something a person has and instead considered the way the environment influences a person's resilience. Calling a young person 'resilient' can increase their risk (Boutrell, 2007; Wexler et al, 2009) as it assumes they are coping without analysing why the young person is having to be resilient. The professionals close to Jasmine understood the strengths of Jasmine within the context that she had grown up in, as this quote from YW1 illustrates:

"She was bright as a button, so resourceful. I don't like using the word 'resilient' as she was just a child"

The learning day gave further reassurance that agencies and professionals, in the room, were working hard to apply appropriate language to describe the experiences of the children in care at this age and in how they spoke to young people, mindful of how language can shape perceptions and actions. There was recognition of the nuance needed in consideration and understanding of young people's experiences but also drew upon professional expertise in knowing when to challenge young people's language, e.g. the use of gang-related monikers.

Whilst different professions are at different stages in understanding how language affects approaches and interventions with young people, the trajectory of progress is reassuring rather than concerning, reflecting the work that the Norfolk Safeguarding Children Partnership (NSCP) has undertaken over the last few years. However, it should be noted that participants on the learning day were there because of their links to Jasmine, both directly and indirectly, and therefore may have more expertise in working with young people of this age. The picture across the wider workforce may not be as positive, particularly for agencies that provide more universal services such as the wider police force or generalist health providers. Understanding where the gaps may be are important for capacity building within the workforce so that more people feel more confident and skilled in working with young people, and subsequently young people receive helpful not harmful responses.

An area that was not as clearly evidence informed was the work with Jasmine around her mental health and emotional stability. The EHCP in 2019 identified that Jasmine had difficulty with emotional outbursts and that she would benefit from therapeutic work outside of the school system. Over the review period, Jasmine talked about feeling low and on one occasion she was not going into school because of her low mood. She had also recognised the impact the drugs were having on her mental health. Her relationships with key people such as YW1 and SW1 were important for her

wellbeing, however, by November 2024 she still had not had any meaningful and sustained therapeutic or specialist input. The timeline details a confused and lengthy process in trying to get Jasmine support in which obstacles included a returned referral, long delays between a further referral and the initial assessment and protracted communication between professionals – issues related to process and resources. Alongside this, she declined her statutory health checks and had been waiting for an ADHD assessment to be finalised. These incomplete interventions were missed opportunities to understand Jasmine's experiences; to consider the role of drugs and alcohol in her life, to help her understand her emotions, to understand the impact of erratic parenting, and therefore missed opportunities to use evidence to inform the members of the network as to how best to support Jasmine.

It could be suggested that Jasmine exercised agency in not attending the statutory health checks or by wanting a different psychologist, however, agency is not the same as making a choice. Agency implies freedom of choice, but Firmin (2020) has highlighted that agency - and therefore perceived choices - are contextual. This means considering what factors are influencing the choice and has the person making the choice been fully informed. Another important element is the ability to be reflective: does the young person have the capacity to think through the longer-term impact of the decision and how is this understanding being developed? Cocker et al (2024) illustrate this with the interviews they did with young people who were care-experienced. The young people associated being in care with little control over their own lives and told the researchers that some decisions they made were based on taking back control of their lives rather than thinking through what may be helpful or harmful in the longer term as they transitioned to adulthood. For Jasmine, turning down her statutory health checks was her right and consideration should be given to respecting these decisions as part of her wider wellbeing (Holmes, 2022). It is a tricky balance to achieve as being evidence-informed means triangulating all knowledge, including professional expertise. Professionals have knowledge that may help to inform decisions, for example, dental checks are not just about 'teeth': they are useful as an insight into general health and welfare. Therefore, what further actions could have been done by health services in engaging with Jasmine to at the very least think through the consequences of not attending. Conversely when Jasmine did express wanting help with her "*low mood*" and was choosing to engage with services, it took a long time to access the specialist help. For Jasmine, her choices did not lead to a meaningful or helpful experience or her right to better well-being.

The context provided by practitioners is crucial to supporting (or challenging) the decisions made by each young person. The discussion at the learning day suggested practice considerations for the future, such as:

- allowing other professionals to refer to mental health services (rather than just the GP)
- the need to have a clear contact point between services when referrals do not initially meet thresholds
- improving capacity to be tenacious or flexible in engagement with and from therapeutic services
- having routine mental health assessments for children who are 'leaving care' to support transition
- greater access to psychological and Speech and Language Therapy (SALT) for children experiencing extra familial harm

- better communication pathways in health provision, and more community-based work no matter the profession.

Evidence-informed practice is challenging to implement; it is important to triangulate all the sources of information including understanding the views and wishes the young person. For this to happen, it is important to have a shared understanding of the young person and their experiences. This needs to go beyond the research that can give general indicators as to what may be happening for each young person (e.g. language use) to ensuring that all individual sources of knowledge regarding the young person are accessed and collated to give a robust knowledge and picture of their personalised experience.

4.3 Relational

If agency and therefore choice for a young person is contextual, then professionals are a crucial contextual resource, particularly for young people living in care. Relationships can increase resilience by giving capacity that support and influence a young person as they negotiate and navigate the world. Transitional safeguarding advocates for "personalised and strength-based approaches" (Cocker et al, 2024, p.57) which recognises trauma and past experiences of the young people and ensures that staff are supported by leadership within reflective spaces. There is ample evidence that Jasmine had a number of relationships that she considered significant, both with family and professionals. This section will reflect on the relationships with professionals, with her family relationships being considered in the next section.

Jasmine had a multitude of professionals in her life which began at a very young age. The exploration of her early experiences shows not only the number of professionals she was expected to get to know but also how many professionals 'left' her and moved on. There are references to Jasmine's 'attachment' in the notes, however, her attachment style was never formally assessed, and it is not clear what purpose the attachment label served when working with Jasmine. In a recent article on attachment, written by a wealth of internationally renowned scholars and senior practitioners, they warn against the poor use of attachment categories as it tends to see attachment as a fixed part of a person "rather than as a potentially changeable description of a current relationship" (Foster et al, 2025, p.4). An alternative and more personalised approach moves beyond categorisation and considers the impact earlier experiences have on current self-identity and understanding of relationships. Whilst the EHCP report in 2019 offered some useful insights and tips for working with Jasmine around self-identify and her relationships, it was not until the review period that there is clear evidence this work had started to happen. For instance, YW1 provided some excellent examples of the youth work she did in supporting Jasmine to think about these areas. This practice was starting to have an impact as seen during the period Jasmine was with Matthew. As part of a wider and explicit strategy this important work would have benefited from more therapeutic support.

The evidence of Jasmine's experiences with YW1, SW1, MACE1, DSL1, her personal adviser and her Youth Justice Workers demonstrate they worked beyond labels and instead focused on Jasmine as a person. In the interviews they spoke of getting to know Jasmine, not just the Jasmine on paper and this is to be commended. The professionals provided Jasmine with stability by investing time and space to get to know her. These key relationships were all supported by managers who understood what the practitioners were trying to do, who had also become familiar (and in some cases worked

directly with) and were respected by Jasmine and her family. Both the practitioners and managers demonstrated flexibility, built trust, provided coherence, boundaries and challenge, and accepted Jasmine for where she was. They facilitated and shared Jasmine's aspirations for her future. It is also a testament to Jasmine that despite all the 'lost' relationships, she ended up invested in these professionals demonstrated by her comments to help other young women and girls engage with the youth justice service:

"*Just do it, in the end it's worth it, you might end up liking them*"

The work to build relationships with Jasmine during the review period are good examples of the relationships with professionals; we would want for all the young people we work with. A relational approach is recognised as a beneficial intervention to help with 'developmental trauma' (see Hickle & Lefevre, 2022 for a fuller exploration) but there are considerations for system leaders in thinking about what this means for practice. Relationships take time and space and can require going beyond the 'working' day which is not always valued, understood or enabled when under pressure to meet targets. During the learning day, the professionals emphasised the need to be flexible, alongside permission to push against organisational pressures to support each young person in a personalised and coherent way. This has to be maintained with psychologically safe spaces for professionals to reflect, with good management support, and a clear and communicated theoretical underpinning to the work(load) so that individual staff members do not become overwhelmed or burnt out. There is a fine line between good practice and practice that is unrealistic over the long term for all young people.

Whilst there were some excellent examples of relational practice with Jasmine, this was not consistent across the partnership. Jasmine was difficult to engage particularly when first getting to know her. She would push boundaries depicted by the words she uttered to a new social worker when she was 13 years old: "*You can fuck off, I'm not talking to you".* All the key professionals were unanimous in that Jasmine and her dad would 'test' you when they first met you and so you needed to have persistence and confidence to see beyond the initial presentation. In response to the felt aggression and due to the difficulty of contacting Jasmine, members of the partnership often relied on key professionals and in particular YW1 and SW1 to communicate with Jasmine on their behalf. Whilst this can be seen as a logical response to not overwhelm Jasmine or in managing time, it also created additional responsibilities for YW1 and SW1. In addition, it meant that if Jasmine 'chose' not to engage, for example with her statutory health checks, it absolved the agency of having to be persistent and responsible for engaging with her. An over reliance on key people caused issues when people were away from work at the same time, such as on leave or due to illness, as it meant possible interventions stalled. These issues were discussed at the learning day and it was noted that there needs to be a balance in having key contacts whilst not overloading them with expectations. More work needs to be carried out together such as shared home visits, coordination around appointments and building relationships within the network through mechanisms such as joint supervision.

The learning day included reflections on the need to make 'every contact count' as this facilitates trust and ensures services are available when needed/wanted for children in care during this transitional period. The reliance of key people is in part due to the very different working practices and cultures of some universal agencies as compared to that of youth workers, social workers and to

some extent alternative education providers. The culture in health agencies tends towards more formality when engaging with a young person, for example, the young person is expected to go to the health agency for appointments rather than the other way round. The reasons for this are often rooted in an evidence base for the treatment or the need to use specialist equipment. However, it fails to account for the transitory nature of young people, their fluctuating motivations and the time it takes to build relationships. It was noted that relational work can be made more difficult with this age group by everyday expectations around practice. For instance, at the learning day, professionals noted how health and police services often have to wear a uniform and easily seen identifiable information such as lanyards which young people perceive as barriers. There was also reflection regarding austerity and the seemingly small cuts to budgets that can have major impacts on building relationships, for example, taking a young person, who is in care, out for a coffee and a chat. Consideration needs to be given to overcoming these seemingly inconsequential barriers whilst enabling the facilitators that are needed for building and supporting relationships with this age group.

Trust is built with consistent and coherent messages and as the professionals reflected "doing what you say you are going to do". These messages have to be reiterated across the partnership so there is a need for each professional to understand the practice of everyone involved. This means understanding the various professional roles, the activities people do and why these are important for the development and safety of the young person. Research shows for effective multi-agency to work, people need to challenge their normal practice and modify their roles accordingly (Ball et al, 2024a). Relational practice requires strength-based and personalised approaches (Cocker et al, 2024) that show consistency between and within the professional network. Relationships with the young person increase what is known of their lived experience and can support resilience and risk management. It is important for the all parts of the partnership to learn from each other in finding the most effective way forward in building a relationship with each young person. This means all parts of the network must attempt to create positive encounters with a young person to improve the likelihood of engagement.

4.4 Ecological

The ecological principle draws on the work of Bronfenbrenner (1979) who recognised the interplay of the environment with a young person's development. This requires professionals to consider the impact of contexts such as immediate family, communities and social structures in supporting the young person to keep safe (Cocker et al, 2024). This section will consider the family context, with wider ecological factors - such as peers and her community - covered in the next section.

For Jasmine, a key influence in her life was her father, as she reflected with YW1 "*He looks after me, I am his world*". Professionals spoke of their close bond and the complicated nature of their relationship. Their love and bond for each other was apparent, even when they were arguing. Dad wanted her to do well. People commented that although he presented as "*very abrasive, extremely immature and unco-operative*", he was not always like this when discussing Jasmine (although this did depend on the professional spoken to). It was widely held that he was unable to keep Jasmine safe and that she did much of the caring for him rather than the other way round. A fundamental concept of attachment work is understanding that of a "safe haven" (Foster et al, 2025, p.5). In Jasmine's experience, her 'safe haven' was her dad; this does not mean he was safe but that he was

the one she wanted comfort from in her moments of need (*ibid*). The importance of Jasmine's dad in her life was apparent but their experiences with services illustrate there is still work to be done in helping fathers to parent and safeguard their children. Both before and during the review period, whilst there seemed to be insight into dad's limited capacity to parent, there is no clear evidence of work with dad to support his capacity to parent safely - a gap that Jasmine's paternal grandmother raised as part of this review. Whilst some professionals were able to at least talk to and challenge him at one level, for example SW1 and YW1, in all the years of contact with him, there was never any sustained input to support and enable him to change his behaviour and ability to parent. The issue of working with fathers in safeguarding have long been known (see Scourfield, 2006) and the lack of recognition of fathers have been indicative of systemic and societal failures in the way fathers are perceived (Osborn, 2014).

Dad's demeanour was often seen as aggressive and intimidating, and professionals recounted instances where their colleagues had been scared or upset by his behaviour. These factors undoubtedly contributed to difficulties professionals had in working with dad but, much like Jasmine's experience, key people were relied upon to build a relationship with him amongst the children's network of professionals. Research has shown that the emotions of fathers such as anger can be perceived and felt differently by social workers as compared to the reactions of mothers (Philip et al, 2019). Dealing with conflict and aggressive behaviour is, unfortunately, part of doing safeguarding work and therefore supporting professionals to deal with this is imperative for safer outcomes over the longer term. The professionals who had built a relationship with dad reflected that you had to be confident and persistent in your boundaries with him and he would listen, much like the approach that was necessary with Jasmine.

One of the features of the work that has been done in Norfolk over the last three years to improve father inclusive practice is the understanding that when practitioners find building relationships with fathers difficult, it is the responsibility of services to adapt in order to manage these relationships more effectively. Labelling a father as difficult, confrontational, or aggressive should be seen as a feature of the interaction between him and services rather than an inherent feature of the man. The workforce needs to have access to learning to gain knowledge, develop skills and build experience to overcome this challenge. It is important to note that learning within a partnership is not just about facts/events re the people concerned (that is sharing information), but also in understanding and sharing what practice works and what does not. There is a need for communities of practice to be built around the family. For instance, dealing with aggressive and uncooperative parents can be taught formally in training courses but equally as important is the experiential and informal learning happening in activities such as reflection in joint supervisions and the modelling of behaviours during joint visits. Within the multi-agency workforce there is a wealth of resource to call upon for this (e.g. probation staff, third sector organisations who work with men, father inclusive champions).

Dad was also the recipient of statutory interventions due to being on licence and because of his known mental health and drug issues. There was evidence of communication between the professionals working with dad and professionals working with Jasmine, however, this tended to be about keeping the network informed rather than working together to understand what was needed as a whole system to support Jasmine and dad, either individually or as a family. There was not a sophisticated analysis of the relationship between dad and Jasmine utilising all professional expertise. YW1 had started to work with Jasmine helping her to understand her other relationships

based on the influence of her dad and the disrupted caregiving she received, but a corresponding piece of work was not completed with dad. There was not a 'think family' approach as highlighted at the learning day with issues such as information sharing causing concerns for particularly adult-focused services. Dickens et al (2024) comment that safeguarding reviews have often made recommendations based on information sharing but this often belies the complexity that lies behind this. For Jasmine, there was a lot of information sharing but analysis and actions arising from the shared information was not always as robust particularly concerning the dual approach of adult and children services working together. A suggestion made at the learning day was to consider family formulations in addition to the individual work for parents and young people, with more co-working to present a consistent message and approach.

Although there is rightly a focus on the role of dad and how the system responded to him, consideration also needs to be given to the wider family context. The absence of mum is notable which is more unusual in terms of safeguarding reviews. The people interviewed were unable to share much knowledge about the role of mum and she appeared very little in the written notes received. Jasmine's mum was in Jasmine's life but not in a sustained way and it was noted that they often clashed. Jasmine would see her mum on occasions and during the review period the visits tended to correspond with when Jasmine was in London at 'raves'. In her last Looked After Child review Jasmine expressed that she did not want her mum to attend but that she had a good relationship with her. There is very little research that attends to absent mothers as compared to the research regarding fathers. Osborn (2014, p.996) wrote "Fathers who are not in our line of vision are often ignored"; this could easily apply to the lack of focus on Jasmine's mum. Professionals spoke of Jasmine being maternal and simultaneously wanting a mother figure, yet there is little evidence of exploration of the impact of mum on Jasmine's self-identity and her understanding of relationships. Similarly, Jasmine did have aunts and uncles (on both parents' side of the families – details are not clear) but this is notable in that they are not seen anywhere in the work with Jasmine. There may have been difficult family dynamics at play but was there, or could there have been, consideration as to how a wider family network could have supported Jasmine even though she was in care? It is important for partnerships to remain aware of all contexts, not just what is happening in the present but also exploring the influence of the past. Again, whilst this can be supported by key professionals such as YW and SW1, there is an important role for mental health services to assess and guide interventions.

The other significant family relationships were with grandparents. Jasmine expressed having a good relationship with her maternal grandparents and that her paternal grandmother was loved. Granny was a consistent and available source of support; one of Jasmine's most stable periods was living with granny and dad during the national lockdown. There were other periods in which Jasmine was officially living with granny but was frequently not there overnight as she did not like living outside of the bustle of the city. Granny was very involved in communication with different professionals and was widely regarded as positive in her efforts to keep Jasmine safer. The narratives around granny and dad were that granny was 'helpful' and dad was 'difficult'. However, the simplicity of these narratives hides the more complex picture as there were significant periods when dad was trying his best to help Jasmine, for example, making sure she attended her education provision. Conversely there were significant periods where despite her best efforts, granny was unable to keep Jasmine at home or make sure she got to her education provision and Jasmine would be considered as 'missing'.

For effective safeguarding, it is important to challenge narratives and general perceptions to really understand what the relationships do for the young person, what or how the relationships contribute to risk management and what they impede. For instance, when dad was trying to be supportive, what could have enabled him to sustain this? Similarly, were professionals aware of all the times when Jasmine was supposed to be with granny but was not there and were there unrealistic expectations of what granny could do? This is not to place the blame on any caregivers. As Firmin (2020) highlights the solution to exploitation and extra-familial harm cannot rest with solutions focused only within homes. The interplay of personal traits, peers and family relationships in relation to the context can increase "increase safety and/or inform risk" (*ibid*, p.23). It was recognised at the learning day that risk emanates from and where young people choose (or not) to spend time, therefore acknowledging and analysing the capacity and reality of different contexts, in this case family members, can contribute to a wider strategy for keeping the young person safer.

Even when young people are in care, families are important contexts to consider, historical or otherwise. When young people are in care, work to understand families tend to focus on interventions such as Life Story work. Jasmine's experience demonstrate there needs to be a wider focus for some young people, more akin to the work that is perhaps carried out in Child Protection such as Family Networking and Family Group Conferencing. This would acknowledge the continuing role of the family, enable maintaining relationships where it is safe to do so and perhaps move the discussion to think about the wider network in supporting Jasmine.

4.5 Developmental/Transitional

Cocker et al (2024) posit that safeguarding systems for children are not designed with reference to the developmental needs of young people but are designed around reaching risk, care, and age thresholds. The authors argue for a more fluid service response that recognises each young person having different needs at different points that is not dictated by the service available according to age.

There was good evidence that the professionals during the review period held in mind that Jasmine was not an adult, that they understood the importance of the impending transition for Jasmine from child focused to adult focused services, and on the need for fluidity and flexibility in their approach. The partnership had consistent concerns regarding Jasmine being either criminally or sexually exploited, and her risk rating would fluctuate sometimes within days. Key professionals reflected that Jasmine did not always see herself as at risk, in one CPM she commented that "*No-one's going to exploit me. It's more likely I would exploit other people*". Jasmine's own perception of her risk did not prevent professionals from expressing and discussing their concerns with her. Jasmine would engage in conversations with key people around addressing the risks, as SW1 said: "*She was capable of being reflective*". The transparency and respect given when voicing concerns demonstrates a collaborative rather than punitive or procedural approach to safeguarding Jasmine; in interviews people reflected that this was the best way to work with both Jasmine and her dad. There is much to commend in the approach used with Jasmine as research has shown how young people regard the punitive nature of safeguarding as a barrier to accessing support (Firmin, 2020). In taking this collaborative approach, the partnership went from frequent periods in which Jasmine's whereabouts were unknown, to the point where Jasmine would proactively let people like SW1 or the SIA know where she was going, for example, to a rave in London. It could be argued that this did not actually

keep Jasmine safer, it simply meant people just felt more assured of her safety. In response to this, it is important to acknowledge two things: 1) working with this age group is challenging, but that "the right to safety must be considered in balance with other rights, such as privacy and freedom." (Holmes, 2022, p.1); and 2) risk is not static, it is dynamic and can change in the shortest amount of time therefore having someone you trust and know you can turn to in a moment of need is imperative. The importance of this was expressed by Jasmine to YW1 "*I must trust you a lot because you were the first person I called the other day after dad*".

Jasmine had not had a typical childhood; she had from a very young age learned to be independent and self-reliant. As she got older, she took responsibility for others and people commented on how Jasmine would organise and parent others, making her seem older than her biological age. The understanding of why Jasmine did this or the reality of what this meant for Jasmine does not appear to have been explicitly explored in her earlier life, with the exception of the analysis carried out by the Educational Psychologist as part of her EHCP in 2019. The learning day discussion identified the importance of curiosity and moving beyond biological age and assumptions about where the young person should be in their development, to really understand where each young person is and what each individual young person needs. This is characterized in the practice of YW1 who appreciated the development gaps in Jasmine's childhood, such as not engaging in play, and sought to address this by doing more playful activities alongside the more serious discussions. Play supports relationship building as it fosters social connections (Hassinger-Das et al, 2024) and it creates safe and relaxed spaces for conversations (Gallardo-Masa et al, 2024). Play is an under-utilised intervention for adolescence, but it is being researched for its usefulness in learning and therapeutic interventions with young people to positive results (Johnston et al, 2023; Norman, 2025).

The nature of the law in England and the UK means there is a designation between children services (up to 17 years and 364 days) and adult services (18 years and over) with considerable differences in the eligibility criteria, cultures of working and legislative frameworks. As a partnership working with Jasmine, the professionals were mindful of the need to support Jasmine in navigating this transition. Jasmine had already been assigned a Personal Adviser (PA) as part of the move to the team overseeing her leaving care. Jasmine had a good relationship with the PA and they were working together to prepare Jasmine for independent living at 18. In November, at her Looked After Child review, Jasmine was looking forward to moving into her own flat. However, the ASB complaints regarding dad's address were being dealt with through a legal process that had the potential to impact Jasmine in securing her own tenancy. The role of housing and ASB interventions in being able to safeguard young people is recognised but perhaps not always drawn upon in the most effective way which was identified at the learning day. Whilst there may have been the perception that housing just 'want the flat back', the misunderstanding perhaps hid the work that they were trying to do in safeguarding Jasmine for the future. For instance, in the interviews, the LA ASB team gave detailed accounts of the mitigating steps they took to prevent issues arising when Jasmine needed to get a tenancy when she turned 18; *"We are thinking about people's futures. Jasmine had a criminality record with police. We didn't want to have that for her housing options as well"*. This practice points to messages that were discussed at the learning day which is a need to parallel plan across all services with a shared knowledge and understanding of good developmental practice and the use of appropriate language that does not contribute to the adultification of young people.

Transitions and development are not a linear process for every young person hence the need for flexible and creative interventions that support the young person where they are, rather than where they should be. This requires significant time and investment from staff in building relationships with young people. It also requires thinking more about the processes involved, for example, how helpful are risk registers for young people if they are aligned to thresholds for services? This does have implications for both resource capabilities as well as the amount of risk that agencies are willing to take. Partnership leaders need to be willing and able to have conversations that challenge themselves and each other in effective safeguarding for young people at this age. As one practitioner said;

> *"We can't be risk averse. We need to be able to work with risk"*

4.6 Equity, Equalities, Diversity and Inclusion - Intersectionality

Cocker et al (2024) write that for an ethical approach to safeguarding, it is necessary to recognise the impact of discrimination and societal injustices in the lives of young people and to challenge these to ensure inclusion and participation. Paying attention to exclusion and discrimination means being aware of the context and the intersectional adversities that young people experience - that is, understanding what challenges young people face based on their various characteristics: gender, ethnicity, class, age and so on.

Jasmine was a young person who learned how to navigate a world defined by the impact of societal injustices. The communities in which she lived, and her own life were affected by the consequences of structural inequality including poverty and crime. Jasmine associated with people, including her dad, who were well known to different agencies, in particular for the risks they posed to others. Professionals were concerned for Jasmine and the risks for exploitation, as reflected in the regular CPM meetings when her risk was regularly discussed, and it was something that Jasmine knew but pushed back against:

> *"They think I'm "unsafe" or "high risk". My dad and mum both did drugs. I've grown up around drugs and dealers – this is my community, and no one will ever change that"*

Professionals were worried that Jasmine did not always see the risks that others posed but similarly there was not as much focus on how Jasmine might have viewed them as protective factors. For instance, when living in her SIA, she typically stayed in her own accommodation three or four times a week. This meant she was often elsewhere overnight, but she always had a place to stay; she would assess her own risk according to her knowledge of her people, as evidenced in the phone calls to key people when she needed help. In the interviews, professionals and paternal grandmother commented on how Jasmine would source money or food if she needed it. Whilst this can be very uncomfortable from a professional perspective, it is important to not exclude or undervalue the ways in which Jasmine understood her world and how this impacted her choices.

Wroe & Pearce (2022) reflect on how individual safeguarding interventions fail to understand the intersectional nature of consent, how consent can be informed by "gender, (dis)ability, race and class" (*ibid*, p.97). The authors argue that recognising the social conditions of consent mean understanding the everyday impact of poverty and inequality. The interventions needed that address these inequities are about facilitating relationships built on trust and genuine empathy. These sentiments were echoed in the discussions at the learning day in which it was recognised that

perhaps there is not enough curiosity and exploration of identity on interventions. Understanding the 'lived experience' of a young person is more than understanding or knowing that trauma informs behaviours, it is about the need to recognise and acknowledge the values of a young person and the community they identify with and how this may impact on any work.

4.7 Participative

The transitional safeguarding approach highlights the importance of recognising the young person's rights and their expertise in their own lives drawing on research that has shown how young people feel disempowered and as having little control (Cocker et al, 2024). This does mean that agencies have to navigate the line for the young person that is both protective and participative. This is tricky to do especially given the focus on managing risk in children's safeguarding, as shown earlier in this report.

Throughout this report, there has been evidence of Jasmine's involvement and participation in managing her safety, including frank conversations about her relationships with others and her use of drugs and alcohol, and in her views being sought after and acted upon where it was possible to do so. The one thing she had always wanted was to live with dad but the experience she had with Matthew and his family, and the conversations she had with YW1, were helping her to understand why this had not been possible. As SW1 reflected; *"She couldn't get rid of social care but understood that they were there to help".* During the review period, Jasmine did voice her feelings but importantly she, also, listened. The approach taken by the professionals that were important to Jasmine were to work *with* Jasmine, and not *do* to or *for* Jasmine, an approach based on strengths based and restorative practices. This meant that Jasmine understood boundaries (and sometimes used this to handle other people's worries) and was able to reflect on her own behaviour when challenged. The relational practice meant that Jasmine was part of her own safety network, something which young people have identified as crucial for support (Clark & Hall, 2022). Young people have reflected that when they feel that are not involved or not heard that it can feel like the coercion and exploitation they may be experiencing from others in their networks (Cocker et al, 2024). Participation is more than just about listening to a young person; it is about giving them the skills and tools to manage their own life.

As discussed previously, the context facilitates the young person having agency and being able to make safer choices, therefore all agencies and professionals need to understand why they are there and be fully involved in supporting and equipping the young person with the skills they need to flourish. In many respects, the multi-agency participation was robust, for instance, there were designated email channels that everyone used: one for general communication and one for urgent information. However, there were occasions when key agencies such as education or the ASB team were not invited to/present at multi-agency meetings. Due to the number of meetings being held on a regular basis, it perhaps would not have been possible for everyone to attend every meeting. This highlights the importance of not just feeding 'into' communication channels but also how you feed 'out' to others. There was respectful conversation at the learning day, highlighting that participation is not just about giving information and attending meetings; participation requires taking responsibility for acting upon information and doing something meaningful with it. Reciprocal communication means that people are aware of and can react to events as necessary and in a more timely way. As Ball et al (2024) highlight, there is a need for not just improved communication but

clear ways to communicate and accountability to communicate. At the learning day the discussion reflected the need to consider joint visits and joint planning of visits to not overwhelm the young person, to learn from each other, to develop working relationships and, most importantly, to facilitate and encourage the young person participating in all opportunities available to them.

5. Conclusion

The Transitional Safeguarding principles are a "boundary-spanning mindset" (Cocker et al, 2024, p.58) that seek to address the challenge of either/or approaches which can close off effective partnership working. The principles are intended to highlight the importance of drawing on different perspectives whilst not prioritising any one source of knowledge. Within this review, the principles have been used to think about different aspects of Jasmine's experiences to highlight possible learning. The crucial aspect is to use the principles to learn and understand what is happening for the young person, and where the system is either helping or harming.

The LA underwent significant changes in both leadership and practice during the 2010s which may partially explain the lack of continuity for Jasmine when in care pre-November 2022. After November 2022, with a team of key professionals around her, Jasmine had many people who loved her and were committed to helping her achieve her aspirations as she approached adulthood. The grief and shock related to Jasmine's death was palpable and the compassion and care that Jasmine experienced from the professionals was assuring. The issue with any review is that hindsight is used to understand what happened; it is not helpful to think that any one thing could have made a difference to the outcome for Jasmine and her family. Instead, the learning is for other young people, and the review of Jasmine's experiences show that learning can recognise good practice as well as where the system needs to improve.

Although not within the scope of the review, given the strong relationships that Jasmine had built with key individuals, there was a need to respond to the sadness and shock at her death. During the interviews and at the learning day, the grief was still evident and so ensuring continued care for professionals became apparent. People spoke of varying degrees of support from their organisations and their line managers with some excellent examples of practice in supporting affected individuals and a notable gap in support for others. The panel have asked that this disparity be highlighted and that the LSCP reflect on this and what can be put in place to support staff in the future.

5.1 Key messages

The analysis of Jasmine's experiences emphasises three key practice and policy messages for consideration:

- Relationships are the foundation of all interventions
  Whilst this can seem obvious, research and previous safeguarding reviews demonstrate that there are many factors that can get in the way of doing this well, therefore these need to be valued and invested in to make every encounter count. This may require changes in practice as approaches need to be flexible and personalised – young person focused not service focused - to ensure young people have parity to access for the support they need. Professionals need to go to where young people are in a timely way, and consideration needs to be given to barriers and enablers so that their experience is understood. Relationship work needs to account for all the relationships the young person has with family, peers and professionals. It also means providing

opportunities for the professional network to foster relationships with each other that allow thoughtful reflection, effective interventions and opportunities to address misunderstanding or conflict.

- Partnership working is more than information sharing, it requires collective action
  Previous safeguarding reviews have documented issues with information sharing but Dickens et al (2023) have highlighted the complexity that lay behind this finding. Information sharing is important, and it is vital to understand the barriers and enablers to this, as well as ensuring that all partners get up to date pertinent information. However, partnership working is more than information sharing; it is about pooling collective knowledge and doing something with this. Strength based partnership working requires understanding what each partner can bring to the work (no matter how on the periphery they may seem), communicating the knowledge, and then utilising this knowledge to achieve a shared understanding and approach. Multi-agency safeguarding is not just everyone's responsibility but a collective responsibility (Ball et al, 2024). This is important not only for work with individuals but also for harnessing responses to safeguard young people in places and spaces outside of the home.

- System leaders need to encourage and enable practice that spans agency boundaries
  The early work on transitional safeguarding highlights the need for flexible approaches that recognise the importance of both/and responses (Cocker et al, 2024) both at an individual and wider level. This has implications for leaders within the system who need to be able to articulate the change they would like to see. Any change has to build upon a shared evidence base that triangulates research, professional expertise and the experiences of young people. Change also has to recognise that this is not simply about changing systems but about recognising the human. Leaders have to support the workforce to make this change through adequate resourcing and structural support, as Dez Holmes (2022, p.9) writes:

"Work with young people facing harm, done well, is relational not only transactional; emotional not only procedural; and is as concerned with 'what matters' as much as 'what works'. Policy, sector leadership and direct practice must all contend with these wider complexities, and must engage with thinking and feeling as much as doing, if we are to continuously improve our offer to young people."

6.1 Recommendations

The specific recommendations are:

Recommendation 1: The partnership needs to conduct a specific, comprehensive mapping pathway of the mental health system in order to understand:

- What are the partners aiming to provide and for whom?
- How are services currently provided and who provides it (to include statutory and voluntary sector provision)?
- How do children and young people access services and how/when do the offers of intervention/support get withdrawn?
- What approaches do services use to engage with children and young people?
- Where does the work happen e.g. in the home, community, or at a specialist building?

- How does each service engage with the wider safeguarding network both in terms of communication and the support for other professionals working with young people accessing mental health support?

Any resulting work needs to consider the strength, speed, creativity, flexibility and effectiveness of mental health pathways in relation to the aims of the partnership and reported to the Delegated Safeguarding Partners within six months of publication of this report.

Recommendation 2: Promote the good relational practice with young people and professionals that was evident in this review through a programme of dissemination.

Recommendation 3: Use existing mechanisms to strengthen multi-agency communication, reflection and accountability across services provided for adults and children: promote the use of the Joint Agency Group Supervision (JAGS) where transitional safeguarding is featured and provide an evaluation of all JAGS that feature this age group, drawing out thematic learning. The reporting period should focus on those JAGS in the six months following the publication of this report and include detail of all participating agencies.

Recommendation 4: The partnership should develop specific resources (e.g. training and a toolkit) for working with men when interactions between fathers and staff are seen as confrontational, lacking co-operation and proving ineffective. Whilst this review was specifically about fathers, any resources produced should be mindful that any person in a care-giving role can have relationships with professionals that are seen as confrontational, lacking co-operation and ineffective.

Recommendation 5: Agencies working with children at risk of exploitation should evidence how they support staff to develop skills to map and work with the extended family network.

Recommendation 6: Each agency needs to review their processes to debrief and support staff following an unexpected death of a child or young person.

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