REPORT OF THE CHILD SAFEGUARDING PRACTICE REVIEW REGARDING

‘ROSIE’

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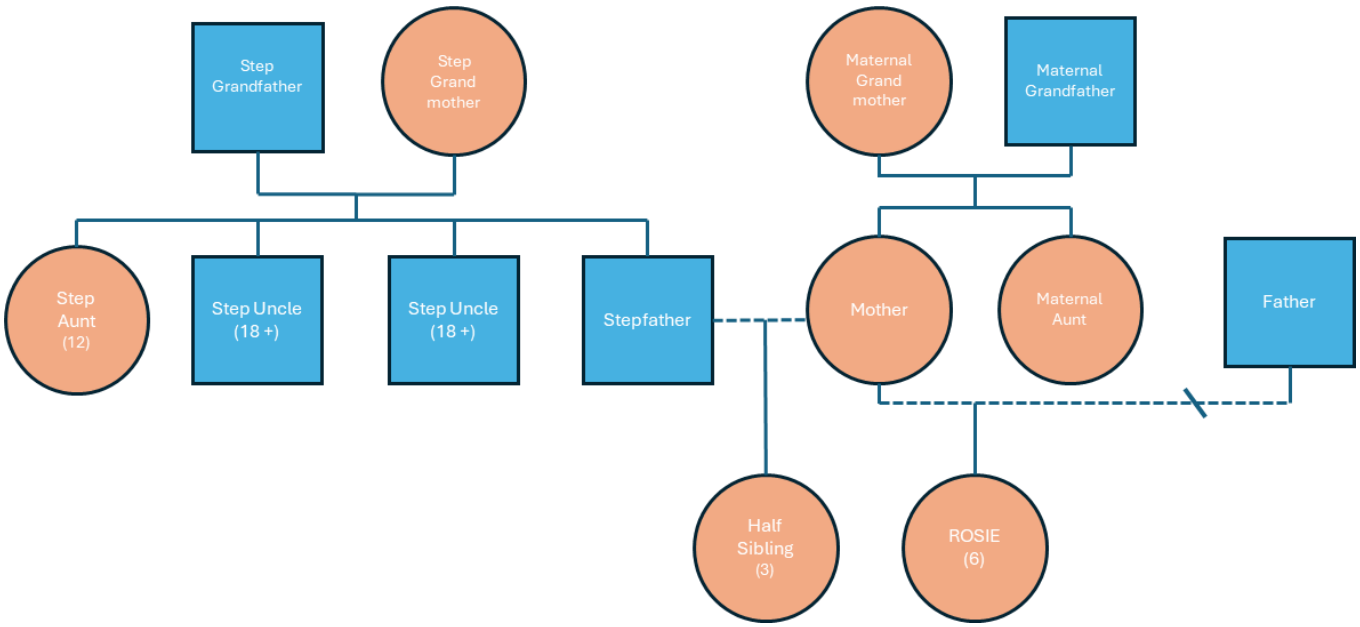
Contents

1. Events that triggered the review.

In August 2023 Rosie told her paternal step-grandmother that she had been sexually harmed by her paternal step-grandfather. This was not reported to the police. On the 2nd September 2023 Rosie told her maternal grandmother that she had been harmed by her paternal step-grandfather. This was immediately reported to the police. The step-grandfather was charged on the next working day. He was subsequently convicted and received a custodial sentence.

2. Family composition.

*All ages are calculated at the time of the trigger incident



3. Key themes arising from this review include:

Importance of identifying all family members and significant adults in a child's life and the need for robust risk assessments
Information sharing
Importance of robust multi-agency safety plans
Challenges for professionals working with children where sexual abuse is suspected but the child has not told anybody about the abuse
Drift and delay in planning for children experiencing neglect
Recognising and responding to domestic abuse and coercive and controlling behaviour
Recording and meeting the needs of children from Mixed Heritage backgrounds

4. The review process

4.1 This review commenced following the Rapid Review meeting in December 2024. The recommendation from the Rapid Review Meeting was that the learning from Rosie's experiences should be considered in a thematic review with two other children, which the National Panel later concurred with. The findings of the Rapid Review meeting and comments made by the National Panel shaped the terms of reference.

4.2 The original plan made in December 2024 to capture the learning from Rosie's experiences in a thematic review was revisited in March 2025. As the review process progressed, it became apparent that the circumstances of the three children were very different. The Partnership then decided to separate the reviews into three individual reviews of the children's experiences.

4.3 To capture the learning for this review, information was drawn from the following sources:

- Rapid review submissions from agencies
- A multi-agency combined chronology
- Documents supplied on the author's request
- A multi-agency practitioner event focused on generic practice
- A multi-agency practitioner survey focused on child sexual abuse
- A multi-agency practitioner event focusing on diversity, ethnicity and inclusion.
- Contributions from the Child Safeguarding Practice Review Panel members.

4.4.1 This review focuses on the period between 4th September 2022 to 1st October 2023, although there was pertinent learning outside of this scope period, which has been included as it adds valuable context to the assessment of and responses to risks of interfamilial child sexual abuse.

5 Family background.

5.1 Rosie's mother was known to CAMHS as a child. In her teens, the mother struggled to manage her anger and self-medicated with alcohol. This was a chaotic time when she dabbled with smoking cannabis and other drugs.

5.2 She was approximately 17 or 18 when she had Rosie. She was referred to the Family Nurse Partnership, where she engaged well with the service, which provided support to develop her parenting and helped her to manage her mental health. During this time, she discussed her struggles with anxiety and depression, which she had suffered from since she was in secondary school.

5.3 Despite offers of support from early help, mental health services, support from a local charity and housing, she was unable to take on advice and fully engage with these services. There was a period of family support to Rosie's mother from 2017 to the first period of child in need planning in 2020.

5.4 Rosie's mother described how she felt 'bombarded' at times by social workers, but valued the support from a worker employed in a local charity, St Basil's.

5.5 Rosie's mother reported struggling to form a bond with her in her early years. Agencies were concerned that her mother struggled to prioritise Rosie's needs, was misusing alcohol and cannabis and had poor mental health. The home conditions were poor, and Rosie was observed at times to smell of cannabis.

5.6 Rosie's father was known to be a high-risk perpetrator of domestic abuse.

5.7 Over the years, there have been several 'anonymous' referrals raising concerns about the care of Rosie.

5.8 The mother started a new relationship and later gave birth to Rosie's stepsister in July 2020. Rosie's stepfather came from a family where there was a range of concerns about sexual abuse. The step-grandfather is a registered sex offender and in 2018 was issued a 5-year Sexual Harm Prevention Order (SHPO), with conditions attached. Namely:

- Not to have access to a telephone or computer
- Not having any unsupervised contact or communication of any kind with any female [or male] child under the age of 16, other than (i) such as is inadvertent and not reasonably avoidable in the course of daily life without the consent of the parent and Children's Services.

5.9 The safety plan devised in 2018 between the step-grandfather, step-grandmother and Children's Services stated that the step-grandfather was to have no unsupervised contact with their children. It was expected that the paternal step-grandmother would

supervise all contact. There were no expectations placed about contact with any other named children.

5.10 Two of Rosie's step-uncles had been the subject of investigations into sexual harm against a child, a non-family member.

5.11 There was domestic abuse in the relationship between Rosie's stepfather and mother between 2019 and 2023, as reported by the mother.

5.12 Rosie was made the subject of a child protection plan in May 2021 due to concerns about neglect and consideration was given to escalating planning into Pre-Proceedings[1]. When Rosie's mother and stepfather told professionals that they had separated, planning for Rosie and her sibling was stepped down to child-in-need planning in January 2023.

5.13 Rosie was offered significant amounts of care from her maternal aunt and her partner, and her maternal grandmother. These periods offered Rosie safety from the unsafe adults and neglect.

5.14 The stepfather had interventions from Children's Services when he was a child. This intervention focused on Harmful Sexualised Behaviour. The records about this historical support are limited, and it has not been possible to establish what the trigger was for this work to begin.

5.15 Rosie's father does not have parental responsibility and has no contact with her.

5.16 Rosie's father is of White and Black Caribbean Heritage. Rosie does not have any contact with her father's wider family.

6. A pen picture of the child.

6.1 Rosie was described as a girly girl who loves bright colours, pampering, and performing, especially a dance show. She is very creative and interested in arts, crafts, and drama. She likes to watch videos and has started making her own videos on her phone, too.

6.2 Rosie is a caring and kind child who is also funny and likes to make those around her laugh. She likes to be organised and keeps her room very tidy. Rosie loves her little sister, but doesn't like it when she messes up her room.

6.3 When Rosie met with the author, she came across as a bright, enthusiastic, engaging and energetic child who, with help, was able to express her views about the way professionals had supported her in the past.

7. Rosie's views and the views of the family

7.1 **Rosie's views:** Rosie was asked to describe things that make her feel safe and unsafe. She shared that she finds it frightening when adults around her argue and she doesn't like

[1] Public Proceedings is a stage prior to entering into Care Proceedings where attempts are made to prevent the case from being dealt with by the courts. Pre-proceedings are an opportunity for the parents to work with Children's Services before going into formal court proceedings.

moving around and changes in where she is living. She also recently changed schools, which meant she had a new teacher and had to make new friends.

7.2 Rosie was given a choice of professional roles that could have supported her. These included doctors, nurses, a priest, a social worker and a teacher. She was not able to recall anything that was helpful done by a priest, nurse, doctor or police officer.

7.3 She shared that she found her Art therapy helpful. Painting makes her feel happy, helps her to talk about her feelings and helps to keep her feeling calm. She shared how a different therapist had helped her talk about and identify her feelings, including feeling happy, sad, fearful and angry. She also recalled how her teacher had listened to her and helped her with her feelings. Her social worker had helped her with knowing where she was going to live, who she was going to see and how she was to be kept safe. She was also able to talk to her social worker about how she was feeling.

7.4 Rosie could not think of anything she would change about how professionals worked with children in general.

7.5 The mother's views: The mother met with the author. She felt that she had received good support from St Basil's and was sad that this support stopped, due to them only offering services for individuals up to the age of 24 years. She valued this support and explained that this seemed to work for her as she was 'asked what she needed help with'. Her support worker from St Basil's devised a step-by-step plan with her, which focused on 'quick wins' and planned for 'bigger issues later on'. Rosie's mother also spoke positively about her current health visitor, who had recognised that her mental health was impacting on her parenting, spoke to her like a 'human' and was responsive, not leaving the mother waiting, which makes her anxious.

7.6 Rosie's mother did not feel that she received good support from social workers, who she felt 'bombarded' her and told her what to do and made her feel like a 'bad mum'. She recognised that she did not always respond well to this approach. She also felt she had been let down by the police when threatened by Rosie's father and his family. She described being provided with a panic button, which, when she tried to use it, didn't work.

7.7 The mother felt that she had been 'kept in the dark' about the risks from the step-grandfather and that she had never been told not to take the children to the step-grandparent's house or why.

7.8 She was told by Children's Services to request a disclosure in respect of the stepfather, not the step-grandfather. She described that the stepfather did not know about the risks posed by the step-grandfather and that she did not understand the Sexual Harm Prevention Order (SHPO), as her reading and writing skills were poor. She said that the step-grandmother was scared of the step-grandfather, who could be aggressive and nasty when he had been drinking alcohol.

7.9 She stated she did not know that the step-grandfather was not allowed a phone or any unsupervised contact with children. She said that social workers had been clearer about the physical risks posed by Rosie's birth father than the risks of sexual harm posed by the step-grandfather. Most of the focus of the child protection planning was about the stepfather and the domestic abuse – the step-grandfather was "never mentioned".

7.10 She felt that asking women to be protective was a big responsibility and may be unrealistic – she queried if the assessment of the stepmother's ability to protect had been correct.

7.11 She recognised that the step-grandfather had groomed the whole family.

7.12 Rosie had to wait for 2 or 3 weeks for a medical at the SARC[2] and when it did happen, it was carried out by a male professional. She was offered a choice of a male or female professional, but given the amount of time Rosie had to wait for an appointment, the mother did not want to create more delay by insisting on a female professional. The mother felt the medical was rushed and was not child focused.

7.13 As potential outcomes of this review, the mother requested the following:

1. To have something on the Partnership website explaining Sarah's Law.
2. Professionals to be honest about offences and not 'sugar coat risks'.
3. For consideration to be given to setting up a support group for mothers affected by domestic abuse.

7.14 The maternal grandparents' views: Rosie's maternal grandmother and grandfather met with the author. They are both committed to the safety of their grandchildren. They told the author that they felt and continue to feel very frustrated. They felt the services that Children's Services had agreed to provide had not been provided. They held information and insights into the risks to Rosie and her half-sibling, but said that they had not been listened to. The grandparents had spoken to the social worker and team manager, but continued to feel as if they were not listened to and their concerns were not acted on.

8. Findings from the practitioner survey.

8.1 The survey sought to test out the confidence levels of frontline practitioners in recognising and responding to interfamilial sexual abuse. The survey was completed by 313 front-line practitioners from a range of services in Warwickshire.

8.2 Training was the main area that respondents cited as being beneficial. Only 168 of the 313 respondents cited having any polices or procedures to guide practice. This is linked in a recommendation further below in the report.

8.3 Most respondents reported average to good levels of confidence in recognising child sexual abuse[3]. The main barriers to recognising child sexual abuse were:

- Lack of training
- No disclosure
- Other preventing factors that might mask the abuse

8.4 When asked about how confident respondents felt *responding* when they suspected a child was being sexually abused but they had not told anyone of the abuse, most respondents scaled themselves at 3 out of 5 (where 5 meant 'extremely confident').

8.5 The lowest levels of confidence shown by respondents were when they were asked how confident they would feel about *having a conversation with a parent or carer* where it is

[2] Sexual Assault Referral Centre
[3] Where 5 is the highest level of confidence scaling 118 rated themselves at 3 and 105 scaled themselves at 4.

suspected that a child was being sexually abused, but the child had not told anyone they were being harmed. These findings very much align with the findings of other recent research carried out at a national level[4].

8.6 Practitioners spoke of wanting a forum to share information where there are concerns about sexual harm, to promote information sharing and offer support in complex cases where there are concerns that a child has been sexually harmed but the child has not told a trusted adult that they are being harmed. A linked recommendation about the use of meetings is made in response to this finding later in the report.

9. Analysis

9.1 Identified good practice.

9.2 The escalation from child in need planning to child protection planning in 2021 was good practice. Planning at this stage was based on an accurate baseline of the children's needs and clarity about what needed to change and within what timescale.

9.3 The Independent Reviewing Officers (IRO) who chaired the Child Protection Conferences recognised the lack of progress against the child protection plans and lack of sustained change in the levels of neglect the children were exposed to. The IROs raised two formal escalations within Children's Services, which set out the concerns.

9.4 The strategy meeting held in September 2023 was attended by a representative of the SARC[5]. This is good practice and usually ensures that the health and well-being needs of the child are met promptly, as well as supporting the effective collection of any forensic evidence.

10. Key learning and linked recommendations for practice improvement.

10.1 The early multi-agency risk assessment of risk between October 2020 to May 2021.

10.2 There was a series of events that happened during this period that shaped the multi-agency interventions for the family going forward. This period sets the scene as to why the risks posed by the step-grandfather were silent throughout the scope period.

10.3 In 2018, the step-grandfather was convicted and became a registered sex offender. An assessment was commenced in respect of the step-aunt (then aged 7 years old) who was living with the step-grandfather. A working agreement was put into place whereby the

[4] The Safeguarding Practice Review Panel. "I wanted them all to notice". Protecting children and responding to child sexual abuse in the family environment. November 2024 & Centre of Expertise on child sexual abuse; Key messages from research on intra-familial child sexual abuse. Second Edition. September 2023

[5] Sexual Assault Referral Centre.

step-grandmother was to supervise all contact between the step-grandfather and the step-aunt, both of whom lived in the same house.

10.4 The risk assessment of the step-grandfather did not include all of the children with whom he was having contact or could potentially have contact. A link was not made between the step-grandfather and Rosie.

10.5 When the link between the step-grandfather and Rosie was discovered in January 2019, Rosie's mother was advised by Children's Services to seek a disclosure from the police about the step-grandfather's offences. Rosie's mother sought a disclosure from the police about her new partner and not the step-grandfather. The police disclosed information about Rosie's stepfather's minor criminal activity linked to drugs, but not about the potential risks from the step-grandfather, as it was thought that the mother knew of these risks and could protect Rosie. Children's Services at this point thought that the mother was fully informed about the risks from the step-grandfather.

10.6 There was also an expectation by the police that if contact did commence between Rosie and the step-grandfather, then Children's Services would either disclose the risks to the mother or contact the police. The assumptions made by Children's Services and the Police meant that the mother was not fully informed of the risks from the step-grandfather and it was believed that Rosie was safe.

10.7 The health visitor 1 made a detailed referral to Children's Services in October 2020. Having worked with the family for 3 months, she was concerned that the children were living in neglectful home conditions. The mother and Rosie's stepfather were using cannabis, the family had not engaged with health visiting or mental health services. Early Help had also recently closed the case due to non-engagement. The referral references the neglect and step-uncle 1's presence in the family home, who was offering care to Rosie's half-sister. This referral prompted the start of a child in need plan due to concerns about neglect.

10.8 In November 2020, the Police Offender Manager (OM) was told by the step-grandmother that they had babysat their granddaughter (Rosie). The step-grandfather had a meeting with his OM the day before and had not mentioned this. Children's Services were informed that the step-grandfather had babysat Rosie, despite his Sexual Harm Prevention Order (SHPO) conditions, which prohibited this. Children's Services' response to this was that there was a safety plan in place and the family was considered to be 'low risk'.

10.9 In December 2020, an assessment was completed by Children's Services in response to the health visitor 1's concerns about neglect. This assessment cites the potential risk from the paternal step-grandfather. Rosie's mother stated that Rosie does visit the step-grandparents' home, but all contact was supervised by the paternal grandmother. There is no evidence that this was discussed with the step-grandmother directly. It is not possible to establish what exactly was exchanged between the assessing social worker and the mother about the exact details of the risk that the step-grandfather posed to children.

10.10 There was no consideration of a breach of his SHPO or consideration that the risk from the step-grandfather may have changed, given his and his wife's non-compliance with the safety plan by allowing Rosie to stay over in their family home without the express

permission of Children's Services. The assumption was made that the mother fully understood the risks from the step-grandfather and would take protective steps.

10.11 In March 2021, a strategy meeting[6] took place in respect of Rosie due to a historical report of rape that was made by a child against the step uncle 1. At that meeting, it was shared that the step-uncle 1 had been staying at Rosie's family home. He ordinarily lived with the step-grandfather and step-grandmother. An assessment was commenced in respect of the step-aunt (aged 10 years old) who was living in the same household as step-uncle 1.

10.12 In discussions about a potential safety plan, the risks posed by the step-grandfather were cited as "he had also been convicted for downloading images", therefore, there were two adults in that family home who should not have unsupervised contact with children[7]. The information that the step-grandfather had babysat Rosie in November 2020 was not discussed in this meeting as the attending police officer did not have access to the police system where the Offender manager makes entries. The step-grandfather's breach of both the SHPO and the agreed safety plan could have provided members of the strategy meeting with an insight into the potential changes in risk, given the couple's non-compliance.

10.13 A further strategy meeting was convened approximately one month later. The responsibility for chairing this meeting changed to a new team manager, and there was a change of social worker. The relevant agency information shared in this meeting was the same as in the previous strategy meeting one month prior, with the notes stating "see previous meeting information". It appears that the minutes of the previous meeting were not referred to, as the risks from the step-grandfather were not revisited despite the same nursery worker, police officer and health visitor having attended both of the strategy meetings.

10.14 The police provided an update on the investigation into the allegation of rape against the step-uncle 1, at the second strategy meeting, not citing the offences against the step-paternal grandfather or that he was a registered sex offender. The only reference to the protection of the girls from sexual harm was the 'safety plan to continue'[8]. The focus of the Section 47 enquiry[9] was on the neglect and emotional harm to the children, not the risks of sexual harm.

10.15 Practitioners who contributed to a reflective event felt that the safety planning for Rosie and her half-sister lacked robustness, as an assumption was made that if the step-aunt to Rosie had been deemed to be safe following an assessment, then it would be safe for Rosie to have ongoing supervised contact with her step-grandfather. Practitioners involved in the review also reflected that there was an assumption that the risk from the step-grandfather had been dealt with by the time of the second strategy meeting, following the disclosure of information to the mother by the police. The disclosure was

[6] A strategy meeting is a meeting which allows the sharing of information that is known by professionals working with a child and help build a picture of what has happened or is happening for a child. The outcomes of a strategy meeting can include the commence of a criminal investigation, any immediate measures that need to be put into place to safeguarding a child and/or for S.47 enquiry to begin.

[7] Strategy meeting minutes dated 24.03.2021

[8] Strategy meeting minutes dated 22.04.2021

[9] A Section 47 enquiry undertaken under S.47 of the Children Act is a meeting where children's services or the police receive information that a child may be at risk of harm and they have a statutory duty to investigate. S.47 enquiries bring together key information about the child and evaluate risk. Possible outcomes include an initial Child Protection Conference; continue to an child and family assessment by children's services or no further action.

made about the stepfather and not the step-grandfather. The risk had not, therefore been dealt with. Lastly, the health visiting team were experiencing severe staffing issues at this time.

10.16 It is perplexing why the information about the step-grandfather was not shared by the social worker with Rosie's mother, rather than signposting her to the police. Although this was a theme that emerged from the evaluation of over 130 reviews carried out by the National Panel[10].

10.17 The lack of robustness of the assessment of risks in respect of the step-grandfather, step uncle 1 and the disappearance of this risk from the first to the second strategy meeting set the scene going forward, where the risks from the paternal step-grandfather were not recognised, which resulted in Rosie not being safeguarded.

10.18 Accepting that Warwickshire Children's Services were inspected in December 2021 and rated as 'Good' and there has been a significant change in the way the multi-agency systems are working under Wave 2 of the Families First Pathfinder Programme[11]. It will be important that Partnership takes steps to ensure that the historical systemic learning that affected this family is not being replicated in current day practices, where:

- The police did not link Rosie or her half-sibling with the step-grandfather.
- Children's Services did not consider all of the children that the step-grandfather was coming into contact with when they assessed in respect of the step-aunt.
- When the children were linked to the step-grandfather, there was poor information sharing, e.g. babysitting; a request to step down the safety plan, which could have prompted a refresh of the risk assessment by Children's Services in the Initial Child Protection Conference.
- The assessment of the step-grandfather's risk to children does not appear to have been revisited by the Offender Manager when he did not adhere to the safety plan arrangements and asked for it to be stepped down as it was inconvenient.
- The identified risk from the step-grandfather did not translate from the first strategy meeting to the Initial Child Protection Conference, even though the same core professionals were present.
- The known risk from the step-grandfather was not shared with the mother by the social worker.

Linked recommendation 1: Within 6 months of publication of this report, Warwickshire Safeguarding Children Partnership (WSCP) will obtain written assurance from all relevant partner agencies confirming that the historic practice referenced in paragraph 10.18 is no longer present in current multi-agency safeguarding practice. This written assurance must outline:

- Improvements made to practice since the time of the cited concern
- Steps taken to raise staff awareness and embed learning
- Evidence of compliance with expected safeguarding standards

[10] https://assets.publishing.service.gov.uk/media/67446a8a81f809b32c8568d3/CSPRP_-_I_wanted_them_all_to_notice.pdf
[11] The pathfinder programme's aim is to move from costly intervention and to offer more meaningful and effective early support. The pathfinders introduces a new delivery model for family help, child protection, family networks and multi-agency safeguarding. In particular, multi-agency safeguarding teams will be introduced.

10.19 Multi-agency Child Protection planning activity between May 2021 and January 2023.

10.20 Assessing and responding to risks of sexual harm: The same core professionals who attended the first strategy meeting in March 2021 attended the conference. The risks identified from the step-grandfather in the 1st strategy meeting were discussed in the first Child Protection Conference. There was a lack of clarity in the discussion and subsequent record about whether the risk came from the stepfather or step-grandfather, although the step-grandfather's offences were clearly recorded. The mother offered reassurance that the stepfather was safe.

10.21 In addition to the discussions about the neglect the children were experiencing, reference was also made to the presence of a 'risky adult' in the children's lives who was under investigation (step-uncle 1). There were concerns that the parents were not adhering to the safety plan around the step-uncle 1, who had been seen in the family home offering care to the children. The minutes reference some ambivalence to the safety plan by the family. Core professionals who had been part of the planning for the children since the first strategy meeting did not pick up on the care that the step-grandmother was offering the children or query where the children were being "looked after".

10.22 There is a record in the Initial Child Protection Conference in May 2021 of professionals offering challenge to the fact that the family (Rosie's mother, stepfather and step-uncle 1) appear not to accept that there is any risk to the children. However, there is no examination of how this may have placed Rosie and her half-sibling at risk or actions to ameliorate this risk. The safety planning in respect to step-uncle 1 was overly optimistic and lacked rigour.

10.23 This conference was undertaken remotely due to the COVID-19 lockdown. The early transition from face to face meetings to remote meetings may have made it more difficult for attendees to follow the meeting and to crisply bring together the concerns, including the fact that the family appeared not to accept the concerns about the step-uncle 1 and that the children were being cared for by the step-grandmother.

10.24 In parallel to this meeting, in May 2021, the step-grandfather asked his Offender Manager if the 'safety plan, which involved the step-grandmother supervising all contact, could cease as it was "inconvenient". This did not trigger a reassessment of the risk posed by the step-grandfather, and this information was not shared with Children's Services.

10.25 In June 2021 the child who made the original allegation of rape against the step-uncle 1 also made an allegation about step-uncle 2, meaning that there were now three adult males in this household who were a potential risk to children. This information was not shared with Children's Services or discussed in the Review Child Protection Conference, which was held remotely in August 2021. A different Child Protection Liaison Officer (Police officer) attended the conference and the update on the investigation into the step-uncle 1 was not referenced, as an investigation was not created on police systems until October 2021.

10.26 A Review Child Protection Conference was held in February 2022. Again, it was held remotely due to COVID-19. The health representative had changed due to a handover from health visiting to school nursing. This handover between the health visiting service and school nursing did not reference any risks of sexual harm.[12]

10.27 There was a change in the Independent Reviewing Officer in September 2022. By which time there had been a change in social worker, the children had started at a new school, Rosie's younger sister had a different health visitor and the support worker from St Basil's had given her apologies for the meeting. The only professional who had any consistent history with the family was the member of police staff, who had no face to face contact with the family. No updates were offered at this conference about the outcomes of the investigations into the two step-uncles.

10.28 The changes in the team around Rosie, the assumption that Rosie was safe if the step-aunt had been assessed as safe, and the lost thread about the risks from the step-grandfather from the first strategy meeting meant that the risk of sexual abuse posed by the step-grandfather continued not to be recognised or responded to effectively by multi-agency partners during this period of child protection planning.

10.29 Since this period of multi-agency safeguarding, there have been considerable changes in the way multi-agency partners and Children's Services assess and support families in Warwickshire. Some of these changes mitigate the systemic learning from this part of multi-agency working in respect of intrafamilial sexual abuse. Namely:

- Multi-agency strategy discussions are undertaken by the Multi-agency Child Protection Team only, which builds consistency and confidence in chairing these meetings.
- The Multi-agency Child Protection team is made up of multi-agency professionals to promote real-time information sharing.
- Child protection conferences are chaired by Child Protection Practitioners (social workers) who are based in the Multi-agency Child Protection Team, promoting better consistency.

10.30 The above practice changes are positive. However, panel members recognised that any period of organisational change can bring risks.

Linked recommendation 2:
Warwickshire Safeguarding Children Partnership (WSCP) will undertake a multi-agency assurance activity to evaluate the impact of the Family First reforms, specifically in relation to the implementation and effectiveness of the Family Connect service within Children's Services. This activity will assess whether Family Connect is improving access to early help and safeguarding support for children and families.

10.31 Quality of safety planning

10.32 The original risk assessment of the risk step-grandfather and the subsequent safety planning in respect of the step-aunt lacked rigour. It was agreed between the step-

[12] Handover entry in the Rapid review report from SWFT

grandfather, step-grandmother and Children's Services that the step-grandmother would supervise all contact between the step-grandfather and the step-aunt.

10.33 The comments made to the author about the step-grandmother being afraid of the step-grandfather and the observations of practitioners indicated that there could have been more exploration of how the step-grandmother was expected to supervise all of the care of their child and challenge concerns where the safety plan was not being complied with.

10.34 It seems unrealistic to place this upon the step-grandmother in both the SHPO and Children's Services safety plan without any ongoing support i.e. to expect total supervision of the care of the children for the following 17 years.

10.35 The safety planning lacked stipulations about what was expected of the step-grandmother.

10.36 This left the step-grandmother having to apply some discretion on the application of the SHPO and safety planning requirements. This lack of specificity in the SHPO also makes monitoring compliance very difficult for professionals. Practitioners reflected that current-day practice requires that all sex offenders living with children be assessed as being high risk. A link recommendation has been made in recommendation 4 to ensure that this practice is in place consistently, and there are robust safety plans in place for children.

10.37 According to the mother, she was given various safety plans to sign, but has limited literacy, so she was unable to read and understand these.

10.38 In 2019, Rosie's mother told the OM that she was aware of the step-grandfather's offences. The step-grandmother confirmed to the OM that Rosie's mother was aware of the history. It has not been possible to see from records what exactly was said to Rosie's mother or understood by her, only that the social worker believed that Rosie's mother would never leave Rosie alone with the step-grandfather and she was aware that he was on the sex offender register.

10.39 Rosie's mother and stepfather showed a level of ambivalence about the potential risks from step-uncle 1 when this was discussed in the Child Protection Conferences. It was known that the mother had periods of feeling very low, which affected her levels of motivation, leaving her at times unable to get out of bed a meet the children's needs.

10.40 Given the general concerns about neglect, the mother's poor literacy, her fluctuating mental health, the mother and stepfather's ambivalence about the risks from the step uncle and the fact that the risks of sexual harm to Rosie were no longer discussed after the 1st Child Protection Conference – it is perhaps unsurprising that the mother did not fully grasp the risks that the step grandfather posed to Rosie until she had already been harmed. A linked recommendation in response to these findings is included later in the report.

10.41 Signs and indicators of interfamilial sexual abuse:

10.42 It is unusual for children to tell safe adults around them that they have been abused and many children do not verbally disclose until well into adulthood[13]. Research indicates that just one in three children talks to a trusted adult. Many other children show

[13]Alcock, A Key messages from research on identifying and responding to disclosure of child sexual abuse. September 2019

emotional, behavioural and physical signs of their abuse. The views of practitioners in Warwickshire echoed that of national research. Practitioners showed low levels of confidence in intervening for children who had not told anyone about the abuse they were suffering. For professionals to respond effectively where a child has not spoken out, it is vitally important that professionals working with children and young people are attuned to non-verbal signs and indicators.

10.43 Professionals need to build a picture of concerns, not only the signs and indicators in the child themselves, but also the potential indicators of sexually abusive behaviour in others around them. Additionally, other family or environmental factors that increase opportunities for children to be abused, such as the presence of domestic abuse, parental substance misuse and neglect[14] which need to be considered.

10.44 Some of the signs and indicators were explicitly known in the multi-agency safeguarding system before Rosie spoke about the abuse she had suffered. These indicators included:

- The step-grandfather is a convicted sex offender and there were known sexual harm concerns about the step-uncles.
- A history of concerns about neglect for most of Rosie's life
- The presence of domestic abuse in both Rosie's father's and stepfather's relationship with her mother.

10.45 Other information that was available but not known across the multi-agency safeguarding systems included:

- A request from the step–grandfather in 2020 to step down the 'safety plan' as it was inconvenient, which did not trigger a reassessment of risk given his lack of compliance and his view that it was inconvenient.
- A complaint by a neighbour that the step-grandfather was having contact with a child.
- The step-grandfather was having contact with Rosie as far back as May 2021.
- A vaginal swab was taken from Rosie by the GP, at the request of the mother, in March 2022 when Rosie's vagina was 'red and sore'. This was not shared with other agencies.
- Requests from the mother to the school nursing for help for Rosie, given she was 'struggling to manage her emotions'.
- Rosie was described as 'flat and unhappy' in June 2023.

10.46 Practitioners who contributed to this review reflected that these signs and indicators were perhaps missed due to the other issues masking the harm Rosie was experiencing, namely, the neglect and domestic abuse. A view that has been corroborated by research carried out by the Child Sexual Abuse Organisation[15].

10.47 Practitioners also reflected that adult family members always seemed to be in crisis, which made it extremely difficult to remain child-focused in their planning and to keep their work grounded in Rosie's lived experience. There had been family bereavements which were accepted as being the cause of the mother's poor mental health, rather than an entrenched pattern where the mother was not able to respond to her children's needs and the stepfather was not able to step in to meet the needs of the children.

[14] Centre of Expertise on child sexual abuse. Signs and indicators – A template for identifying and recording concerns of child sexual abuse. 2021

10.48 There is often no single or combination of indicators that signify that a child is being sexually abused. Signs and indicators of sexual abuse may also be indicative of other forms of harm and abuse a child may be experiencing. As a result, signs of sexual abuse are often missed or dismissed, and children who have not told anyone about their abuse continue to be at risk.

10.49 Signs and indicators: A template for identifying and recording concerns of CSA is a template, produced by the CSA Centre, which has been designed to support professionals across a range of organisations and agencies in systematically observing, recording and communicating their concerns about possible CSA.

10.50 The use of these tools in the context of a professional meeting (see linked recommendation 4) would have enabled professionals working with Rosie to 'build a picture' of the concerns known in the safeguarding system and potentially identify the sexual harm she was experiencing.

10.51 Recommendations have been made in response to these findings later in the report under Linked Recommendation 4.

10.52 Responding to children when they have told about abuse – local learning.

10.53 Rosie told her maternal grandmother of the abuse she had experienced on a Sunday. The maternal grandmother took immediate action and reported this to the police. A strategy meeting was convened on the same day involving Out of Hours Children's Services and the Police.

10.54 The following day, a further strategy meeting took place. In line with good practice, the SARC were invited to this meeting. It was reported that the last time Rosie had been harmed was 3 weeks before she told her grandmother, which would have been in the later part of the school summer holidays. As this was considered a 'non recent' incident of sexual harm, Rosie was seen at Birmingham Hospital on the 18th of September 2023, 15 days after she first told someone she had been harmed.

10.55 On the 18th, she received a holistic assessment, which included a full physical examination, referrals to counselling and an ISVA [16], and testing for physical harm, such as sexually transmitted diseases.

10.56 Rosie was seen with her mother at the Birmingham hospital, which is approximately 40 miles from her home. The decision for Rosie to be seen at the hospital was influenced by the availability at the more local clinic and the need to prioritise children who have reported more recent abuse or harm.

10.57 Rosie's mother spoke to the author and explained that she felt uncomfortable that Rosie was seen by a male practitioner. Although she had been offered an opportunity for Rosie to see a female practitioner, she felt that the delay of two weeks was too much and accepted this appointment to prevent further delay for Rosie.

10.58 Rosie's mother felt that the SARC practitioner favoured speaking to the social worker over speaking to Rosie and described how the appointment was not child friendly.

[16] ISVA or Independent Sexual Violence Advocate.

10.59 It has not been possible to speak to the practitioner who carried out the examination. Feedback from the local SARC showed that this appointment was carried out by an experienced practitioner who was supported by a crisis support worker whose role is to ensure that the child understands the process and limits distress.

10.60 Although in this case the practitioner was experienced and was reported to be child-focused, the mother's report of the experience differed.

10.61 The timeliness of the appointment is in line with good practice guidelines set out by the Royal College of Paediatrics and Child Health[17]. However, the lived experience of 6 year old Rosie was to be seen 15 days after her third disclosure of abuse to a trusted adult. There is no linked recommendation linked to these findings as the National Panel has already recommended that the Government should ask the NHS England (or equivalent) and public health commissioners to ensure that pathways are in place to identify and respond to children who have experienced both recent[18] and non-recent abuse cases.

10.62 When the author spoke to the mother, she felt that Rosie still did not feel safe. It is important that professionals are clear with children, in an age-appropriate way, to let them know what steps are being taken to keep them safe.

10.63 It can sometimes be assumed that it is the role of the non-abusing parent to assure the child that they are safe. Recent research has shown that non-abusive parents are similarly traumatised by this form of harm and can be debilitated by feelings of shock, "feeling blamed, judged and not understood by friends and family[19]".

10.64 In Rosie's case, there had been a long history of neglect and domestic abuse. It will be important going forward that professionals recognise the short and long-term trauma experienced by children after they have told adults about their abuse, and that children are given the information and services they need to enable them to feel safe. For example[20]:

- Assuring children that they are not to blame for the abuse they have experienced
- Telling children that the person who harmed them has been arrested
- Explaining to children which adults are going to be responsible for keeping them safe going forward
- Explain that they won't have to contact the person who harmed them
- Assuring the child that their siblings will also be kept safe
- Talking to the child about what to do if they ever feel unsafe again

* Although it is noted that Rosie told the author that the social worker had told her how she was going to be kept safe.

10.65 Warwickshire Safeguarding Partnership have begun a multi-agency Practice Lead Programme, has adopted a model which includes Child Sexual Abuse Champions and has agreed the use of the CSA Signs and Indicators template. In addition, Children's Services arranged for a psychologist who specialises in sexual risk to deliver training on

[17] https://childprotection.rcpch.ac.uk/purple-book/
[18] Within the previous 3 weeks
[19] Sara Scott DMSS Research. Key messages from research on intra-familial child sexual abuse. 2nd Edition September 2023
[20] Not an exhaustive list

risk assessments to social workers. These are promising developments which began before the conclusion of the review.

Linked recommendation 3 in response to findings on Child Sexual Abuse:
WSCP to consider developing and publishing local practice guidance for professionals working with children where child sexual abuse (CSA) is suspected but not disclosed. The aim of this will be to ensure practitioners across the partnership have a clear, consistent guidance to support early identification, effective planning, and safe responses in complex CSA cases.
This guidance will include:

1. CSA Response Pathway and Signs and Indicators Tool into assessments and planning for children.
2. Use of child in need or strategy meetings in cases where there are concerns that a child may have been sexually harmed but has not disclosed the abuse.
3. Practice standards for safety planning, including how safety plans are communicated to both children and their parents/carers.
4. Guidance on appropriate interventions for children where CSA is suspected but not confirmed through disclosure.
5. Information-sharing guidance to help professionals reassure children about their safety in both the short and long term.

10.66 Assessing and responding to neglect:

10.67 Child protection planning for Rosie began in May 2021 and ceased in January 2023. She was the subject of a child protection plan for 18 months until it was unanimously decided that this should cease.

10.68 It is evident from the Child Protection Conference notes that the mother and stepfather's engagement was inconsistent. Any positive changes that were achieved during the period the children were on child protection plans were not maintained for any significant period. This pattern was apparent from October 2020, when the mother's periods of poor mental health left her lacking in motivation, which impacted her ability to meet the children's basic needs consistently.

10.69 In May 2021, the neglect the children experienced included:

- Not being brought to health appointments
- Medical attention not sought which was against medical advice
- Being left in the care of unsafe adults – namely step step-uncle 1
- Basic care needs not being met
- Poor bonding with Rosie
- Rosie saying she was very unhappy at home (aged 4)

10.70 At this time, consideration was given to commencing interventions under the Public Law Outline (PLO) due to the lack of progress for Rosie and her half-sibling. However, at this time the parents' engagement had increased slightly and some improvements were made.

10.71 In February 2022 the Independent Reviewing Officer, who had chaired the Child Protection Conference, raised a formal escalation as a result of the lack of progress made against the Child Protection plan and recommended that the assessment of the family should be revisited and that legal advice should be sought. This recommendation was not carried out.

10.72 Practitioners involved reflected that by September 2022, any consideration to initiate PLO had dropped off the agenda. The newly allocated Independent Reviewing Officer (IRO) had taken over without a handover from the previous IRO. Despite the lack of handover, this IRO did raise another formal escalation about the progress of the child protection plan.

10.73 Although there are formal processes to check the outcome of escalations, in this instance, it was not responded to, and there is no senior manager record of the agreed response to the escalation. Partners involved with Rosie at the time were not aware that a formal escalation had been raised in Children's Services, so they could not offer any further challenge to support this process.

10.74 Children's Services practitioners reflected that not all escalations are responded to in a timely manner despite internal monitoring processes.

Linked recommendation 4:
Warwickshire Children's Services to complete an internal audit of the effectiveness of its escalation processes in safeguarding and child protection cases. The audit will:

- Assess how well internal escalation procedures are understood and applied by staff when concerns arise.
- Identify any delays or barriers in resolving professional disagreements internally.
- Evaluate the potential benefits and risks of sharing formal escalations with multi-agency partners involved in child protection planning.

10.75 By the final Review Child Protection Conference in January 2023, there had been changes in professionals working with the family, namely:

- A change of school
- New health visitor for Rosie's half sister
- New social worker
- Different team manager
- New Independent Reviewing Officer

10.76 The improvements that parents made between September 2022 and January 2023 were accepted as 'sustained improvement' and the decision was made to end the child protection plans. Practitioners reflected that there was a certain amount of 'pressure' to end the child protection plans as the plans had been ongoing for 18 months.

10.77 Although the family had engaged in some parenting support, it was accepted that the mother's enduring mental health needs would be solved by having "an adult mental

health social worker whom she met last week". The mother was still refusing to take the antidepressant medication prescribed to her since May 2021.

10.78 The end of the child protection plans appears to be overly optimistic and did not fully consider the cumulative and fluctuating nature of neglect. The reflections of practitioners that it was hard to remain child-focused are demonstrated in the Child Protection Planning minutes, where one agency stated, "the mother has come such a long way, not being stepped down to a Child in Need Plan would set her back".

10.79 Neglect is a priority for the Partnership in the business plan 2025-2026, and a Multi-agency Task and Finish Group has already been established. The Partnership intends to develop a Neglect Strategy and introduce a Neglect Toolkit. It will be important going forward that Partners can be assured that these are being effectively embedded in practice and impacting upon the way children are safeguarded from neglect in Warwickshire.

Linked recommendation 5:
Following the implementation of the Neglect Strategy and Toolkit, Warwickshire Safeguarding Children Partnership (WSCP) will undertake a focused scrutiny activity aligned with the Neglect Business Priority.
This scrutiny will:

- Evaluate the effectiveness of the Neglect Strategy and Toolkit in improving the identification, assessment, and response to neglect.
- Assess the impact on outcomes for children, including timeliness of intervention, quality of planning, and multi-agency coordination.
- Use evidence from audits, practitioner feedback, and performance data to inform findings.
- Report outcomes and learning to the WSCP Assurance and Review Group and Delegated Safeguarding Partners, with clear recommendations for further improvement or embedding.

10.80 Assessing and responding to risks to children of domestic abuse:

10.81 Domestic abuse was first reported between the mother and the stepfather in October 2022, when she first fled to a neighbouring town. The following month, the mother reported one report of domestic abuse and stalking and one report of coercive and controlling behaviour to the police. She described to officers how she had been physically assaulted in the 4 years they had been together, having separated 3 or 4 weeks before presenting at the police station.

10.82 The police did not attend the last Child Protection Conference in January 2023 due to capacity issues but did relay the reports that the mother had made to the police. Both parents attended the conference and shared that they recognised that they needed to do some work on 'themselves' and the mother welcomed some 'family counselling'.

10.83 The impact on the children of witnessing physical violence, 'shouting' and controlling and coercive control over a four-year period does not appear to have been recognised.

Minutes of the meeting describe the domestic abuse as 'bickering' and that Rosie picked up on 'tensions'. Only the school used the terminology 'domestic abuse'. The minutes also describe how the stepfather would withhold money from the mother, which resulted in her getting into debt and not having enough money to pay bills. This was also not considered as a form of coercive control.

10.84 The couple resumed their relationship 16 days after the children's child protection plans ceased. There was no re-evaluation of the risks to the children and the family were stepped down to Early Help following a child in need meeting in March 2023. The acceptance that the couple had separated from each other and the unhelpful language used to frame the abuse are indicative that there was overoptimism in the assessment of domestic abuse and a poor understanding of potential risks to survivors post-separation. Research shows that survivors can return to pre-abusive relationships on a number of occasions before being able to fully remove themselves from the abuse.

Linked recommendation 6:
For the Warwickshire Children's Partnership to gain assurance that multi-agency practitioners have the skills to recognise domestic abuse and controlling and coercive behaviour by:

Creating a Map of the Current Training Landscape:

- Identify and document all DA and coercive control training currently offered across agencies.
- Assess the level of practitioner uptake and engagement.

Identifying Gaps and Areas for Development

- Highlight any inconsistencies or gaps in training provision.
- Ensure plans are in place to build practitioner confidence in recognising and responding to domestic abuse and coercive control.

Monitoring and Evaluating the Impact of training:

- The review will assess the impact of the current training offer and identify areas for improvement.

10.85 Responding to parental needs that inhibit parenting and engagement

10.86 The multi-agency practitioner group were asked to reflect on the intersecting needs of the mother and how these may have impacted her engagement or access to services. The mother experienced multiple barriers to accessing services. She was living with poor literacy, had ongoing mental health difficulties, was living in poverty and was experiencing domestic abuse.

10.87 There is also evidence of some gender bias during the child protection planning, as she was seen as the main carer for both Rosie and her half-sister, whereas Rosie's stepfather was absent from much of the planning and assessments.

10.88 There appeared to be very little consideration given to holding the stepfather to account for his lack of input into the family and conference minutes imply that this was left to the mother to deal with rather than the professionals working with the children.

10.89 The mother's poor literacy and 'dyslexia'[21] would have directly impacted her access to assessments, social work reports for conferences and written expectations of her regarding the contact between the children and the step-grandfather. Conference reports show that the mother refused to 'see' reports before conferences as she found this stressful. She told the author that she did not know what the SHPO set out or at times, what she was signing for, when asked to agree to safety plans and provide parental consent.

10.90 The early conferences recognised her additional needs in accessing written information. This was not apparent in later conferences, as the chair had changed and this additional need had not been shared. Similarly, the health visitor, SARC professionals and mental health professionals did not know that the mother had additional needs in respect of her literacy skills.

10.91 The impact of these intersecting needs on her ability to engage with and understand professionals in the safeguarding system was recognised by the practitioners in the reflective event, who made the following recommendation:

Linked recommendation 7:
Within six months of the publication of this report, all partner agencies will provide written assurance to the Warwickshire Safeguarding Children Partnership (WSCP) confirming that they have implemented procedures to identify parents with intersecting needs—particularly those related to mental health, literacy, and other vulnerabilities—and to offer access to appropriate, independent advocacy support.
This assurance must reflect the understanding that advocacy varies by context (e.g., mental health, learning disability, domestic abuse, child protection), and should include:

- Clear and specific referral pathways to different types of advocacy services, ensuring families and professionals can access the right support for their circumstances.
- Evidence of staff training to help practitioners recognise barriers to engagement and understand how to navigate and refer to appropriate advocacy services.
- Monitoring mechanisms within each agency to evaluate the uptake, accessibility, and impact of advocacy support.

This includes addressing potential barriers such as funding constraints and ensuring advocacy is not only available but actively utilised to improve parental understanding and meaningful engagement in safeguarding processes.

[21] Reported by the mother – not formally diagnosed

10.92 Safeguarding children from Mixed Heritage backgrounds

10.93 A reflective event was structured using the reflective questions highlighted in the National Panel Report "It's Silent": Race, racism and safeguarding children[22].

10.94 There were some similarities in the findings of the National Panel and the experiences of Rosie. Most agencies in the practitioner group reflected that Rosie's ethnicity had not been and continued not to be recorded on systems, which arguably means none of these agencies were in a position to assess or safeguard Rosie as a child of Mixed Heritage.

10.95 Rosie did not and continues not to have any contact with her paternal family. The mother has a poor view of Rosie's father's wider family, having reportedly been threatened by them in the past. In May 2021, it was identified in the first Child Protection Conference that Rosie knew she was different from others in her family.

10.96 It was recommended that Rosie be supported to better understand her culture, heritage and identity and that direct work should be commenced by Children's Services and Rosie's Nursery. This did not happen. Eventually, it was agreed that Rosie's need to understand her identity should be promoted via a generic discussion about race and ethnicity in a classroom setting. It is difficult to see how her individual needs could be met in a group, generic session about culture and heritage.

10.97 It became apparent that whilst Rosie's mother celebrated Rosie being 'different' and there was evidence that her basic needs around hair and skin care were met, but otherwise there were very limited opportunities for Rosie to explore her Mixed Heritage background, culture, cuisine or history.

10.98 Late into the reflective session, it was identified that the maternal aunt's partner is Black Caribbean, meaning that Rosie did in fact have access to positive role modelling and the opportunity to celebrate her heritage. What was apparent was that this had happened as a result of the actions of the family and not any professional response to Rosie's needs.

10.99 Reflective discussions about race and ethnicity can feel difficult and confronting at times[23]. Participants were engaged and open to reflections, but it was the author's view that there was a lack of confidence in the group about exploring how race and ethnicity impacted on Rosie's lived experience. Participants confirmed this by citing the need for further training, 'safe spaces' to reflect and tools such as cultural genograms to assist professionals from a predominantly White, British ethnicity to be able to be alert to unconscious bias, racism and develop insights into the lived experiences of children of Mixed Heritage.

Linked recommendation 8:
Within 6 months of publication of this report, all partner agencies will give written assurance to the Warwickshire Safeguarding Children Partnership (WSCP) that they are recording children's ethnicity in a clear and consistent way. This information must be used to better understand and respond to the needs of Black, Asian, and Mixed Heritage children.

[22] "It's Silent": Race, racism and safeguarding children. Panel Briefing 4. March 2025
[23] "It's Silent": Race, racism and safeguarding children. Panel Briefing 4. March 2025 p2

The assurance should include evidence of:

- That staff know how and why to record ethnicity properly
- That checks are in place to make sure the data is complete and correct; and
- That the data is being used to plan services and support that meet the needs of individual children.

Linked recommendation 9:

The Warwickshire Safeguarding Children Partnership (WSCP) will establish a Task and Finish Group to review the National Panel's report on Race, Racism, and Safeguarding. The aim is to strengthen inclusive safeguarding and support professionals in addressing race and inequality.

The group will:

- Assess the report's relevance to local practice
- Explore the need for safe, reflective spaces for professionals; and
- Make clear recommendations with defined timelines to embed anti-racist and culturally competent practice across the partnership.