Child Safeguarding Practice Review (CSPR)

The sexual abuse of children living outside of their birth families

Coco

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Introduction

1. In 2020, the Warwickshire Safeguarding Partnership agreed to undertake a local Child Safeguarding Practice Review (CSPR) to consider the sexual abuse of children living outside of the birth families. This was due to two separate children making allegations of sexual abuse from foster carers. The Partnership recognised the potential that lessons could be learned about the way that agencies work together to safeguard children in care, or otherwise placed outside of their family, from sexual abuse in Warwickshire.
2. There has been a significant delay in the publication of this report, due to the criminal investigation taking five years to conclude. It had originally been a thematic review about two different children. Due to the delay the Partnership agreed to the earlier publication of the CSPR in respect of one of the children, Marie. This report, therefore, will focus on the learning in respect of the other child, to be referred to as Coco[1]. As the reports were initially written as a thematic review, some of the analysis and learning from Marie is repeated here in areas where the findings were relevant to both children.
3. When Coco was thirteen years old, she told friends at school that she had been 'raped' and that the perpetrator was her male carer, who she said had sexually abused her numerous times. Coco had previously been in the care of Warwickshire County Council and lived with her former foster carers on a Special Guardianship Order (SGO)[2]. Her younger sibling also lived with her on the same basis. They had

[1] The name was chosen by the child.
[2] Special Guardianship is an order made by the Family Court that places a child or young person to live with someone other than their parent(s) on a long-term basis. The person(s) with whom a child is placed will become the child's Special Guardian. The Adoption and Children Act 2002 introduced Special Guardianship and Special Guardianship Orders.

been living as a family for four years. Prior to coming into the care of the local authority in 2016 there had been long term concerns about emotional neglect and sexual abuse in the birth family. Coco and her carer are both white British.

4. Learning has been identified in this review regarding:
    - The risk of abuse and neglect of children in care or SGO placements
    - The importance of relationships with professionals for children living outside of their birth families
    - Understanding a child's lived experience and that behaviour is communication
    - Identifying, understanding and responding to adult behaviours that might indicate they pose a sexual risk to children
    - Responding to a child when they make an allegation of sexual abuse
    - The need for effective and timely criminal investigations that support children and young people

Process

5. An independent lead reviewer was commissioned[3] to work alongside a panel of local professionals to undertake the review. Agency Information Reports (AIRs) were requested and received. These provided in-depth analysis and identification of single agency learning by all involved partner agencies with the child and with the carers. Despite the impact of COVID 19, professionals involved at the time were meaningfully involved in discussions about each child's circumstances and were consulted about practice more generally.
6. The lead reviewer and a representative from the Partnership Business Unit met with Coco in February 2026, nearly six years after she made her allegations. It was not possible to meet her in advance due to concerns from Warwickshire Police about this compromising the ongoing investigation. While the report written in 2020 remains and reflects the learning identified at the time, it has been updated to include Coco's words. The review thanks Coco for her cooperation and her commitment to improving services for other children in Warwickshire. A final copy of the report was shared with her pre-publication.
7. In 2025 the carer was found not guilty. There were significant delays in the investigation that impacted on the outcome and on Coco, that the review acknowledges. The extent of the potential learning from considering the quality and the timeliness of the investigation and the court trial, including the support provided to Coco and the other care experienced young people who were witnesses, has resulted in an additional recommendation being added in 2026.
8. This report has been written with the intention that it will be published and only contains the information that is required to identify the learning.

Learning and analysis

9. The review has identified learning gained from information shared during the Rapid Review meeting, in the AIRs, during the consultations with professionals involved at the time, from Panel discussions, and when speaking to the child. This learning is outlined below followed by the explanatory analysis.

[3] Nicki Pettitt is an independent social work manager and safeguarding consultant. She is an experienced chair and author of Serious Case Reviews and LCSPRs and is entirely independent of the WSP

Learning point 1: Children who are in the care system or placed with carers outside of their birth family can remain at risk of abuse and neglect and be abused in these situations. Their history makes them more vulnerable to abuse.

10. It is reasonable to expect that children who have been removed from abusive or neglectful home situations will be safe and cared for when in the care system. Children who are being or were formally 'looked after' need to be protected and nurtured, and while this is usually the case, it isn't always so. In reality, research shows[4] that moves and transitions, non-biological family relationships and the children's earlier experiences of abuse may increase the risk of child sexual abuse in care.
11. It was hoped by those involved at the time that the placement would be a long-term fostering placement for Coco and her sibling. However, there is evidence of concerns about the quality of care provided to the children in the care of the carers prior to any allegations of sexual abuse being made. The known concerns were in relation to the attitude of the carers, their often-difficult relationships with professionals, and examples of them having and voicing negative views of children in their care.
12. The NSPCC, Action for Children and Research in Practice investigated the potential relationship between neglect and child sexual abuse[5]. Research by York University and the NSPCC in 2014 considered local authority records on abuse in care placements. They concluded that while foster carers generally do an excellent job in often difficult circumstances, most abuse or neglect of children in foster care is perpetrated by the carers. They found that there are between 450–550 confirmed[6] cases of different types of abuse or neglect in foster care across the UK each year[7] and that around 11 per cent of this abuse is sexual. The Independent Inquiry into Child Sexual Abuse reminded us in 2017 that children who experience sexual abuse may suffer from life-long consequences, such as mental health issues, substance misuse, offending, unstable future relationships, and being vulnerable to further sexual abuse or other types of abuse, so being aware of the possibility of sexual abuse in care is important when aiming to provide children in care with the best possible life chances.
13. While any child can potentially experience sexual abuse, some are likely to be more at risk, and they include children who have experienced other forms of abuse[8]. Coco had experienced abuse in her birth family. As the majority of children in care are likely to have experienced abuse or neglect, they are more vulnerable to later abuse or exploitation, so professionals need to be alert to the possibility of sexual abuse and be able to 'think the unthinkable' about carers who they may know well and who they may work closely with.

Learning point 2: Children at risk, particularly those not living with their birth families, need to have significant relationships with a professional if abuse or neglect is to be identified.

[4] The Prevalence of Child Sexual Abuse in Out-of-Home Care: A Comparison Between Abuse in Residential and in Foster Care. Saskia Euser et al (2010)
[5] Elly Hanson, Debbie Allnock and Simon Hackett (2016)
[6] These findings are likely to underestimate the problem, over half of the unsubstantiated allegations could not be proven
[7] The figures were taken from referrals to the LADO (Local Authority Designated Officer) in respect of carers, to ensure they did not include abuse of children in foster care outside of the home.
[8] Finkelhor, Ormrod, and Turner, 2007

14. In January 2020 the NSPCC published a short report[9] which summarises the learning from published case reviews about child sexual abuse. The case reviews considered show that professionals should 'take the time to build a consistent, stable and long-term relationship with the child. This includes talking to children away from parents and carers and fostering an environment where children feel safe to talk.' Children in care often experience multiple changes of professionals, including their social workers, Independent Reviewing Officers (IRO) and those providing therapeutic interventions. Coco was no exception, as she did not have a relationship with any particular professional once she became subject to an SGO. She told the review that every child on an SGO needs to have a key worker who is there to ensure that they are happy and being well cared for and that the child should be seen regularly and without the carers present. The kind of questions should include 'is there anything happening at home that worries you.' She believes she would have told if she was asked by someone she knew and trusted. She wanted to advise any child who is not safe when living with foster carers or special guardians, that they should tell someone what is happening. She said, 'you will be believed and will never have to go back there.'
15. When the SGO was made by the court (more on this below) Coco and her sibling were no longer in the care of the local authority so had no allocated social worker and no statutory reviews. There was no expectation that they had any additional support, other than the fact that the carers were paid to care for them. Because the Special Guardians had other children in care living with them, they continued to have an allocated social worker in the fostering team. There were also social workers who visited the home to see other children fostered by the carers. Coco, however, was effectively part of the family now and had no extra provision, other than at school where there was some oversight by the school's Child Looked After Coordinator. The school also received pupil premium payments[10].
16. There were no known current concerns about Coco, but there were three referrals in 2019 about her sibling that suggest that she may be exposed to emotional harm from the carers. Two were from the child's school and one from the police due to concerns about how the female carer was managing the sibling's behaviour. The carers were spoken to by the MASH and explained they often found both the children hard to manage. There was little exploration of why the children may be behaving as they did however, other than a perceived understanding that their prior experiences would lead to complexities for them as they grew older. The MASH signposted the family to the Family Information Service[11] for support without undertaking any assessment or meeting the children, and without doing any checks with other professionals involved, including Coco's school. It appears that the voice of the carers was felt to be sufficient to make this call, without considering the voice of the child or giving them an opportunity to talk about how they were.
17. It was the fear of pregnancy that led to Coco confiding in her friends. A child is unlikely to make a disclosure of sexual abuse, even when they have a good relationship with professionals working with them, and particularly when the perpetrator lives with them. The Children's Commissioner inquiry states that only one in eight children who are sexually abused come to the attention of statutory authorities, and that many

[9] Child sexual abuse: learning from case reviews - Summary of risk factors and learning for improved practice around child sexual abuse. NSPCC January 2020

[10] The central government 'pupil premium grant' is designed to allow schools to help disadvantaged pupils by improving their progress and the exam results they achieve.

[11] An information and signposting service for families with children 0-25 years.

younger children may not recognise that they have been abused until they are older. NSPCC data suggests that seven years is the average time from start of sexual abuse to disclosure for those that do disclose[12].

18. Even when a disclosure is made, professionals should consider that it may only be a partial disclosure, and the child may under-disclose to test out the response and reaction to what is said. An abused child is likely to have complicated feelings about disclosing[13] due to their relationship with the abuser and the grooming that has occurred, and for a child who has been in care there is likely to be fear of what a new placement may hold.
19. Children in care or previously in care need to have a professional they can talk to and have access to when required. A NSPCC and University of York 2014 study[14] stated that 'visiting children, listening carefully to what they say and spending some time with them away from placements are of fundamental importance' as is communication and information sharing between agencies. It is evident that there were concerns about the carers, although there is no evidence that any professional was concerned about the risk of sexual abuse.

Learning Point 3: Professionals need to explore and understand a child's lived experience and what they may be communicating by their behaviour.

20. Listening to the 'voice of the child' has emerged as key learning in many reviews in recent years,[15] as has the importance of recognising behaviour as a means of communication. Understanding the lived experience of a child is a complex process and the importance of professionals having a child centred approach is well recognised. As well as giving children access to a professional they can talk to, it is essential to consider a child's behaviour to identify what they may be communicating without words. This is particularly the case where children are behaving in a concerning way, such as self-harming or abusing substances. The 2020 NSPCC report states that 'if professionals are not continually challenging and curious about the source of a child's distress, this can lead to missed opportunities to recognise and stop sexual abuse'. It is known that over half of the children who report sexual abuse have some mental health issues such as anxiety or depression. Many also exhibit angry or self-destructive behaviours. Professionals need to be alert to this, even when other explanations could account for the behaviour (such as the previous trauma of early childhood abuse or neglect.) The behaviour of the young people needs to be viewed through the lens of their history and experiences, including an open mind to what may be happening at the time.
21. There was no professional visiting the house to directly see Coco or her sibling, however the social worker from the fostering service visited the carers and often saw the children. She would always ask how they were doing, and the children would sometimes speak to her about school or their hobbies. There is no doubt that the carers were difficult to work with. The male carer was seen as quiet, and the vast majority of contact was with the female carer. She was often verbally aggressive and negative, to and about

[12] 'No one noticed no one heard' 2013
[13] In this report reference will be made on occasion to the child 'disclosing'. This is because they are believed by the professionals involved. The review is aware of the dialogue about the use of language by professionals who work with children. It is noted that the alleged perpetrators was found not guilty of abuse in court. http://www.transparencyproject.org.uk/why-words-matter-the-debate-about-disclosure/
[14] Nina Biehal, Linda Cusworth, Jim Wade with Susan Clarke 2014
[15] The voice of the child: learning lessons from serious case reviews. Ofsted 2010

professionals. Those involved with her had to learn to manage her behaviour and believed that her 'bark was worse than her bite' and that she was a good enough carer, providing opportunities and practical support to the children despite her difficulty with professionals. The carers were described as strict and rigid in their thinking. It was known that they were not 'warm' with the children. Professionals shared that they would be unlikely to be accepted as foster carers if they were assessed today and reflected that this had been part of the reason that the local authority had not supported the SGO applications for Coco and her sibling. The court made the order regardless. Coco told the review that any foster carer who had been assessed a long time ago, needed to be reassessed and approved when expectations and standards change.

Learning point 4: Professionals need to identify and understand how perpetrators of child sexual abuse operate and be confident in responding to adult behaviour that might indicate a risk to children. This includes knowing about any concerns during previous placements with the foster carers.

22. As well as considering the behaviour of the child, it is important that professionals also consider the behaviour of adults. This includes recognising potential 'grooming' techniques. The purpose of grooming is to reduce the likelihood of detection or the child disclosing and reducing the chance of the child being believed if they do disclose. As well as grooming children, perpetrators also groom and manipulate the adults around the child and the professionals involved. Perpetrators can be charming, or they may intimidate and frighten professionals so that they are distracted from abusive behaviours. It is complex work, and it can be very difficult for professionals to understand what is happening in a family environment.
23. None of the professionals working with the carers (or previously with Coco and her sibling) were fully aware of the full history of the carers that was held by the fostering team. Since Coco made her allegations, information has been found that might have been helpful to those responsible for the children. For example, there an allegation made by a foster child in 2014, following which the male carer admitted making a sexually inappropriate comment to the child. All of those consulted with during the review agreed that this is not common practice to read and consider the background history of a child's carer. However, knowing about previous placements can help us understand how best to support and challenge carers and can also provide information on what the risks might be. Although there were no other allegations about sexual abuse, there were other concerns evident and a history of difficult behaviour from the carers, including them not attending training to support them as carers.
24. Anger and aggression are common alongside child sexual abuse. If professionals fear how carers may react, this is both a powerful grooming technique and a way of ensuring that professionals do not challenge too forcefully. The female carer was known to have a forthright and forceful personality. Those who knew them well described them as 'formidable' and they regularly intimidated professionals. The fostering social worker described having to work very hard to build a relationship with the carers and how she never really knew what to expect when she visited them. This did not stop her challenging them, but she knew she was always likely to have a battle on her hands when having to do so. The 2014 NSPCC and University of York report states that past allegations and concerns about foster carers should be carefully recorded and that any new allegations that arise should be placed in historical context. This was something that

would have been helpful and good practice when the foster carers applied to become Special Guardians for Coco and her sibling.

Learning point 5: When there are concerns, over time, about the way that carers continue to treat children and professionals, robust consideration must be given to formally reviewing their foster care approval.

25. The carers had a history which included difficult relationships with many professionals. Despite this, there were numerous good examples of these professionals challenging the carers, holding them to account and being clear about the expectations and improvements required. Support and training was also offered. There is little evidence that this made any difference in the longer term, however, as their behaviour did not improve over time.
26. Those involved in recent years did not have a complete understanding of the history of the carers, of how many times they had been given the opportunity to improve and how many chances they had been given with these children and others previously in their care. There was an acceptance they were 'old school' carers who were set in their ways and that this made them resistant to change. It is a difficult balance for those working with carers who are hard to engage or who avoid support and training. There is a need to challenge them and address parenting deficits, yet a need to keep the carers engaged to try and facilitate improvements for the children. This can result in professionals not always being as forthright as they wanted to be, and no repercussions when the carers behaved badly.
27. The carers received support from the WCC fostering service, with supervision from a fostering team social worker and annual reviews[16] as they continued to foster other children. The National Minimum Standards[17] (NMS) for fostering were revised in 2011. Regulation 21 focussed on the provision of supervision and support for Foster Carers: It stated that the fostering service must 'support their foster carers to ensure they provide foster children with care that reasonably meets those children's needs, takes the children's wishes and feelings into account, actively promotes individual care and supports the children's safety, health, enjoyment, education and preparation for the future'[18]. The review was told that supporting the carers was a challenge for those providing the support.
28. Both the work undertaken following the allegations and this review have found that there is a lack of clarity regarding when concerns about a foster carer result in a Cause for Concern[19] or are dealt with as a standard of care matter. For example, a carer who is verbally aggressive to professionals in front of the children could be seen as a standard of care matter and dealt with between the fostering service and child's social worker, or could result in a Cause for Concern, resulting in a multi-agency response and information sharing that focuses on the child. If it is the latter this will be taken to the Fostering Panel at their next meeting, whereas if it is seen as a standard of care issue it will just likely be shared at the foster carer's annual review. It has been found that there needs to be more clarity within procedures and practice regarding what response should be used. There is also a need to ensure that every separate incident is seen within the context of previous issues with the carers, to build up a picture of concerns over time, and

[16] When undertaking a review of the placement, the fostering social worker consults the foster carer, any children in placement during the last year, and the children's social workers and IRO. An annual review report is then written.
[17] The national minimum standards, together with regulations on the placement of children in foster care, such as the Fostering Services (England) Regulations 2011, form the basis of the regulatory framework under the Care Standards Act 2000 for the conduct of fostering services
[18] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/192705/NMS_Fostering_Services.pdf
[19] This is a process that will involve the LADO and will be responded to as a potential child protection investigation.

whether, cumulatively there is a need for action. WCC have now introduced the need for every foster carer file to have a chronology, which needs to include any concerns throughout their history as carers. This also needs to be available to social workers for children placed with the carers.

Learning point 6: The particular vulnerability of children on SGOs.

29. The making of an SGO can undoubtedly be positive for many children and can secure a child's long-term placement. It grants 'parental responsibility' to the special guardian away from the local authority. This enables the special guardian to have day-to-day control and thus provides a more 'normal' family experience for the child/ren. There was a significant local and national increase in the number of children leaving care to SGO arrangements around this time. Statistics show that in the year ending March 2010 5% per cent of children in care left due to the making of an SGO, whereas in the year ending March 2014 it was 11% (Department for Education, 2015). There are benefits to an SGO over long term foster care for some children where there is no need for social work involvement or for the local authority to be a corporate parent to the child. However, there is also a potential loss. When a child is in care, they have the right to support from their social worker, they have a formal health and education plan, they have the oversight of their IRO and are prioritised for therapeutic support if it is required.
30. Coco was in a vulnerable position. She was effectively a child in care without any of the additional support and oversight the status provides. The carers had applied for the orders only having cared for the children for around seven months, when the children were in primary school. The LA was concerned that the placement had not yet been tested and knew that the carers had a track record of placement breakdown during a child's adolescence. The court decided, following seeking the advice of an independent social work assessment and the view of the children's Guardian, that the orders should be made. The independent social worker had stated in their report, which was written after a short assessment, that the carers provided good basic care to the children and had the ability to provide stability and keep the children together. They also stated that the carers had learned from previous difficulties with children they had fostered and that while the female carer may struggle with children who are not willing to abide by the rules she sets, she now had knowledge from her past experiences. This professional, CAFCASS and the court has not been part of the review, but the professionals spoken to in the local authority shared that they continued to have reservations about the plan and the fact that parental responsibility was no longer shared for the children. They stated that they felt helpless in light of the court's decision. It was their belief that with no evidence or a level of concern to remain involved in the longer term, they had to accept the result.
31. The SGO provided on-going financial support to the carers but no expectation that there was any monitoring of the children or the placement. It was only because the carers continued as foster carers for other children that there was any contact with Coco and her sibling at home. The concerns about the ability of the carers to manage the children as they got older and potentially more challenging were based on the real knowledge of how the carers had cared for other foster children. It appears that the independent social worker's assessment was largely based on the self-report and reassurance of the carers and their assertion that they would do better this time.
32. When it comes to the making of SGOs, there can be conflict when the LA and the CAFCASS officer/guardian disagree. The courts tend to put a lot of weight on the view of the guardian, as they appear

to have in the case of Coco and her sibling. There is no expectation, requirement or mechanism for the court to seek any follow up on how children fare when the court does not follow the Local Authority's recommendation, despite research advocating this.[20] The review recognises that the Local Authority can appeal the decision of the court, but in this case the grounds were not met as the court tested the evidence and made a decision. The Local Authority could have considered their concerns and worked with the children and the carers on a child in need basis, but this would have required the consent of the carers.

33. It is noted that there is a mixed message to say that a couple can foster children but not be special guardians. This stance is also likely to have negatively impacted on their relationship with the Local Authority, and this may have been a factor in the often-difficult interactions with the carers. Research shows[21] that making SGOs quickly, before relationships have been properly tested, may carry some future risk and that a period of time in which these relationships can be tested before moving to a final order is to be recommended. (Wade et al, 2014). Coco and her sibling had not lived with the foster carers for even a year when the order was made. The children were said to be keen to leave care however and they wanted to be with a 'forever family' which is understandable. The carers were also said to be supportive of contact with the birth family, who had supported the making of the SGO. The review was told that there have been numerous changes since the SGO for Coco in 2016, including in the way that the Local Authority assess SGO requests, the expectations of the courts in such cases, and the provision of additional support following the order.
34. There were three referrals to the MASH in 2019 that suggested that Coco and her sibling may be being exposed to emotional harm in their placement. One was to the police from a neighbour alleging adults shouting at the children at the property. The others were from the younger child's school. The school voiced concerns about the way the child was treated in placement. they had told teachers that they had been threatened with having to move to another placement, that they had been told they could no longer call the carers 'Mum' and 'Dad' and that they had been threatened with physical abuse and restraint by the male carer. The carers were spoken to after the MASH received each referral and admitted their ongoing frustration with the children's behaviour. The children were not spoken to however and there is no evidence that full consideration was given to why the children might be behaving in this way. No wider checks were undertaken, and the views of the carers dominated the decision making, leading to no further action.
35. When children are the subject of SGOs, there is no requirement for them to have health checks or any reviews of their care. This removes the oversight of an IRO and the view of the nurse responsible for children in care. Learning has been identified in other reviews about the need to take seriously any referrals from neighbours, friends or the community, and to ensure that they are likely to include details about a child's lived experience that was not available to agencies.
36. There is an understandable dilemma for professionals who know how important it is for children to have a stable placement, somewhere they feel is their home, with carers who are like parents to them. These children wanted a forever home and people they could call Mum and Dad. There is also a concern about what the alternative is for children in care, with limited foster care placements, which is increasingly an

[20] Farmer and Lutman, 2009
[21] Wade, J., Dixon, J. and Richards, A. (2010). Special Guardianship in Practice. London: BAAF.

issue as children get older. The Fostering Network[22] notes a long-term shortage of foster families in the UK.

Learning point 7: It is essential that when a child makes an allegation of sexual abuse to a professional that they record exactly what was said and accurately record the processes that follow, with clear dates and times. There must be clarity regarding the processes that follow to ensure the child is safeguarded and receives the services required.

37. There was a delay in the school making a referral to the MASH after the concerns emerged about Coco. She had left school and gone home by the time the referral was made, which led to the urgent need to consider if she should remain at home overnight and be spoken to the next day, or whether the police and a social worker should visit the family that evening. On balance, including considering the risk of a further incident taking place that evening, the decision was made to see the child in school the next day. This was a thoroughly deliberated and child-centred decision made by experienced staff in the police and the MASH.
38. This review has had difficulty in gaining information from Coco's school about this delay and exactly what happened on the day that the allegations were made. It was clearly a stressful and upsetting experience for the staff involved who were new in role and relatively inexperienced in safeguarding matters. While they undoubtedly provided good supportive care to the children involved, including Coco, they did not keep any record of the events and were unable to recount them accurately for the review. As their referral stated that the alleged perpetrator was the child's 'stepfather' without confirming his name, this led to confusion regarding who the allegations were about in the MASH, and a delay in contacting the HAU police development officer for triage until 5 pm. At the request of the review the school are reviewing their recording expectations when there is a safeguarding concern and understand that it is important that records are kept at the time or immediately after a serious allegation is made to a member of staff.
39. The following day Coco was seen at school and confirmed her allegation and that the last incident of abuse had been at least a week previously. The priority was therefore to undertake an ABE interview as the suspect was by then in custody, and to provide a pregnancy test and health check, rather than an acute forensic medical assessment for trace (DNA) evidence [23] or to seek evidence at the home. There was some confusion about who should provide medical input, and following discussion with the GP and the child in care nurse it was agreed that Coco should have her initial health assessment as a new child in care and that her child protection medical should be undertaken at the sexual health clinic, as is the process when non-immediate sexual abuse allegations are made. This led to some delay in the child protection medical, with an appointment offered three months after the allegations were made, which Coco decided not to go through with. A lack of clarity about what should happen in a case like this also led to a lot of time being spent by the social worker trying to work out how to action the various health requirements. At the time there was a change of providers of forensic medical assessments which added to the delay and confusion.
40. All children or young people who may have been sexually abused should be offered a timely specialist child protection medical assessment. Where there is the possibility of fresh injuries or trace-evidence (when

[22] A charity that brings together 'everyone who is involved in the lives of **fostered** children'. They 'champion fostering and seek to create vital change so that foster care is the very best it can be.'

[23] Any child protection medical assessment (for injuries or sexual abuse) can have legal significance, including following non-recent sexual abuse. Although many examinations will be anatomically normal, where there are physical findings, these may persist indefinitely. An examination can never rule out sexual activity, but can sometimes confirm it, even years after the event.

the alleged event was within 7 days) this should be done as soon as possible, with the examination within 24 hours[24]. Where the allegation relates to non-recent abuse/assault, the examination should be offered within ten working days.[25]. Specialist CSA medical service providers should be included in strategy discussions, and a referral for a medical evaluation in suspected child sexual abuse should be considered with the same rigor and threshold as that applied for physical abuse. Coco stated that a child who alleges they have been sexually abused by a man should always be examined by a female doctor.

41. The police have also identified learning regarding communication/debriefs between officers following the ABE interview, as in this case there were personal items that should have been seized for forensic analysis. There was also some delay in information being shared about children placed previously with the carers to enable an investigation into the care they received within these placements.

Conclusions and recommendations

42. It is now possible to see that Coco was let down by a system that assessed and supported the carers, that placed her with the carers, that made the SGO, and that investigated the allegations she made. There were no particular concerns about Coco prior to her making allegations that have led to this review. However, she was not seen regularly by any professionals other than teachers at her school and in passing by the fostering social worker working with the carers. Some concerns were identified about her sibling however that may have indicated that both children's care was not as good as should be expected, particularly emotionally.
43. There were known concerns about the carers and their ability to provide good emotional care to children. Professionals used the word 'intimidating' to describe the female carer. Examples were shared of their angry outbursts, their derogatory statements about professionals and on occasion the children, and the need for professionals to have to 'manage' them to ensure that meetings and other contacts could take place. Those involved reflected on the difficulty of working with the carers and an acknowledgement that they accepted behaviours that should have been seen as unacceptable from those being paid to care for the county's most vulnerable children. Those involved with Coco recognised that it was their wish to ensure on-going stability for her and her sibling, an understanding of the limited options of alternate placements, a wish to keep the siblings together, and a case of 'better the devil you know' with carers who had been fostering for many years. None of those involved had considered that the children could be sexually abused in their placement.
44. When carers (or indeed parents in other cases) are intimidating and unpredictable, this is incredibly hard for professionals. It is a good way of them avoiding scrutiny and professional persistence and challenge. It is essential for professionals to support each other in these circumstances. Reflective supervision is important for all professionals working with highly complex families; particularly helpful is inter-disciplinary group supervision if there are several professionals providing services. In light of the learning from this review, this should include a discussion between professionals about whether a child could be sexually abused in a placement where there are concerns about other types of abuse or standards of care.

[24] FFLM guidance
[25] RCPCH Child Protection Companion 2nd edition 2013

45. Significant and extensive single agency learning has been identified during the review and recommendations have been agreed to address the need for improvement actions, including single agency outcome focussed and SMART action plans which will be monitored by the Safeguarding Partnership.
46. Two recommendations were made in the parallel review, Marie (1), that are also relevant to Coco. The first focused on changes required in the fostering service, including the use of chronologies for carers. The second on the need for professionals needing to think about and always consider the very real possibility of sexual abuse of children who are care experienced.
47. Having considered the learning from this review that has not been addressed in the single agency actions or the Marie CSPR, the following additional recommendations are made to ensure improvements in practice/systems.

Recommendation 1 (2020):

That the Partnership considers advocating for the transparent, meaningful and creative offer of an 'exit interview' for care leavers, to provide them with an opportunity to reflect on their experiences of the care system, including their placements.

Recommendation 2 (2020):

The Partnership Education Subgroup to consider how all schools are supported and aware of their responsibilities to children who were previously in care but are now on SGOs or adopted.

Recommendation 3 (2026):

That Warwickshire Police provide written assurance to the Safeguarding Partnership that, if Coco were to present today, her experience as a victim in the criminal justice system would be demonstrably different, reflecting embedded changes to the investigation and management of sexual abuse cases since 2019. The assurance should be shared with Coco.

Recommendation 4 (2026):

That Children & Families Services review current processes for children previously looked after and subject to unsupported Special Guardianship Orders (SGO). Where gaps are identified, a consistent approach to be implemented to ensure these children are supported through a time-limited, multi-agency Child in Need plan. This will include robust step-down arrangements to universal services, particularly where the SGO was contested by the Local Authority.