



HM Inspectorate
of Probation



CareQuality
Commission



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Dear Leicestershire Local Safeguarding Partnership

Joint targeted area inspection of Leicestershire

This letter summarises the findings of the joint targeted area inspection (JTAI) of the multi-agency response to child sexual abuse in the family environment in Leicestershire.

This inspection took place from 8 to 12 December 2025. It was carried out by inspectors from Ofsted, the Care Quality Commission (CQC), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and His Majesty's Inspectorate of Probation (HMIP).

The inspectorates recognise the complexities in providing a multi-agency response to children and families where there is a risk of child sexual abuse in the family environment. This joint inspection of the multi-agency response to children who are at risk or victims of child sexual abuse in the family environment will highlight areas of practice and strategic leadership that need to improve as well as strengths. All references to children in this letter relate to children at risk or victims of child sexual abuse in the family environment. We anticipate that these JTAIs will identify learning for all agencies and will contribute to the debate about what good practice looks like. These JTAIs are being carried out in accordance with the recommendation from the Child Safeguarding Practice Review Panel (CSPRP) report into child sexual abuse in the family environment.

Headline findings

The partnership in Leicestershire has prioritised and is working to strengthen their understanding of Child Sexual Abuse in the Family Environment (CSAFE), with regular reviews of key achievements through an agreed action plan. Although the partnership's strategy is still in draft form, its ambition is evident through collaboration with the National Society for Prevention of Cruelty to Children (NSPCC) and the Centre of Expertise in Child Sexual Abuse (CSA Centre). The strategy has also drawn helpful insights from local safeguarding practice reviews, thematic briefings, surveys and audits to inform planning and practice. Some of this work was



far-sighted in advance of publication of the CSPRP report into child sexual abuse in the family environment in 2024 and work has picked up pace since the panel report. Strong governance within the partnership through a task and finish group has built a solid foundation in this work and has clear safeguarding arrangements with a commitment to disseminate learning, provide resources and develop a trauma-informed workforce. Young people's voices are strengthened through initiatives such as young scrutineers, and multi-agency audits monitor whether children get the right support.

Positive steps include inviting the Sexual Assault Resource Centre (SARC) to strategy meetings where CSAFE is an issue and the creation of a professional advice and guidance line. The partnership monitors whether children receive appropriate help through multi-agency audits.

While frontline staff demonstrate sensitive, child-centred practice and work collaboratively to reduce harm, gaps in the clarity and accuracy of information continue to compromise risk assessments, leaving some children vulnerable to unassessed risks.

What needs to improve?

- Improve information-sharing across the partnership, especially at the initial contact and referral stage. While thresholds are appropriate, not all relevant details are consistently shared early on, limiting the effectiveness of risk assessments.
- Timeliness of child protection processes, particularly strategy meetings and initial child protection conferences, and sharing of minutes of these multi-agency meetings. For a small number of children subject to child in need and core group meetings, not all appropriate practitioners consistently attend these meetings. Increase the capacity of specialist support services so that children at risk of, or victims of, CSAFE can access timely help. Ensure that all partners have a shared understanding of when therapeutic support should begin and what types of interventions are appropriate.
- The take-up and accessibility of multi-agency training on CSAFE, including achieving best evidence training.

Strengths

- There are robust strategic governance arrangements in place, with strategic leaders sitting on several boards to provide continuous and consistent oversight.
- The priority afforded to and pace of action to address CSAFE prior to and following the CSPRP report.

- Senior leaders across the partnership know their services well and share their openness for learning and supporting staff's continuous improvement through some well-received training.
- Most staff across the partnership show their commitment and engage with great skill and sensitivity to support and protect children who have been victims of sexual abuse in the family environment, and are not frightened to name CSAFE and talk openly about this.
- The SARC is routinely considered for invitation to strategy meetings for all children affected by CSAFE.
- The quality of assessments, including capacity to protect assessments.
- The Children's Independent Sexual Violence Advocate (ChIVSA) service offers excellent emotional and practical support to children and families for as long as this is needed by them.

Main findings

The partnership in Leicestershire is committed to recognising and responding to child sexual abuse in the family environment. The two safeguarding partnerships, Leicestershire and Rutland and Leicester City (LLR), work closely together to consider shared matters of governance, funding and intelligence, to seek to ensure consistency across the wider area.

CSAFE is a clear priority for the partnership, and a range of activity has taken place over the past 18 months, leading to a draft strategy. The draft strategy and action plan are comprehensive. They indicate a commitment to increasing the profile and understanding of CSAFE and to support the partnership to identify, assess, protect and support children who are victims of CSAFE. The strategy has also drawn helpful insights from local safeguarding practice reviews, thematic briefings, surveys and audits.

The partnership has responded promptly to the findings of the CSPRP report and subsequently commissioned a system-wide snapshot review alongside the NSPCC in 2025. As a result, a sexual abuse strategy and framework was recommended and is currently being developed.

As part of the strategic journey, the partnership has updated child sexual abuse policies and procedures, promoted the East Midlands Child & Young People sexual assault service and hosted a child sexual abuse conference facilitated by the CSA Centre in May 2024. The partnership has undertaken local child safeguarding practice reviews with a focus on child sexual abuse, promoted the child sexual abuse response pathway and developed and promoted thematic 7-minute briefings on CSAFE to practitioners across the partnership.

Management reports show that leaders understand local contexts and the number of children identified as being at risk of CSAFE. However, multi-agency data analysis remains limited, restricting a full picture of prevalence and needs across Leicestershire. While the CSA Centre data hub provides national comparisons, joint regional analysis is lacking. Planned next steps include a comprehensive needs analysis, deep-dive audits into harmful sexual behaviour, and the development of resources such as training and staff development. The action plan also prioritises raising community awareness of CSAFE.

Frontline practitioners across the partnership recognise and understand the signs and indicators of CSAFE and are alert to the risks and impact it has on children. Practitioners respond quickly to initial reported concerns and build trusting relationships with children. Health practitioners understand the importance of documenting all adults in the household and those who accompany children to appointments. However, their record-keeping systems sometimes limit the effectiveness of quickly accessing all relevant safeguarding information.

Police, children's social care and health colleagues feel supported by managers when they need support and advice, for example helping them with any concerns they have and providing guidance if needed.

Despite the lack of structured CSAFE training for some of the partnership, learning has been disseminated from reviews, and many frontline practitioners report that they have received 'Think Practice' information and the CSAFE resource pack, which has supported their learning and understanding of risks for children. Parts of the partnership are accessing the multi-agency training offer well. However, all agencies, including those that do not have bespoke CSAFE training, would benefit from taking up multi-agency training offers.

Police only share public protection notices (PPNs) with children's social care services. This means other agencies who may be involved with or hold information about children or linked adults, such as health and probation, are not aware of any police involvement. As a result, they are unable to inform the risk assessment or decision-making at this early stage to better protect children.

Children's social care decisions are generally effective, but initial referral information from partner agencies is sometimes incomplete, and is lacking in detail, rationale and the child's voice, especially for those with complex needs. These gaps hinder early decision-making and may delay safeguarding responses. Once engagement begins, practitioners typically capture and consider children's views in a supportive environment.

Managers and social workers in children's social care screening are alert to indicators and risks related to CSAFE. Referrals are responded to promptly and there is no delay in handover to the assessment service when threshold is clearly met. When threshold is less easy to determine, checks are completed routinely with most partner agencies. However, information-sharing between the police and other partner agencies is not sufficiently robust in all cases to make sure that children at risk of CSAFE are assessed well enough.

Requests for police information from partner agencies are routed through multiple channels, causing delays in sharing critical details for risk assessments. Although a formal process exists, practitioners do not consistently follow it. As a result, screening decisions often rely on incomplete information from multi-agency referral forms (MARFs) and PPNs, which may omit key safeguarding details.

Probation has direct access to children's social care recording systems through the probation safeguarding hub, and this has sped up information checks at the same time as reducing workloads. However, access is limited to current information, and, where further information is required to inform risk assessment, a MARF is often requested by children's social care, meaning that responses to such requests are not timely enough to inform pre-sentence court reports.

Probation services have encountered inconsistencies in how different agencies interpret and apply risk thresholds. These variations affect decisions about assessing and managing risks to children. The lack of a shared understanding highlights the need for a fully integrated approach across all partners, ensuring that thresholds are clearly defined and consistently applied to keep children safe.

Although all referrers are sent an outcome letter from children's social care when the decision for the referral is made, some partners say they are not consistently receiving this information. Not being aware of the outcomes of their referrals into children's services, means that partners are not always able to provide a timely follow-up or be reassured that their referrals have been appropriately managed. Overall, threshold and outcomes of MARFs and contacts are appropriate. However, these outcomes are based on partner information provided and may not always give the widest or best information. The partnership is reviewing the content of outcome letters and working to understand what the issues are in relation to some partners not feeling informed about referral outcomes.

Managers overseeing children's social care screening are alert to CSAFE risks and encourage partners to handle referrals sensitively. They consider the child's history and additional agency information when making decisions and provide clear rationales for recommended next steps. However, the partnership recognises the

need to improve the quality and detail of referral information to ensure accurate decisions and appropriate support for children.

Contacts through the children's social care 'front door' for family help are promptly screened and appropriate actions are identified. Key workers in family help are alert to the risks linked to CSAFE and work is sensitive to how this may impact children, even when it may not be the presenting issue.

Practitioners across the partnership 'name' sexual abuse as just that and share information on that basis rather than couching it in other terms. Partners are clear when there are risks and concerns for children's safety in terms of CSAFE and prioritise these children.

Probation practitioners are proactive in their approach to keeping children safe. MARFs are made quickly, and they often take the initiative in their communication with children's social care and police management of sexual or violent offenders (MOSOVO) teams. This includes prompting disclosure decisions by the police to keep children safe and to expediently enforce breaches of licence conditions to help prevent offending and reoffending.

Health practitioners feel confident in considering all available information to explore the possibility of CSAFE and can refer via telephone or via MARFs, with most referrals being accepted by children's social care. Health practitioners operate a health visiting duty line, where social workers' screening processes can follow up on referrals and seek additional health information. Health practitioners can access regular safeguarding supervision as needed to inform actions to be taken.

The out-of-hours service understands the processes surrounding CSAFE to identify children early and works with partners to protect where necessary. The service is co-located with police during weekends and undertakes urgent visits and investigations when necessary. Practitioners from the out-of-hours service work closely with health practitioners, particularly in maternity, where safety plans are put in place to protect children.

When risks for children escalate, child protection strategy meetings are too often delayed due to partner availability, and this delays the sharing of information and the timeliness of investigations. Partners are aware of these concerns and additional police and health practitioners are being made available to give more capacity to address this.

When strategy meetings are held, key multi-agency partners are present, and more recently representatives from the SARC are also being invited. They can give

guidance and support on pathways for children and families who have been victims of CSAFE. Further strategy meetings do not always take place when there is a change, for example when a perpetrator is released from custody, meaning full information is not always shared promptly.

Police information is shared with partner agencies when requested, such as for strategy meetings or child protection conferences. Staff are unclear about what details can be shared due to the absence of clear guidance, relying instead on professional judgement. Probation staff often receive redacted police information, which limits its usefulness for risk management and court reports. Although the police plan to improve this, important information that could help safeguard children is not always available to partners.

Practitioners across the partnership told inspectors that they do not consistently receive minutes for strategy meetings and case conferences, and some partners reported that they record their own minutes of strategy meetings. While there is evidence that minutes are distributed through a central business system, which is checked regularly and has a clear process in place, this is not consistently reflected in practitioners' experience. As a result, partners may not have a complete or shared record of discussions, and there is a risk that differing versions of the same meeting exist. The partnership will proactively explore this feedback with practitioners to understand and address the issue.

Most children receive timely and appropriate support at the correct threshold. Child in need and child protection plans are generally well structured, detailed and timebound, ensuring that actions are clear and focused on the child. Safety plans are implemented promptly and updated regularly with input from families and children. However, these plans are not consistently shared across all partner agencies, which can reduce their effectiveness. Where safety plans are in place, they are clearly aligned with police bail conditions and supported by unannounced visits, making enforcement straightforward and enhancing protection for children.

The quality of assessments is a strength, with culture, diversity and inclusion identified and their consideration in assessment developing. Workers complete specialist assessments to understand risk and protective factors. Some perpetrators of abuse are properly engaged in and considered as part of child in need and child protection planning, with assessments of risk completed and social workers appropriately challenging denial of risks to children's safety.

Capacity to protect assessments are detailed, and social work interventions as part of these assessments support the 'protective' parent to understand and come to terms with how to manage risks. This understanding leads to risks reducing for children, enabling them to remain living with their families due to effective intervention.

Children's needs are routinely addressed in child protection conferences and reviews, with strong engagement from schools and health services. While police attendance is inconsistent, social workers maintain effective communication through written or verbal updates. The police are trialling a new attendance model to prioritise requests. Probation practitioners are not consistently included in core groups or conferences, and their concerns do not always translate into actions, leading to occasional gaps in coordination and creating a sense of working at cross purposes at times.

In stronger examples, we saw key partners such as police and education being engaged in child in need and safety planning for children, helping to build a supportive infrastructure for them, for example creative practice in making an application for a sexual risk order where there was not enough evidence to meet criminal threshold for prosecution.

Children's safety plans are consistently reinforced by probation practitioners, when those practitioners are present at core groups and child protection meetings. Practitioners from probation collaborate well with social workers, helping to identify risks from adult offenders. There was some strong practice in the delivery of structured interventions to perpetrators to reduce the risk of sexual harm to children.

Children receive meaningful and sensitive direct work during child in need and child protection planning. Key workers and social workers use tools to help children understand their experiences and risks and to develop appropriate safety plans and strategies. Workers across the partnership are professionally curious and build relationships with children, which helps them gain an understanding of their experiences.

Children and families who are victims of CSAFE can access dedicated, committed and experienced workers from a range of commissioned support services, where counselling is offered. However, these services struggle to keep up with the demand for such resources. The ChISVA team provides highly valued, specialist support for adults and children with recent or non-recent experiences of sexual abuse, offering ongoing emotional support, advocacy and a safe space throughout often lengthy criminal justice processes and beyond. Specialist officers told inspectors they regularly refer children to the ChISVA service for support for all children who have experienced child sexual abuse. Officers spoke positively about the ChISVAs and the support they provide and said they had a good working relationship with the service.

Staff in the SARC are knowledgeable and have provided training to various services across the partnership. Health practitioners who are aware of the SARC are

signposting to the service, but there is some confusion around who will refer to SARC, which potentially limits the input of holistic and robust safety planning for children and families. This is particularly pertinent when considering children who may require sexual health support and/or therapeutic interventions.

There is a need for a common understanding across agencies of what therapy is appropriate for survivors of abuse when awaiting court proceedings, to ensure there is consistency in the support that children receive. Currently, some practitioners perceive that therapy is not allowed when court hearings are pending.

There is clear information-sharing between probation and the police MOSOVO teams, which leads to crucial information-sharing to manage risk. For example, this includes disclosure decisions, jointly managing registered sex offenders due to be released from prison, three-way meetings with offenders, and enforcement of Sexual Harm Prevention Orders. The realignment of MOSOVO officers to specific geographical areas has helped to build relationships between probation and the police.

Police senior leaders have good oversight of offender management processes, having regular updates on risk assessment, risk management plans and visit regimes. There is good use of police systems both regionally and nationally (including the Police National Database) to monitor the highest-risk offenders.

Police awareness of, and application for, civil court orders to manage perpetrators who have posed or may pose sexual risk to children is strong. The force works closely with the regional legal teams to obtain appropriate orders with conditions and requirements to help make sure that children are protected from child sexual abuse in the family environment.

The police have a good process for receiving and processing Sarah's Law applications from both members of the public and professionals. However, police and partnership colleagues did not use the Child Sexual Offender Disclosure Scheme (CSOD) 'Right to Know' process to make a prompt disclosure to protect children more quickly. Inspectors were told of incidents where professionals were advising the 'protective' parent to request a disclosure of CSODs under the 'Right to Ask' approach, despite the professionals already holding sufficient information that children were at risk and could have used the process to disclose promptly.

The police Artemis team that deals with referrals relating to individuals who download and distribute child sexual abuse media online takes a child-centred approach. The team shares information with children's social care to understand whether children may be linked to addresses or people posing a risk, and they

update children's social care regarding planned enforcement activity. Investigating officers from this team also attend strategy discussions when required, which means partners have up-to-date details of the risks posed to any children.

There is good attendance at Multi-Agency Public Protection Arrangements (MAPPA) meetings by CSAFE partners. Strong relationships across the safeguarding partnerships contribute to and support MAPPA arrangements in Leicestershire.

There is a backlog in probation administrators uploading records on ViSOR (the police, probation and prisons shared database to manage violent and sexual offenders). The impact of this delay is that MOSOVO police officers do not consistently have access to up-to-date risk assessment information to manage CSAFE perpetrators effectively. There are plans to improve the timeliness of information-sharing through an uplift in administrative resource from January 2026.

MAPPA level 1 reviews are not consistently undertaken through an information-sharing panel being held between probation, police and prisons. There are examples of level 1 reviews being completed as a 'tick-box' exercise, which misses the opportunity to consider vital information from partnership agencies, including children's services in relation to CSAFE, although we did not see the direct impact of this on children.

There is some scope to increase the use of probation interventions with registered sex offenders. Use of probation toolkits, including 'Maps 4 Change', has increased, and senior leaders are committed to further improving delivery of interventions through refresher briefings for staff.

Overall, practitioners have a good welfare offer to support them in dealing with children and families who are harmed by child sexual abuse. There are options for staff to self-refer to a range of support services and some partners have bespoke therapeutic supervision available to staff most in need.

Schools have clear, effective systems in place supported by good-quality training to ensure that they have the knowledge and expertise to identify children who are at risk, or are victims of, child sexual abuse in the family environment. They advocate for their children from a position of knowledge and understanding. Information is shared quickly and appropriately with partners, with the best interests of children at the heart of the actions they take. Schools are often a safe space for children, and the partnership is currently developing the education role through a subgroup in the local safeguarding partnership.



Social workers have attended Achieving Best Evidence (ABE) training, as have police officers, but this is not currently joint agency training, and social workers are rarely involved in undertaking these interviews. This is a missed opportunity for children to have the widest range of support possible or to choose someone outside the police to support them for this sensitive interview.

Practice study: highly effective practice

Through engagement and presentation with the family GP, one family was carefully supported to understand the risks of sexual harm, following disclosures about the father who was living with the family. Although none of the children made disclosures about their father, practitioners were extremely concerned about self-harming and low mood for one of the children. Due to multi-agency professional concerns about the potential risks to the children, a safety plan determined that the father could not live in the same house, and the family also faced potential homelessness and held wider concerns about bullying at school.

Work was agreed within the child protection plan, and the public health nurse offered a package of care using a mental health workbook, allowing the children to explore 'big feelings' and 'worries'. The children were supported by sensitive social work practitioners to understand why they could not live with their father, as well as a joined-up, multi-agency response to explore other concerns. The children's journey improved remarkably, to the point of one child no longer presenting with self-harming, and others being empowered and supported to make choices for themselves and to understand why it was not safe for them to live with their father. Once they were helped to understand their father's actions towards children, they were able to decline further contact. The children were offered wider specialist counselling support in school, and other specialist therapeutic services and assessment, including a children's rights officer.

The tenacious approach of practitioners, in the absence of any disclosures, but through the multi-agency assessment of need, has helped to protect these children from child sexual abuse in a family environment.

Practice study: area for improvement

Safeguarding referrals concerning individuals who may pose a risk of harm to children do not always receive prompt responses at the front door. In one instance, acceptance of a referral was delayed due to a request for a written MARF. Notification back to the probation practitioner after the MARF was completed was slow, requiring repeated follow-up and chasing. A strategy discussion was eventually initiated following persistent efforts by probation. Further delays in convening the strategy discussion and the initial child protection conference postponed safety planning, limiting the multi-agency response to provide timely protection and planning for the child.

Next steps

We have determined that Leicestershire County Council is the principal authority and should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving the individuals and agencies that this report is addressed to. The response should set out the actions for the partnership and, when appropriate, individual agencies. The local safeguarding partners should oversee implementation of the action plan through their local multi-agency safeguarding arrangements.

Jane Moore should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 28 May 2026. This statement will inform the lines of enquiry at any future joint or single-agency activity by the inspectorates.



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Yours sincerely

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