RBSCP
ROCHDALE BOROUGH
SAFEGUARDING CHILDREN PARTNERSHIP

Child Safeguarding Practice Review
Completed March 2026
Executive Summary
Lead Reviewer: Nicki Pettitt[1]

The Executive to consider how the learning from this review can be safely published.

1. The Rochdale Borough Safeguarding Children Partnership (RBSCP) commissioned a local Child Safeguarding Practice Review (CSPR) in 2025 to consider practice and systems with children where assessments and interventions are required due to behaviour that indicates significant trauma.
2. The RBSCP have decided that publication of the full report would present a significant risk to the family. In line with data protection obligations and safeguarding duties, the Partnership has decided to publish this summary which provides transparency and accountability and captures the learning arising from the review but should protect the welfare and privacy of the family.
3. Learning has been identified in the following areas:
   Learning area: The response to allegations of child sexual harm/abuse, when there are concerns that the parents may not believe the allegations.
4. When a child makes allegations of sexual harm /abuse from a sibling, there is a need to investigate these issues robustly, and to consider the safety of the child/ren at the time and going forward. This includes the perpetrator if they are also a child. In this case child protection and criminal processes were followed initially but stalled when the child victim stated that they did not wish to support a criminal investigation, and shared concerns about the impact on their mental health. The review found that the response of the parents at the time was significant, as they implied that they did not believe their younger child. This likely contributed to the child's decision not to continue with the plan to be formally interviewed by the police and support the investigation.
5. While the child had opportunities in the days and weeks that followed the disclosure to speak to their mentor, to a teacher at school who they were particularly close to, and to a social worker, there is no evidence of a plan at the time for them to receive any specific support in respect of sexual harm. There was also little evidence of a focus with the parents on what the child might be experiencing at home following the significant allegations and the agency involvement that followed, including the older sibling being arrested. In her 2024 report, Understanding and Responding to Sibling Sexual Harm and Abuse[2], Dr Elly Hanson outlines the serious and long-term impacts for victims of sibling sexual abuse. The report states that it can lead to anxiety, depression, PTSD symptoms, sexual difficulties and lowered self-esteem, but that the extent of the impact likely depends on the response from the family and whether support is available. In this family it appears that the required support from the family was not available to the child.
6. Dr Hanson states the importance of agencies and professionals considering three key areas when responding to sexual abuse between siblings: *safety, healing and justice*. This requires a whole family approach which robustly considers family dynamics and the needs of each family member. Best practice includes the need for and use of specialist trauma informed service pathways. While there was less risk of ongoing sexual abuse, with the victim here insisting the abuse had stopped some time ago, consideration of emotional harm needed to be considered as a specific risk. A formal child protection response focusing on the impact on the child of the parents not believing them. A timely review strategy

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[2] https://learning.nspcc.org.uk/media/lirh1dgi/understanding-responding-sibling-sex ual-harm-abuse-report.pdf

meeting that considered not just the sexual abuse, but the wider emotional concerns, would have enabled the consideration of the child's safety more holistically.

7. The focus was on the child with less focus on the parents and the need for them to protect and support the child. The required need for 'healing' was not likely while the child remained in an environment where they were not believed or were even blamed. It is not known what pressure was on the child at home, and whether there was persuasion to either withdraw the allegations or not to support the police investigation. Work was needed with the parents to understand the impact of the allegations on them and a focused assessment on their ability to meet their child's needs. Dr Hanson's report states that parents and other siblings are likely to be deeply affected by sibling sexual abuse, experiencing stress, guilt, and emotional turmoil, and that effective whole family support is crucial for recovery.
8. It is known that domestic abuse was an issue in the family prior to their move to Rochdale. Assessments were also undertaken as there was a family culture of using physical abuse as a punishment, although this was often minimised by professionals as chastisement. Children that have grown up with domestic abuse at home have had to adapt to an environment where there are significant consequences to angering or upsetting a parent. There is also a known risk of different types of abuse co-existing in a family. The same environment that allows domestic abuse creates conditions where child sexual abuse can occur, including silence which is enforced by fear. The UK Centre of Expertise on Child Sexual Abuse state that where there is domestic abuse within the family, children may be living in fear, which can lead to them being scared to tell anyone about any other abuse. The trauma experienced by children living in households with co-existing abuse will be complex. There was also likely to be a degree of fear about making an allegation which would anger and upset the parents within the context of a family where domestic abuse had occurred. This was considered by those working with the child, but there was limited consideration of the need to assess and ensure ongoing emotional risk to them, and to challenge the parents about the need to support them.

   Learning area: The need to consider why a child may not wish to speak about sexual abuse, and the required response if the child does not wish to make a formal statement or support a police investigation.
9. The child's allegations likely brought shame and unwanted professional attention onto the family. The social worker explored this with the child and recognised that this was a pressure for them. The expectations a child is under at home can influence how a young person speaks about their experiences, expresses distress, and whether they seek help. In communities where reputation and honour are highly valued, a child who speaks out may be worried about how the family would be seen within their community and of the anger that then may be shown to them. This can prevent a child from disclosing abuse, mental health struggles, or stating unmet needs. This may have contributed to the child's feelings of guilt, anxiety, or low self-worth. In cases such as this, there is a need for work with the child to explore these pressures. The school told the review that the child's father would often compare them unfavourably to the older siblings, and the child's experience following the allegations appears to have led to a focus from the family on the impact on the older sibling, which likely exacerbated the child's feeling of being less important at home.
10. It is also important to consider the potential stigma attached to sexual abuse, particularly when the child is from a community that is conservative about sexuality and where sexual preference may even be seen as a sin. This can lead to confusion, shame and fear of rejection or blame from family or peers, which could have a significant impact on the child's mental health. Boys who have been abused may have learned that aggression is a way to regain control, to avoid vulnerability, to protect themselves, and to disconnect from overwhelming feelings.
11. The child changed their mind about making a formal statement to the police. The police decided to take no further action due to the evidential threshold not being met without evidence from the child. Those who knew the child well, including the school, shared their concerns across agencies about what may have influenced this decision, and the need to review the safety plan in light of this. The child died before the plan was adapted to reflect this. Processes had been followed at the time of the allegations, including a strategy meeting. The decision was formally made to continue with child in need planning rather than

progressing to an initial child protection conference, as the family were agreeing to the ongoing child in need planning. This was despite concerns that the parents may not abide by the safety plan in place, could apply pressure on the child to withdraw the allegations, and would not support them. This required a child protection response.

Learning area: The importance of those working with the family having awareness of the history, including seeking, sharing and curiosity about information held in areas where the family have previously lived or were receiving services from, to help recognise the impact of long-term trauma when making decisions.

12. The family history was not entirely known to agencies in Rochdale. This was due to the number of moves and attending schools in other Local Authority areas. Most agencies were aware that the family had lived in at least three other areas in the UK and abroad before they moved to Rochdale. The children in the family told the reviewer that they experienced significant racism in another area of the country.
13. The children had several moves of home, area and schools in a relatively short time. The review has not looked in detail at the involvement of services in the other areas, but the review is confident that the children were never the subjects of child protection planning, although there were interventions due to concerns about physical and emotional harm and about domestic abuse. Working Together to Safeguard Children 2023 (the guidance at the time) emphasises the importance of stability and information sharing, and the risk posed when families move frequently. Keeping Children Safe in Education[3] reflects on risk to the wellbeing of children who move schools frequently.
14. There were also education disruptions when he was living in Rochdale. There were several short-term suspensions from school when the child was living in Rochdale, because of incidents of serious violence in the education setting. The child also spent time in two different schools, as part of a plan to manage the risk and avoid permanent exclusion. Ultimately, following permanent exclusion, the child began the transition to a pupil referral unit (PRU) shortly before they died, and an initial meeting was held between the child, his parent and the PRU while he remained on roll at his school. The CSPR has identified learning about the decision to permanently exclude the child, which was made 16 days prior to their death, and about information sharing and communication between his school and the PRU, including attendance at strategy meetings.
15. The reason for the permanent exclusion was due to violent behaviour towards other pupils and staff members over time, with the school having a responsibility to keep other children and staff safe. The school acknowledged that the timing of the decision to permanent exclude was close to the end of term, and shortly after the child shared their history of being sexually harmed. They also recognised that a move to a PRU can exacerbate risks to a child. Child Safeguarding Practice Reviews, and national research consistently highlight that permanent exclusion from mainstream school can have significant negative impacts on a children's safety, wellbeing, and long-term outcomes**.** School provides a child with routines, a sense of identity and belonging, and support from adults and potentially peers. Exclusion can lead to the child feeling rejected, stigmatised, isolated, without a focus and with increased fears for their future, which can then lead to a decline in their mental health and can exacerbate the behavioral challenges that led to the exclusion. At the same time the child had a goodbye meeting with his social worker, due to the way services are delivered. This was another loss. The review was informed that the Family First reforms should lead to more consistency of social workers for children.
16. Learning is found about the need to ensure that non-education professionals understand the processes, and the importance of advocating for children, using existing processes (school and safeguarding partnership policy) to challenge a decision, and advising families to seek independent legal advice[4] about the decision[5].

[3] https://assets.publishing.service.gov.uk/media/68add931969253904d155860/Keeping_children_safe_in_education_from_1_September_2025.pdf

[4] The Garden Court Chambers School Inclusion Project[4] recognise that nationally, racially minoritised children are more likely to be permanently excluded than their white peers and provide pro-bono support in these circumstances.

[5] The Academy Trust told the review they include this in the paperwork about the permanent exclusion.

17. The family said that the child found the PRU system difficult, being shocked that pupils are searched on arrival and that they were very sad to not be returning to school. The psychologist who knew the child told the review that as a child who had been sexually and physically abused, they were likely to have been triggered by a physical search. The swift transfer to the PRU meant that information from the previous school was not shared beyond the basics. During the meeting sensitive information was shared that should not have been, and the PRU were not aware of the child's recent sexual abuse allegations.
18. There is learning for criminal justice agencies about the need to ensure that multi-agency information sharing and planning for a child when there are concerns about violent, aggressive and offending behaviour, that recognises the child's lived experience and trauma. It has been established that despite the Police initially enquiring with the Youth Offending Service YOS for outcome resolutions, this did not happen. The child in need plan was an opportunity to ensure that there was a multiagency response, and to think creatively about how best to support the child. There is a need to undertake a piece of work regularly with children about the important people in their lives, personal and professional, to ensure those who know the child best speak to each other, and to introduce the possibility of some joint work to support the child. For example, the child's social worker and school-based mentor.
19. The review also identified learning for all professionals about understanding #Thrive and whether this was appropriate for a child with complex issues and requiring a trauma informed response. The family told the review that they had not understood that it was a drop-in service and that they did not have a specific appointment.

    Learning area: To ensure that interventions are meaningful, to reduce avoidance of services, and to keep the child's lived experience central to safeguarding practice, professionals working with families from other cultures require training and guidance to develop confidence in culturally sensitive safeguarding practice.
20. Some of the professionals working with the child in the months before they died told the review that despite knowing them well and working hard to build a relationship with them, they did not tend to discuss the child's race and cultural background with them. A sibling told the review that they have rarely been spoken to about what it is like to be a black person, and how this and racism impacts their life. Exploring a child's experiences of racism is an important part of understanding their lived experience and enabling a trusting relationship with a professional. Childhood experiences need exploring and validation to ensure resilience and coping.
21. A number of those who contributed to the review recognised that they do not feel confident in discussing race with children and families. In 2024 the Centre for Expertise on Child Sexual Abuse published a knowledge review - Child Sexual Abuse of African, Asian and Caribbean Heritage Children[6]. It identifies significant gaps in knowledge and understanding, with little research that engaged directly with these children, instead there was a reliance on accounts from adult survivors or practitioners, or on analysis of case records. What was clear was that poor experiences with statutory services combined with societal racism can lead to children and non-abusing parents to stay silent about abuse within the home.
22. The national Child Safeguarding Practice Review Panel's March 2025 report, It's Silent: Race, Racism and Safeguarding Children, discusses the "systemic silence and reticence" within child protection services regarding issues of race and racism and calls for professionals to have more open and specific conversations about the role of race and racism when working with children and their families. It recommends that 'safeguarding partnerships should create conditions that empower practitioners to have conversations with children and families about race and identity, building skill and confidence. This includes ensuring there are safe opportunities for self-reflection within teams and in supervision to enable them to acknowledge their own biases.'

[6] https://www.csacentre.org.uk/app/uploads/2024/07/Child-sexual-abuse-of-African-Asian-and-Caribbean-heritage-children-A-knowledge-review.pdf

23. The review considered the wider knowledge of the family and their cumulative experience of services. This included parenting practices where physical abuse was used as discipline. There were interventions on several occasions (prior to the move to Rochdale) due to concerns about this, and a dilution of concerns as physical abuse was termed as 'chastisement'. Improvements were only maintained temporarily when agencies were involved. This experience along with the resulting professional response will likely have added to the child's trauma, expression of angry emotions, and low expectations of professionals. Having a good understanding of the history of interventions about this issue was essential, including the involvement of agencies in other areas. A S47 investigation following the child physically assaulting a sibling reflected that there were growing concerns around how the child presented at home, at school, and in community, which indicated they were struggling to manage conflict and were holding a great deal of unresolved anger and emotional pain.
24. As well as considering the impact on the children, there is also a need to consider the impact on the parents of professionals telling them how to parent their children. Finding out if a parent feels that their culture is being criticised or dismissed, whether they feel undermined, and if they are wary of having British parenting norms imposed on them, is essential. Culturally sensitive relationship-based approaches are required**,** to explore a parents' beliefs and experiences, including how they feel about professional involvement, to avoid resistance and build trust. This includes an acknowledgement and respect of the family's cultural background and beliefs without condoning harm. Understanding the family's views of parenting and how children should behave was an important part of the work required with them, alongside aiming to understand their fears and worries about working with professionals, including their experiences in the past. Understanding and recognising family norms and the impact this has on parenting is important with any family, but particularly with those not from the dominant culture.

Conclusion and recommendations

25. There is no doubt that the child was well liked and well known by many of the professionals who worked with them. There were those who advocated for them with their family and with other professionals, and most recognised the trauma they had experienced. The death has had a significant impact on them, and they have helped the review by reflecting on their individual learning as well as wider system lessons.
26. Single agency learning has been identified during the review and recommendations have been agreed to address these, including single agency SMART action plans. The recommendations include improved challenge in respect of holding strategy meetings, considering emotional harm, revising permanent exclusion processes, and improving handovers between schools.
27. Learning has been identified about the need to ensure that there is a multiagency response (with both challenge and support) when a child who has a plan (child in need or child protection) and is about to be permanently excluded, before the final decision is made. The DofE need to consider how this can happen within the current legislation and expected timescales. A recommendation has not been made, but this will be raised with the national CSPR panel by the RBSCP. Having considered the rest of the learning, the following recommendations are made, with the aim of ensuring that the required improvement actions are achieved:

Recommendation 1

The relevant partner agencies must ensure that non-education staff understand processes and pathways for exclusions used in schools, and review practice and expectations within their agency for

- provision of support and contingency planning when there is a risk of permanent exclusion
- advocacy and challenge for vulnerable children who are on the verge of or are permanently excluded.

Recommendation 2

Partner agencies to seek evidence that they request and consider the need for a review strategy meeting when there is a significant change to a plan or investigation, and that emotional harm to a child is considered as a child protection issue that may require a child protection conference. This should include

promoting awareness of roles and responsibilities for requesting a strategy meeting and challenging other agencies if one is not held and is required.

Recommendation 3

The Partnership to request that agencies undertake a quality assurance piece of work to ensure that parents who do not believe their children in respect of sexual abuse or sexual harm are being challenged and supported, and that work is being completed with them to address this issue. An action plan should then be developed to include how professionals are supported to undertake this complex work in Rochdale.

Recommendation 4

The Partnership to tell agencies that they must include the learning from this review in the work that they are undertaking to action the practice recommendations[7] made in the 2025 report 'It's Silent' (page 53) including the need to explore how professionals can develop confidence to explore a child's experience of racism with them, and challenging parents about physical abuse.

Recommendation 5

The learning from this review must be considered by the Rochdale CSA working group. They must then focus on the need for professionals to consistently consider the resources provided by the sexual abuse Centre of Expertise, in respect of how professionals challenge and support[8] parents who do not believe a child who has made allegation of sexual abuse, including the consideration of emotional harm.

- Black and Asian children and young people in the UK are very aware of racism and want professionals to discuss their experiences with them.
- The younger members of the family reflected that it seems like physical abuse is normalised and accepted as being culturally acceptable in some families. Professionals therefore need to consider if certain forms of punishment, for example being hit with a belt, would be seen as acceptable in a white family.
- The need to be clear with children and parents about what they can expect from services.
- Identified support to teenagers needs to be available quickly, if they wait too long the moment might be missed.
- While avoiding criminalising a child might seem like a good idea, there is also a need to have consequences for behaviours.

Additional learning from the consideration of agency involvement with this child was found in respect of:

- Working with a child who has said they have been sexually harmed when they are not believed by their parents.
- Implementing child protection procedures when there are concerns about emotional harm.
- Considering the impact of long-term trauma when making decisions.
- Professional challenge across agencies and borders.
- Culturally sensitive safeguarding practice.

[7] - Safeguarding partnerships should create conditions that empower practitioners to have conversations with children and families about race and identity, building skill and confidence. This includes ensuring there are safe opportunities for self-reflection within teams and in supervision to enable them to acknowledge their own biases.
- Safeguarding partnerships to review their local strategies and approach to addressing race, racism and racial bias in their work with Black, Asian and Mixed Heritage children, giving specific account to local multi-agency practice, and the design and commissioning of services (including but not limited to translation services).
- Safeguarding partnerships should ensure appropriate internal structures are in place to support practitioners to recognise, discuss and challenge internal and institutional racism.

[8] This should include work to increase their capacity to parent safely.

Addendum 1

Process:

1. An independent lead reviewer was commissioned to work alongside local professionals from Rochdale and relevant professionals from a neighbouring Local Authority area, to complete the review. This panel worked closely with the lead reviewer to identify the overall learning, and the recommendations included in this report.
2. The starting point for the CSPR was the detailed information shared during a Rapid Review process in 2025. The panel members then provided further reflection on each agency's involvement and consideration of whether single agency recommendations were required.
3. A face-to-face multi-agency meeting was held in October 2025 with many of the local professionals who had been involved with the child and family. The meeting included discussions about their involvement with the family, about their practice more generally, and about the wider systems in which they work. Some one-to-one meetings were held with professionals for clarity or because they did not attend the event.
4. The lead reviewer met with the family who generously spoke about the child and shared their thoughts on services. To protect their confidentiality, limited information about their circumstances is shared in this Executive Summary.