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Lisa Lyons, Director of Children's Services, Oxfordshire County Council
Dr Martin Reeves, Chief Executive, Oxfordshire County Council
Dr Nick Broughton, Chief Executive, Thames Valley Integrated Care Board
Matthew Barber, Thames Valley Police and Crime Commissioner
Jason Hogg, Chief Constable, Thames Valley Police
Tom Browning, Regional Probation Director South Central
Ian Sutherland, Independent Scrutineer

Dear Oxfordshire Safeguarding Children Partnership

Joint targeted area inspection of Oxfordshire

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 Oxfordshire.

This inspection took place from 9 to 13 February 2026. 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

When children are at evident risk of being sexually abused in their families, or they have disclosed that they have been sexually abused, the response to safeguard and support them is swift and effective in the majority of circumstances. Children benefit from prompt access to therapeutic support, and police investigations are well coordinated and timely. When there are exceptions to this, it is usually linked to poor communication about the level of risk posed by sexual offenders.

The quality, timeliness and effectiveness of information-sharing across key partner agencies is inconsistent, and while there are pockets of strong practice in terms of professional curiosity and being alert to the possibility of child sexual abuse in families, this level of awareness is variable across the local safeguarding partnership. When there are indicators of child sexual abuse but there has not been a disclosure by the child, these indicators are not always recognised or responded to soon enough.

Although the number of children at risk of sexual abuse in the family environment who are being identified is slowly increasing from a low starting point, and this improving identification is a positive, the Oxfordshire Safeguarding Children Partnership (OSCP) is not currently making the best use of the information and expertise at its disposal to fully understand the extent, nature and gravity of child sexual abuse across the county.

Alongside statutory partner agencies, schools and the community sector are active participants in building capacity to identify children at risk of sexual abuse, but the probation service is not meaningfully involved at a strategic, and often operational, level.

What needs to improve?

- The involvement of the probation service in the partnership at a strategic level.
- Coordination and analysis of performance information and data to better understand the type and prevalence of child sexual abuse in the family environment and to target resources accordingly.
- The quality and effectiveness of safety planning for children.
- The sharing of information between and within partner agencies to identify and assess risks to children.
- Identification of children who are at risk of child sexual abuse in the family environment when there has not been a clear disclosure of sexual abuse.
- The range and impact of specific training on child sexual abuse in the family environment provided to include more staff who do not have specialist roles.
- The identification and assessment of risk posed to children by adult sex offenders.
- The rigour and effectiveness of the multi-agency public protection arrangements (MAPPA) process.

- Levels of confidence and curiosity across the partnership when children's behaviour may indicate that they are being sexually abused in the family.

Strengths

- The consistency and strength of professional networks around children and their families when it has been recognised that there has been child sexual abuse in the family.
- The contribution of the local authority clinical psychologists to helping social workers understand the barriers to working with children who have been sexually abused in their family.
- Trusting and safe relationships between children, investigating officers and social workers during police investigations that help children know what is happening and why.
- The timeliness and quality of police investigations once child sexual abuse has been identified in a family.
- How quickly children have access to therapeutic support.
- The response by the local authority designated officer (LADO) to allegations of child sexual abuse made against adults in a position of trust, including the assessment of transferable risks.
- The strengthening of practice because of joint training of police officers and social workers on how to conduct video and achieving best evidence (ABE) interviews.
- The role of education providers in supporting children who have been sexually abused.

Main findings

When referrals into the multi-agency safeguarding hub (MASH) clearly identify that children have been, or are at immediate risk of being, sexually abused in the family environment, almost all are responded to quickly. Children and young people are prioritised for examinations by the sexual assault referral centre (SARC), and timely strategy discussions take place, including relevant staff from most key partner agencies. Within the child and adolescent mental health services (CAMHS), specialist therapeutic teams such as Horizon and the child and adolescent harmful behaviours service (CAHBS) act quickly, offering joint visits and trauma-informed assessment without waiting lists. These teams support children who have been sexually abused and children displaying harmful sexual behaviours towards family members.

Some initial assessments lack reflection and insight when the risk of sexual abuse is less clear, lacking the depth to support informed next steps in supporting the child and reducing the risk of sexual harm in the family. This is in part due to the volume of referrals into the MASH from a variety of sources that provide information without sufficient risk analysis by the referrer.

The probation service in particular is not consistently involved in identifying and assessing risks associated with present and past child sexual abuse by adults who pose a risk to children. Consequently, a small number of children are left in situations of unassessed risk. The partnership took action to remedy an instance of this through a reconvened child protection strategy discussion following increased concerns from the inspection team.

At the early point in the identification and referral of children at risk of sexual abuse, and beyond, there are several gaps in information-sharing. For example, police information is only shared with children's social care; there is limited information-sharing between probation and children's services; schools do not always gather information that they need from other schools; and several parts of the health service do not consistently receive updates from children's social care. This is particularly the case for primary care settings, including GPs. As a result, professionals supporting children do not always have full knowledge of the factors influencing the current level of risk.

Licence conditions for adults who pose a risk to children are not always informed by management of sexual offenders and violent offenders (MOSOVO) staff, police officers and children's services assessing risk together prior to offenders being released. Partner agencies are often unaware of what the safety plan is for children, beyond the involvement of children's social care and, sometimes, the police. The sharing of outcomes from planning meetings with partner agencies is inconsistent.

When children receive support, the majority of work is child centred and focused on the child's experiences, both of child sexual abuse and of their childhood in general. The context of their background, history, age and ability is considered and responded to sensitively. Effective and meaningful relationships are built with children and their families to help them navigate their futures after the trauma of being sexually abused. In many children's experiences, this work is exemplary and achieves the difficult balance between painful conversations and unconditional support. For most children, direct work leads to a comprehensive understanding of their world, timely multi-agency action and effective plans that give them the knowledge to build positive relationships.

The quality of safety planning varies and, for many children, lacks a fully informed assessment of adults, and other children, who might cause them harm in the family. Initial plans typically result in either the victim or the alleged perpetrator of sexual

abuse being removed from the family. If this is not the case, adults who have been charged with keeping children safe are rarely assessed to find out if they have the capacity to do so. The result is too often an unrealistic expectation on adults who may lack the capacity to protect and may themselves have been victims of sexual or other kinds of abuse.

Children are helped to understand what has happened to them and to begin to heal, through the provision of trauma-informed and relational services. This is the case in the SARC, throughout child protection investigations, when they are seen by community paediatricians, and have consistent social workers and investigating police officers. These approaches and this level of understanding are inconsistent in probation practice, when it involves or relates to children.

Practitioners in specialist services, for example the disabled children's service, help children to 'be seen and heard' in line with the findings of the child safeguarding practice review panel 2024 report, 'I wanted them all to notice'. Practitioners are alert to the fact that children's behaviour may indicate that they are being sexually abused in their family. This approach is supported by the effective use of practice tools, augmented communication techniques and consistent personal relationships.

Most social care assessments are detailed and clearly gain the voice of the child and an understanding of their world. The voices of children and their individual needs are not consistently gathered by staff from other partner agencies. Although police officers increasingly record the voice of the child, this information is not consistently used to best effect. The gathering and consideration of children's voices in probation risk assessments is underdeveloped, and there is more to do to capture the voice of the child in MAPPA meetings, as there is too often an overreliance on children's social care to reflect this.

MAPPA threshold panels are under review by the coordinator, as the majority of requests by probation practitioners to increase the level of MAPPA management of offenders, to better reflect the risk they pose, are being rejected and risk management reviews often take place without safeguarding updates from partner agencies. As a result, the risks posed to children are not fully understood, and this means that suitable actions are either not agreed or do not adequately reflect the nature and level of the risks present.

In families with complex needs and risks, when the involvement of professionals is longer term, practice is variable. In most work, ongoing support during police investigations is strong; it is planned effectively and is provided in children's timescales. Support from the in-house clinical psychology team helps social workers understand some of the barriers to making progress experienced by many children and families and to adjust planning accordingly. In weaker work, there is a compartmentalised response to risk with other forms of abuse not being addressed

once sexual abuse in the family environment becomes the focus. Similarly, professionals can lose sight of adults on the periphery of families who pose a risk to children. As a result, planning often lacks enough urgency and progress is slow.

When there are allegations of child sexual abuse made about adults in positions of trust, the LADO organises timely, multi-agency meetings. Detailed information-sharing leads to clear plans that help to ensure that children are well protected. In addition, the LADO draws themes and trends from their work to inform training and resource allocation across the partnership.

Dedicated and experienced workers from a range of commissioned services support children and families who are victims of child sexual abuse in the family environment. The children and young person's independent sexual violence adviser (ChISVA) team provides highly valued, specialist support for adults and children with recent or historical experiences of sexual abuse. However, the ChISVA service is working to the edge of its capacity because of delays in the court system.

When a criminal offence is suspected in relation to child sexual abuse in the family environment, there is an effective, child-centred multi-agency response. Investigations are timely and of good quality with meaningful supervisory reviews. Appropriate decisions are made when risks to children are identified. Some delays are seen when investigations involve the examination of electronic devices and because of lengthy delays in the criminal justice system.

When the police have an offender on bail who is suspected of child sexual abuse in the family environment, the starting point is to use police bail to impose conditions to safeguard children. This is working effectively. When the suspect is a child, partnership discussions inform the most appropriate response that includes safeguarding both children.

The police have an established approach for responding to the Child Sex Offender Disclosure Scheme (CSODS, also known as Sarah's Law) right to ask requests when there are concerns about individuals who may pose a risk of sexual harm to children. The decision to make the disclosure is informed by effective multi-agency information-sharing. The CSODS disclosure is made by specialist child protection officers who are best placed to help the requester understand the risks to the child or children. Although officers are aware of CSODS, not all are aware of how the police execute their responsibilities under this scheme.

When children have disclosed sexual abuse, joint investigations involving the police and social workers are well managed. There is clarity to their differing roles, and this is well explained to children and to parents. These investigations are timely and result in the children being well supported in very difficult circumstances. The partnership training offer for ABE interviews is good. Both social workers and police

attend joint training. This also results in more confident and analytical social work because of how the training strengthens workers' understanding of joint investigations and evidence-gathering.

A good offer is in place through the offender personality disorder pathway (OPDP), which enables probation practitioners to consult forensic psychologists for guidance on formulating risk management strategies.

There is some targeted delivery of the 'Building Choices' accredited programme for men who commit sexual offences, although waiting times for this programme are long. This has included tailored work with a small group of men with needs related to neurodiversity and a small group with learning difficulties.

Community service is organised and used well to help reintegrate men who sexually offend into the community in a safer way, and to reduce the risk of further offending. With similar positive impact, welfare support for people on probation includes building networks of both support and accountability to help them understand and manage their lives more safely.

Most schools have clear, effective systems in place to ensure that they have the knowledge to play their part effectively in the identification and support of children who are at risk of, or are victims of, child sexual abuse in the family environment. They largely advocate for children from a position of knowledge and understanding, ably supported by the education safeguarding advisory team (ESAT). Information is shared in the best interests of children. Sensitive, joint working reduces risk and supports the child. While schools monitor children affected by child sexual abuse in the family environment closely, there is sometimes an overreliance on verbal disclosure before taking action.

Currently, and across the partnership, profiling, data sets and subsequent targeting are not sophisticated or used in the most effective way. The safeguarding partnership has undoubtedly made significant progress in understanding the nature and extent of child sexual abuse linked to exploitation, but this has not been replicated for children at risk of sexual abuse in the family environment.

However, there are several key building blocks in place that the partnership has identified that have the capacity to support a greater understanding of why identification and reporting are low. Work on aligning relevant data sets from across the partnership, and on analysing and reporting on this, is at a stage where additional information could be included. Analysis by clinical psychologists, audits and practice weeks and better use of the academic rigour available in the local authority's research policy hub are other examples.

There is a distinct lack of engagement between probation and the safeguarding partnership. This is the case at a strategic level and, to a large extent, at an operational level. Significant pressures on the probation service, linked to a relatively inexperienced staff group compounded by staff shortages and difficulties with staff recruitment and retention, are key factors in this separation at an operational level. Strategically, there is little evidence of a strongly developed focus on child sexual abuse in the family environment that has probation 'at the table' in a meaningful sense. However, as a response to the inspection, an openness to improving this relationship has begun.

Changes to the structure and governance of the OSCP have resulted in a more streamlined and effective approach to monitoring and strengthening practice. Several mechanisms to evaluate the quality of practice are in place and are well established, for example regular police/SARC meetings, performance and quality assurance frameworks, practice weeks, quarterly partnership oversight, and improving internal logs for tracking referrals about children. As a partnership, the OSCP has a good understanding of the areas it needs to strengthen, particularly in terms of shared data and analysis.

A survey on professional curiosity and the impact of multi-agency audits on child sexual exploitation, including those completed for this inspection, has helped the partnership to increase confidence levels for many staff in being aware of the possibility of child sexual abuse in the family environment. In the last four months, the partnership has created a strategic risk register where issues escalated to delegated safeguarding partners are recorded.

Leaders and managers across the statutory partner agencies regularly engage in critical reflection. To strengthen the voice of children at a strategic and practice level, the partnership has recently recruited participation workers, one within the OSCP, to increase ways for survivors of sexual abuse and their families to be involved in shaping policy and resources. The partnership maintains a focus on continuous improvement over several different themes, including child exploitation, which have varying degrees of connectedness to this area of practice. However, there is insufficient overlap to enable a sufficient understanding of the prevalence and profile of child sexual abuse in the family in Oxfordshire.

Not all professionals know how to escalate issues when there is disagreement between partner agencies about the level of risk children are exposed to, often because of a lack of knowledge or confidence. When professionals do formally escalate their concerns, this is not always recorded.

The number of police staff in Oxfordshire trained to investigate child sexual abuse in the family environment is comparatively high. The police have invested heavily in the learning and development of staff to investigate child sexual abuse in the family

environment, including a bespoke supervisory investigation course which focuses on the quality of MASH referrals and risk assessments leading to an improved initial response.

The safeguarding partnership promotes multi-agency learning about identifying, assessing and responding to generic safeguarding effectively. Across the wider partnership, some of this training lacks the depth that practitioners need to respond to child sexual abuse in the family environment.

In comparison, the delivery of the specialist child abuse investigation development programme (SCAIDP) course, delivered jointly by staff from children's social care, the police and health, provides a holistic approach. The training on offer to specialist workers, when they access it, is reflective and contemporary, and equips staff with the skills and knowledge they need to deliver high-quality services to children who may have been sexually abused in their family. The partnership has already identified that increasing attendance and mapping the impact of training is an area for further consolidation.

Practice study: highly effective practice

This example highlights how consistent relationships and 'thinking the unthinkable' can protect children who do not use their voice as their main way of communicating.

A primary school-aged child was referred to the MASH by his school. Unable to verbalise his feelings, some of his behaviours were worrying the school and had become sexual in nature, towards both children and staff. This was also the case at home. Much of the assessment of what the risks were to others was based on observation by highly skilled teaching and family support staff. Crucially, the assessment reflected on why the child may be behaving in this way, with sexual abuse in the family considered as a potential reason from the outset. This and other possibilities, including what he may have seen in real life or online, and sexual behaviour linked to sensory-seeking behaviour, were clearly identified and considered, with evidence gathered to test each hypothesis. The workers engaged the family sensitively with all the options, supported by consultation with clinical psychologists about the best way to remain non-judgemental but alert to possibility. As a result, the family, including this child and his sibling, have a network of support that is set up to notice changes in behaviour, mood, emotional responses and physical demeanour. Cultural genograms, and direct work on boundaries and relationships, have made the environment safer for the child and other children he spends time with.

Practice study: area for improvement

This example highlights the impact on children of poor risk assessment and information-sharing.

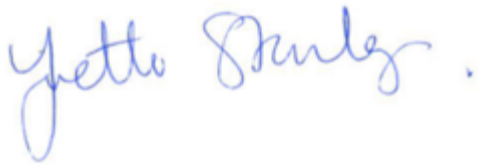
This child lives with his mother, father and two siblings. The local authority's children's services were concerned for his and his siblings' welfare following a disclosure by his father's now adult daughter that she had previously been sexually abused by the father. Children's services checked with probation if the father was known to them and probation initially stated that he was 'not known', which was a serious error. On further enquiry, it was established that the father is a serial perpetrator of domestic abuse and previous allegations of child sexual abuse, and more recent allegations of harassment had been made against him. Concerningly, the probation service assessed the father as posing a medium risk of serious harm and approved his release from prison on home detention curfew to live with his vulnerable partner and children. The father was reassessed following a child protection strategy meeting, and probation then took appropriate action to change the conditions of his licence to remove him from the address the same day, a decision that should and could have been made significantly sooner.

Next steps

We have determined that Lisa Lyons, Director of Children's Services (DCS), in her capacity as chair of the OSCP, 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.

The DCS should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 21 August 2026. This statement will inform the lines of enquiry at any future joint or single-agency activity by the inspectorates.

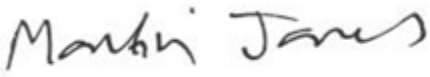
Yours sincerely



Yvette Stanley
National Director Regulation and Social Care, Ofsted

Professor Aidan Fowler
Interim Chief Inspector of Healthcare, CQC

Kathryn Stone OBE
His Majesty's Inspector of Constabulary
His Majesty's Inspector of Fire & Rescue Services



Martin Jones CBE
His Majesty's Chief Inspector of Probation