THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

“I wanted them all to notice”

Protecting children and responding to child sexual abuse within the family environment

November 2024

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Foreword

This report describes very shocking things about the lives, distress and pain of children who had horrific abuse perpetrated on them, by adults who should have cared for them and kept them safe. What is even more disturbing is that safeguarding agencies were unable to listen, hear and protect these children. This report, and the evidence on which it is based, stands as both an invitation and a challenge to government and professionals, to respect and recognise the voices and experiences of the children at the heart of this review, so that children in the future might receive the help and protection that should be their undeniable right.

Forty years on from the publication of the *Cleveland Report* (1988), we must ask why the sexual abuse of children in the family environment provokes undoubted and profound professional unease, and in so doing, systematically silences and shuts out children from the protection and support they need. More recently the Independent Inquiry into Child Sexual Abuse (IICSA) evidenced the countless ways in which organisations, professionals and government have too often denied and deflected attention from the realities of child sexual abuse. This was powerfully demonstrated in the courageous testimonies of adult survivors in IICSA’s Truth Project.

Over the past 20 years or so, the light on the sexual abuse of children within families has gradually dimmed. We have witnessed a worrying evaporation of the skills and knowledge that professionals (leaders and practitioners) must have to work confidently and sensitively in this complex area of practice. This dilution of focus and expertise may be partly explained by the greater public and professional attention on the sexual abuse of children in institutions, by ‘famous’ people and on the sexual exploitation of children outside their home. This was undoubtedly urgently required, but it may also have drawn our eyes away from the more common experience for children, of sexual abuse in their families.

Despite commonalities between different types of sexual abuse, the ‘othering’ and moral outrage that can accompany media attention on extra-familial sexual abuse has perhaps distracted attention from the more commonplace nature of familial abuse. In turning our attention away from the latter, we have undermined the confidence and capability of professionals to identify and respond to sexual abuse in families.

In over a third of the reviews, the people who harmed children (98% of whom were men) were known to pose a risk of sexual harm. The risk of harm was known (and often over many years) but ignored, denied or deflected. Therefore, it is often not a matter of professionals not knowing about the risk of abuse, but rather of a system that simply does not see, notice and comprehend this type of risk. The review highlights too that shame, fear and concern about betraying their families means that children struggle to tell others what is happening. A profound change is overdue in how professionals, in their different roles, engage with and talk to children about abuse. This involves wholesale change in training, supervision and leadership.

These challenges are not about the failings of individuals or one agency to do their job. They are systemic and of a multi-agency nature. This is emphasised by the fact that in 2022/23 just 3.6% of children on child protection plans were there because of a primary concern about child sexual abuse (and tellingly this is at its lowest for a very long time). This may be because of institutionalised avoidance and disinclination to name sexual abuse as a concern, and also because safeguarding agencies are failing to notice when children are at risk of this form of harm. It may also reflect a system that too often is criminal justice led.

A national strategic response, led by government, is needed. This will involve investment in better working together, not only between the trinity of safeguarding partners (local authorities, police and health) but also with schools and other education providers, with the criminal and family justice system (including probation), and with the third sector.

The voices and testimonies of the children at the heart of this report make plain that we cannot turn our minds away from acknowledging the reality of sexual abuse for too many children. The child whose quote forms this review's title reminds us of our responsibilities to notice what is happening to children. If we do not, then those perpetrating abuse will continue to wield their corrosive and abusive power in many children's lives.

Very many people have contributed to this review, sharing their insights and experiences. These include survivors of abuse, practitioners and leaders, and government officials. We are heartened by the candour and openness to change of many professionals. That change can and must be secured is beyond any doubt. The Children's Wellbeing Bill provides important opportunities for changing how we protect and help children, including through proposed multi-agency child protection teams which could provide children with a more timely, sensitive and coherent response.

Finally, I would like to express gratitude to Anna Glinski, Sophie Laws, Diana Parkinson and their team from the Centre of expertise on child sexual abuse, to Panel members Jenny Coles and Alison Steele, and Luke Beckett and Michelle Sharma from the Panel Secretariat. Everyone’s commitment to delivering a review that will make a tangible difference to children in the future was unyielding.

Annie Hudson
Chair of the Child Safeguarding Practice Review Panel

Executive summary

Introduction

This national review set out to explore the challenges that feature in the identification, assessment and response to child sexual abuse within the family environment. It recommends changes to local and national multi-agency safeguarding policy and practice to better reflect evidence about how to protect children and support family members.

It has uncovered significant and long-standing issues. Children who are sexually abused by someone in their family are frequently not being identified by practitioners, nor are they receiving the response needed for their ongoing safety and recovery. Child sexual abuse in the family environment has been allowed to thrive in secrecy and silence for far too long. With this review, we aim to break this silence and drive whole-system change that empowers practitioners to identify and respond to concerns of child sexual abuse, putting the needs of children first, confident in the support of senior leaders at local and national level.

Methods

Between 2018 and 2023, the independent Child Safeguarding Practice Review Panel (the Panel) received over 130 rapid reviews and related serious case reviews (SCRs) and local child safeguarding practice reviews (LCSPRs) which featured child sexual abuse in the family environment. The Panel considered that the volume of incidents and the severity and complexity of the issues highlighted required further exploration and analysis.

While there is no single agreed definition of child sexual abuse within the family environment (also referred to in this report as intrafamilial child sexual abuse), this is broadly understood as sexual abuse by a relative, for example, a parent, stepparent, sibling or grandparent, those closely linked to the family, such as a parent's partner, or someone within the home environment with caring responsibilities, such as a foster carer. However, intrafamilial child sexual abuse often overlaps with other forms of sexual abuse. Most online child sexual abuse material is created at home, with research indicating that around half of those producing this type of online content are family members, often biological/adoptive parents or stepparents.

The research involved a number of inter-related strands of work which were carried out concurrently.

- A review of recent research and practice guidance, summarising what is known about child sexual abuse in the family environment and the response to it.
- Analysis of 136 rapid reviews, 40 related SCRs and LCSPRs, and one thematic review relating to child sexual abuse in the family environment received by the Panel between June 2018 and November 2023.
- 10 online reflective group discussions with 107 practitioners in 9 local safeguarding partnerships who had been involved in 10 of these reviews.
- One-to-one interviews with 2 of the children at the heart of these reviews and 5 people who had been convicted for sexually abusing children in these reviews.
- Reflective discussions involving experts by experience, practitioners and senior leaders from a range of agencies including policing, probation, children's social care, universal health and specialist health services.[1]

The local reviews we looked at as part of this study had to have reached a sufficient threshold of concern about harm to trigger a formal review.[2] But it is notable that many of the issues identified have been highlighted in national studies and inspections over a number of years, as well as in our reflective discussions with stakeholders.[3] We do not therefore consider that these reviews present an atypical picture of current issues in practice. Nonetheless, we recognise that this is a complex area of work and there will also be many examples of effective multi-agency working around intrafamilial child sexual abuse.

1 We use the term 'expert by experience' to refer to people with lived experience of being sexually abused as a child.

2 A serious incident notification is triggered when a child dies or is seriously harmed, and abuse or neglect is known or suspected. See www.gov.uk/guidance/report-a-serious-child-safeguarding-incident

3 Children's Commissioner (2015) 'Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action'; Ofsted, the Care Quality Commission (CQC), HMI Constabulary and Fire and Rescue Services (HMICFRS) and HMI Probation (HMIP) (2020) 'The multi-agency response to child sexual abuse in the family environment: Joint targeted area inspections (JTAIs)'.

Our analysis of these local reviews, supported by insights from our interviews and discussions, has provided a rich base of evidence which has enabled us to consider many aspects of this form of abuse and explore the challenges that practitioners face in identifying and responding to it. From this, we have developed a suite of recommendations to transform how children are protected from and supported after sexual abuse by someone in their family environment. The prevention of child sexual abuse was not within the scope of this review, although we believe that addressing the recommendations made in this report would certainly contribute to preventing future harm.

Key findings

The findings of this national review clearly illustrate the scale of the challenge facing practitioners, and indeed wider society, in identifying, responding to and preventing child sexual abuse in the family environment. They highlight a systemic failure across all agencies to recognise and respond when children are at risk of, or are already, being sexually abused by someone in their family environment.

Not hearing children's voices and understanding their needs

The review found that practitioners working with children and families have not been equipped with the knowledge, skills and practical guidance to identify and respond confidently when there are concerns of child sexual abuse in the family environment.

> Overwhelmingly, practitioners are relying on children to verbally report their abuse before taking action, which has particular implications for pre-verbal and non-verbal children. Furthermore, children are not being given opportunities to communicate what is happening to them, and are sometimes not believed when they do tell.

There appear to be uncertainties about what can and cannot be said to children which have dominated practice for many years, leading to a culture of fear and silence. In particular, a fear of interfering with any possible future criminal investigation means practitioners feel they should not talk to children directly about possible abuse. This, coupled with an over-reliance on the criminal justice system to confirm whether a child has been sexually abused means children about whom there are concerns of intrafamilial sexual abuse are not receiving the protection and support they need.

Practitioners have been led to believe that they need children to approach them to speak about sexual abuse rather than proactively talking to children when they have concerns that a child might be being sexually abused, either because the child was displaying signs of possible abuse or because there was someone in the child’s family who presented a sexual risk. As a result, we saw many reviews where practitioners had not created opportunities that would enable a child to tell or communicate to them what was happening or had acted in ways that created a barrier to them telling.

> **“I couldn’t talk about the sexual abuse. It was too difficult. I wanted them all to notice and to ask me what was going on.” (Interview with child who was sexually abused)**

Yet when children did tell someone, as they did in nearly three-quarters of the reviews we looked at, they were often not listened to or were disbelieved, with subsequent retractions taken as proof that the abuse had not occurred, and leaving them at further risk of harm.

> Single and multi-agency child protection enquiries, investigations and assessments into concerns of child sexual abuse do not always keep the best interests of the child as the central consideration. Children’s needs are not always adequately considered in strategy discussions, and the right information is not consistently shared.

Practitioners were not always clear about the need for joint social work/police child protection investigations, despite there being strong evidence that there was a need to undertake both criminal investigations and child protection enquiries to establish risk and safety for the children in line with ‘Working Together’ (2023).

There was also a lack of consistency in the identification and response to sexual abuse according to individual characteristics, experiences and backgrounds (such as ethnicity and disability), types of harm (such as sibling sexual abuse and abuse in online contexts) and related difficulties (such as poor mental health). Strategy discussions did not always include someone who knew the child and how best to communicate with them or bring in appropriate health expertise.

Although over a quarter of the children in the reviews were from Black and other minoritised communities, in only 13 of these reviews was there any specific reference to children's race, ethnicity or culture and how practitioners had taken this into account in responding to children. None recognised the impact of racism, bias and wider systemic experiences of discrimination including on people from ethnic minoritised communities. As a result, there was little learning available from these local reviews, other than highlighting how practice is failing in this respect and that this needs to be addressed.

Similarly, a quarter of the 35 reviews involving a disabled child did not include any discussion of the child's impairment or give consideration to how this might affect them, what the implications were for communication and engagement with these children and what this would mean for effective practice for those working with them.

> The review highlighted the significant harm to children's emotional and physical health and, in some cases, lifelong impact resulting from intrafamilial sexual abuse. Yet practitioners do not always know what they can do within their roles to support children's wellbeing and recovery.

Tragically, 7 children in the reviews we looked at had died by suicide and a further 14 children had talked about or attempted suicide. One of these children was aged 7 when she talked about hanging herself. Many children had self-harmed, developed an eating disorder, been diagnosed with depression or post-traumatic stress disorder, or had begun misusing substances or alcohol. The abuse had also impacted children's education, leaving children unable to attend school or engage in learning due to the emotional distress or physical harm resulting from the sexual abuse. In addition, 10 children in the reviews were known to have become pregnant as a result of the sexual abuse, at least 6 of whom had gone on to give birth, with youngest being just 11 years old at the time.

Practitioners need to have a better understanding both of the impact of intrafamilial child sexual abuse and how a child's distress resulting from abuse may show in their behaviour, and recognise the need to provide support that responds to children's needs. Following the identification of the sexual abuse, practitioners and managers across multiple agencies often appeared to be unclear about what they could do in their role to support the child and their family. In addition, despite guidance making it clear that children can access therapeutic support while a criminal investigation is underway, there still appeared to be a perception that this was not possible. Furthermore, some children were taken into local authority care following the identification of sexual abuse without foster carers being sufficiently informed and supported to look after children with the significant behavioural and mental health needs that had resulted.

Children in extreme emotional distress did not have access to specialist support from practitioners who understood and could talk to children about the abuse they had suffered and reassure them of the normality of this distress. While specialist professional help was often not available, it is critical that this is not seen as the sole response to sexual abuse. Children will also benefit immensely from receiving a supportive response from the practitioners around them who can reassure them of the normality of their responses and support them in understanding the abuse was not their fault.

It is therefore imperative that practitioners across the whole children's workforce are enabled to create safe and supportive contexts for children who have been sexually abused – in particular through staff training and support, access to resources to support their practice, and sensitive, proportionate information-sharing systems.

Understanding parents' and carers' contexts, vulnerabilities and needs

The review also highlighted the lack of an appropriate response to parents and carers.[4] This included practitioners not taking sufficient account of parents' contexts and vulnerabilities, particularly for those subject to domestic abuse.

Of particular note was the lack of understanding of parents' and carers' contexts and vulnerabilities, and especially the impact of domestic abuse and coercive control in the lives of mothers and the way in which this could result in child sexual abuse not being considered by practitioners.

We saw an unrealistic over-reliance on parents and carers to protect their children, without giving them the guidance and support they needed to do this. Practitioners were often using working agreements and safety plans which did not take full account of parents' and carers' own situations and needs, such as learning difficulties or disabilities, or being victims of domestic abuse. Parents and carers were often left feeling that practitioners did not believe them, blamed them, or would not listen to them, particularly when they had additional communication needs related to language or disability.

4 When referring to parents and carers, we have avoided terms such as 'non-abusing' and 'safe'. Instead, we refer simply to parents and carers, and make it clear when the parent or carer is the person who has sexually abused the child.

Practitioners were not sharing information appropriately with parents and carers, seeking their views or listening to them. A particular concern was practitioners not advising parents about a partner's previous convictions or investigations for child sexual abuse.

Generally, there was a lack of recognition of the information and support parents and carers needed to enable them to parent a child who had been sexually abused. Some parents found that making sense of and navigating the various interventions available for their child, while caring for their child, required a level of financial and emotional resource they did not have. Others revealed the difficulty of responding to the needs of all their children after sibling sexual abuse had come to light and, particularly, in knowing whether and how they could keep their family together in a safe and appropriate way.

Challenges in identifying signs, understanding risk and raising concerns

Practitioners across all agencies were not routinely identifying and acting on signs of sexual abuse. This was due, primarily, to a lack of training and resources that supported and empowered them to recognise and respond to signs (both in the child and the adults around them) that a child may be being sexually abused by someone in their family environment. This also highlighted the need for practitioners to be supported in their work through good supervision, with time and space to reflect on this emotionally challenging and often uncomfortable area of practice.

In addition, stereotypes and assumptions around both victims and those who harm, and a lack of understanding of 'grooming' and coercive control, impacted on practitioners' ability to recognise signs of intrafamilial child sexual abuse.[5] Signs of sexual abuse in disabled children were frequently missed by practitioners who had often interpreted signs and indicators of sexual abuse as being a result of the child's impairments, including both physical and behavioural difficulties. Equally, practitioners misunderstood the behaviour of children who had been sexually abused as indicative of a possible disability, rather than signs of sexual abuse. In addition, practitioners did not sufficiently connect children's emotional distress or changes in behaviour with the possibility of child sexual abuse, even when this had previously been a concern.

5 Grooming is a process that involves the offender building a relationship with a child, and sometimes with their wider family, gaining their trust and a position of power over the child, in preparation for abuse (CEOP, 2022). Coercive control is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim (Women's Aid, 2024).

Over a third of reviews featured a family member with a known history of sexual offending or who was known to present some risk of sexual harm. We saw reviews that featured convicted sex offenders and family members who had been previously prosecuted for sexual abuse, including rape of family members, moving into a home with young children without a risk assessment or an effective safeguarding response being put in place.

Practitioners appeared to lack knowledge and resources to support them in understanding how a history of sexual violence or child sexual abuse offending might translate into risk for children in the family environment.

There was also insufficient collaboration and information-sharing between children’s social care and those agencies which do hold relevant knowledge and information on sexual offending, particularly police and probation. This meant that concerns relating to adults who pose a risk of sexual harm are not always understood, shared and effectively assessed, leaving children exposed to ongoing sexual harm.

In addition, we found that practitioners often did not understand guidance on information-sharing and consent, believing that they must obtain parental consent to gather information from other agencies or undertake a child in need assessment, where this is not in fact the case. This led to a lack of action to address concerns of child sexual abuse.

Where child and family assessments did take place, we found in many instances they lacked depth, did not focus sufficiently on sexual abuse and were not informed by contributions from the multi-agency network. It was particularly striking that those who knew the children best, such as school staff, were often not invited to contribute, or where the practitioners’ views differed from those of the assessing social worker, they were disregarded.

We noted the siloed nature of assessments, with information not being shared across agencies, and each new incident being treated as unique rather than as part of a wider picture. Similarly, practitioners did not always have access to relevant information when families had moved across local authority areas.

We were also particularly concerned about some of the family court's decisions described in reviews – in both public and private law proceedings – where a lack of recognition of the risk presented by a parent or carer had resulted in children being placed with or having unsupervised contact with the person who was abusing them. It appeared that courts had at times failed to understand the risks they knew about. At other times, there had been inadequate investigation of the history of those concerned through the commissioning of Section 7 reports (Children Act 1989), leaving children at risk of further harm.[6]

Issues in responding to concerns of intrafamilial child sexual abuse

Once concerns had been raised, there was often a lack of thorough investigation and effective action to safeguard and support children. This was partly due to inadequate multi-agency exploration and sharing of concerns, but also stemmed from misunderstandings and confusion around thresholds and the way in which the incorrect use of the criminal justice standard of proof prevented practitioners from taking effective action to safeguard and support children.

> We found that the criminal standard of proof (which requires evidence 'beyond reasonable doubt') was frequently used as the threshold for ascertaining whether a safeguarding response was required, instead of the safeguarding threshold of 'balance of probabilities' which includes an evaluation of likely or actual significant harm.

Linked to these misunderstandings around what constitutes sufficient evidence to take action to safeguard children, we noted an overarching fear and uncertainty among practitioners to name the sexual abuse of children, and explore and record concerns. This seemed to be based on misconceptions around what constituted sufficient evidence to act, resulting in collective silence and inaction. This often meant that practitioners subsequently involved were not aware of a history of, or previous concerns around, child sexual abuse offending or its implications when further concerns about sexual abuse emerged.

6 Section 7 reports (Children's Act 1989) relate to private law proceedings when the court is wanting information about a child's welfare to determine what course of action will be best for the child.

The application of this higher threshold was evident across the system, preventing the safeguarding and support of children at multiple points. From initial identification where practitioners believed the child must verbally report their abuse, to decisions taken at the front door of children’s social care about whether to accept referrals, to strategy discussions, child protection conferences and legal decision-making forums, including court, no further action was taken by any agency if evidence ‘beyond reasonable doubt’ was not confirmed by police. Even when children did verbally report their abuse, where evidence ‘beyond reasonable doubt’ was not found, the rest of the system became paralysed and children were neither safeguarded nor supported.

Where practitioners had recorded concerns in case files and an investigation had taken place and been concluded, the reasons for the police not to take further action were not shared with practitioners who subsequently recorded simply ‘no further action’. We saw repeatedly that when police had decided to take no further action due to the high evidential threshold for criminal proceedings not being met, children’s social care and other agencies often understood this to mean that the child had not been sexually abused and that there were therefore no safeguarding concerns or other actions needed. This not only left children at risk of further abuse, but also without the support needed at the time, or at any point in the future.

Finally, our interviews with people who had sexually abused a child in their family highlighted the importance of services being available that can help prevent offending and re-offending, and that practitioners can direct people who are at risk of offending, or who have offended, to them. When these services are not available, opportunities will be missed for those who have abused to be challenged about, to consider and to change their behaviour post-conviction.

Conclusions and recommendations

This review has revealed a system in which children are all too often ignored or disbelieved, in which risks posed by adults within the family are frequently overlooked, misunderstood or minimised, and in which practitioners consistently lack the support, guidance and direction required to intervene effectively. We recognise that this national review was inevitably skewed towards a focus on situations where a serious incident notification had been made and where there had often been poor practice.

However, many of the issues that we have identified, emerging both from our analysis of reviews and discussions with practitioners, managers and senior leaders, have been consistently highlighted in previous research and inspection reports and are strongly indicative of wider systemic problems.[7]

We need to create a system in which all those working with children and families are equipped to confidently identify and respond to intrafamilial child sexual abuse (including abuse committed online). They must be supported by a robust system of strong leadership and accountability, clear guidance, supervision and support, ensuring that child sexual abuse within the family is identified early, the risk of further harm is prevented and the impact of child sexual abuse is reduced.

This review provides the opportunity for real and lasting change to be enacted which will fundamentally transform the identification of this abuse and the response that children and families receive. These long-standing issues require concerted and determined cross-government activity, with sustained commitment over the coming years. Enabling effective multi-agency practice requires a fully joined-up approach from government departments, including, but not limited to, the Home Office, the Department for Education, the Ministry of Justice and the Department of Health and Social Care.

The government's mission-led approach provides an opportunity to implement the recommendations from this review, with relevance across the missions on opportunity and safer streets. The 10-year timescale for delivery of its commitment to tackling violence against women and children fits well with the extent of commitment and investment required. The Children's Wellbeing Bill also brings opportunities for protecting and helping children, with the proposed multi-agency child protection teams giving the potential to help address many of the practice challenges identified.

Our key recommendations at a national level are therefore outlined below.

7 Children's Commissioner (2015) 'Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action'; Ofsted, CQC, HMICFRS and HMIP (2020) 'The multi-agency response to child sexual abuse in the family environment: Joint targeted area inspections (JTAIs)'.

Recommendation 1: National strategic plan

Government should develop and publish a strategic plan to secure the necessary practice improvements identified in this report.

Recommendation 2: Professional knowledge, skills and confidence

Government should take the necessary steps, working with professional bodies, to ensure that practitioners and managers have the necessary skills, knowledge and capabilities, including access to relevant guidance.

Recommendation 3: Enquiries and investigations

Government should take necessary steps to improve the quality of joint enquiries so that decisions are more consistently in children’s interests.

Recommendation 4: Assessment of people presenting risk of sexual harm

Government should ensure that there is robust assessment and management of people who present a risk of sexual harm and who have contact with children.

Recommendation 5: Talking to children

Government should ensure that practitioners understand that they can and should talk directly to children, and families, about concerns of sexual abuse.

Recommendation 6: Health

Government should ask NHS England and public health commissioners to audit local commissioning arrangements to ensure that pathways and services are in place to identify and respond to the health needs of sexually abused children (recent and non-recent).

Recommendation 7: Criminal investigations and charging advice

Government should take action so that there is a clear and agreed process for ensuring that where cases cannot be considered against the threshold test, early charging advice is sought in cases of intrafamilial child sexual abuse.

Recommendation 8: Family courts

The Panel invites the President of the Family Division to consider the findings of this review and determine what actions are needed to support judicial decision making when children may have been sexually abused.

Recommendation 9: Cafcass

The Panel invites Cafcass to consider the findings of this review to determine what actions it needs to take.

Recommendation 10: Inspectorates

The Panel invites the relevant inspectorates (Ofsted, the Care Quality Commission, HMI Constabulary and Fire and Rescue Services and HMI Probation) to consider the findings of this review.

The report also makes recommendations for safeguarding partners in England.

Introduction

1. The review question

Between 2018 and 2023, the independent Child Safeguarding Practice Review Panel (the Panel) received over 130 rapid reviews and related serious case reviews (SCRs) and local child safeguarding practice reviews (LCSPRs) which featured child sexual abuse in the family environment (also known as intrafamilial child sexual abuse). The Panel recognised that there was already ongoing research in this field but considered that the volume of incidents, and the severity and complexity of issues highlighted required further exploration and analysis.

1.1 Children who are abused by someone in their family environment should receive effective protection and support that recognises their individual needs. The Panel, along with national, regional and local leaders, has a clear responsibility to make sure that there is a deeper understanding of intrafamilial child sexual abuse, and of what should be done to protect children better in the future.

1.2 By commissioning a national review into child sexual abuse in the family environment, the Panel is seeking to shine a light on the contexts, experiences and needs of these children and their parents or carers. From this, we have identified 10 national recommendations and 6 key recommendations for local safeguarding partners to enable leaders and practitioners to better understand and uphold their responsibilities in protecting and supporting children.

1.3 The overarching review question was:

What specific challenges feature in the identification, assessment, and response to child sexual abuse within the family environment and how can multi-agency local and national safeguarding practice change to better reflect evidence about how to protect children from intrafamilial child sexual abuse?

1.4 Within this, 3 key lines of enquiry set for the review focused on:

- early identification of risks, risk assessment and strategies to mitigate those risks
- robust responses to concerns of intrafamilial child sexual abuse to protect children from ongoing or recurrent harm
- a series of cross-cutting themes and questions (see Appendix A)

A note on terminology

For the sake of simplicity, we use the term 'child' to refer to anyone under the age of 18. However, it is important to remember that teenagers as well as younger children can be sexually abused.

We use the term 'parent or carer' to encompass any adult in a parental or principal care-giving role to a child. This may be, for example, the child's biological parent, stepparent or other relative in that role. It also includes adoptive parents and foster carers. We have avoided terms such as 'non-abusing' and 'safe'. Instead, we refer simply to parents and carers and make it clear when the parent or carer is the person who has sexually abused the child.

This report refers to those who work in a range of roles:

The term 'strategic leaders' is used to refer to chief executives of local authorities, chief executives of integrated care boards, chief executives of NHS trusts, chief constables, police and crime commissioners, and chief executives of multi-academy trusts, directors of children's services, leaders and lead members for children's services in local authorities, and chairs or scrutineers of local safeguarding children partnerships.

'Managers' may include heads of services and team managers in local authorities, designated and named professionals (GP, nurse, doctor, midwife) in health, the Chief Superintendent and Chief Inspector (and equivalents) in police, and head teachers, designated safeguarding leads and nursery managers in education.

'Practitioners' refers to those in direct practice which may include frontline social workers, health visitors, police constables, teachers and those working in the voluntary and community sector.

Finally, we have avoided using the terms 'disclosure' and 'allegation' in relation to children reporting abuse as these terms have been subject to much debate. Instead, we talk about 'children telling' or a 'child's report'.

2. Context

This chapter sets out the context for this review, summarising the research literature and key practice guidance relating to the identification and response to child sexual abuse by someone in the family environment.

Definitions

Child sexual abuse is defined in 'Working Together to Safeguard Children' (2023) as:

> "Forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts, such as masturbation, kissing, rubbing, and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse. Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children." [8]

2.1 While there is no single agreed definition of child sexual abuse within the family environment (also referred to in this report as intrafamilial child sexual abuse), this is broadly understood as sexual abuse by a relative, for example a parent, stepparent, sibling or grandparent, those closely linked to the family, for example a parent's partner, or someone within the home environment with caring responsibilities, such as a foster carer.[9] Some definitions have set a wider remit than this, and included family friends, neighbours and babysitters within the definition of intrafamilial child sexual abuse.[10]

8 Department for Education (2023) 'Working Together to Safeguard Children: A guide to multi-agency working to help, protect and promote the welfare of children', page 162.

9 Horvath, MAH, Davidson, JC, Grove-Hills, J, Gekoski, A and Choak, C (2014) '"It's a lonely journey." A Rapid Evidence Assessment on intrafamilial child sexual abuse' Office of the Children's Commissioner.

10 Children's Commissioner (2015) 'Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action'; Vulnerability Knowledge and Practice Programme (2024) 'National analysis of police-recorded child sexual abuse and exploitation crimes (CSAE) crimes report', National Police Chiefs' Council.

2.2 In this review, we have used the tighter definition provided by Horvath and others as this best reflects the experiences of the children at the heart of the reviews that have come to the Panel (see Chapter 4).[11]

2.3 We use the term 'Black and other minoritised communities' when referring to communities affected by inequality. We use this term because it is important to recognise that experiences and challenges can vary for individuals with different ethnic or racial heritages. By using this inclusive language, the Panel aims to address the specific issues faced by various communities while emphasising the common goal of promoting equity and addressing disparities. We recognise that the language used when referring to children, their families and communities can at times be contested and that preferred terms can develop and change quickly.

Prevalence

Child sexual abuse is far more prevalent than is routinely acknowledged or understood. It is estimated that at least 500,000 children in England and Wales are sexually abused each year, with survey evidence finding that at least one in 10 children will be sexually abused before the age of 16.[12]

2.4 Most child sexual abuse is carried out by a person who the child knows and trusts, with the latest available survey data showing that around a quarter to a third of child sexual abuse victims and survivors (and around a third to a half of those whose abuse involved penetration) said a family member had been involved in their abuse.[13]

2.5 Those who are mostly likely to harm a child within the family environment are fathers (including stepfathers), siblings (or other children living in the family environment) followed by other family members such as uncles, grandfathers and other relatives.[14] Most people who have sexually abused a child in the family environment are male, although abuse by women and girls does occur.[15]

2.6 Existing research indicates that, compared to extrafamilial abuse, child sexual abuse in the family generally starts at a younger age and involves more serious and frequent offending over a longer period.[16]

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11 Horvath and others (2014).

12 Karsna, K and Kelly, L (2021) 'The scale and nature of child sexual abuse: Review of evidence' CSA Centre.

13 Office for National Statistics (2020) 'Child sexual abuse – Appendix tables'.

14 Children's Commissioner (2015) 'Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action'.

15 Office for National Statistics (2020) 'Child sexual abuse – Appendix tables'.

16 Scott, S (2023) 'Key messages from research on intra-familial child sexual abuse', CSA Centre.

2.7 As such, intrafamilial child sexual abuse often overlaps with other forms of sexual abuse. For example, family members have been involved in the organised abuse of children by multiple abusers and in the production and distribution of online child sexual abuse material.[17] In fact, most online child sexual abuse material is created at home, with 'highly traded' images often involving the abuse of prepubescent girls by their fathers.[18]

Which children are more likely to be sexually abused

While any child may be sexually abused, research suggests that some characteristics and contexts increase a child's vulnerability.

2.8 In surveys, girls are at least 3 times as likely as boys to describe experiences of child sexual abuse.[19]

2.9 Children of any age may be abused. Around one third of victims and survivors report that their abuse started before the age of 9. Another third said that it started when they were aged 9 to 12, and the remaining third that it started between ages 13 to 15.[20] Pre-verbal children face particular risks.[21]

2.10 Disabled children are at least twice as likely to be sexually abused than non-disabled children. They may be more dependent on their caregivers, may experience greater barriers to communication and may be less likely to be perceived as potential victims of intrafamilial sexual abuse.[22]

17 Scott, S (2023) 'Key messages from research on intra-familial child sexual abuse', CSA Centre.

18 Salter, M, & Wong, T (2024) 'Parental production of child sexual abuse material: A critical review', Trauma, Violence, and Abuse, volume 25(3), pages 1826-1837.

19 Karsna, K and Kelly, L (2021) 'The scale and nature of child sexual abuse: Review of evidence', CSA Centre.

20 Office for National Statistics (2020) 'Child sexual abuse – Appendix tables'.

21 Vrolijk-Bosschaart, T, Brilleslijper-Kater, S, Widdershoven, G, Teeuw, A, Verlinden, E, Voskes, Y, van Duin, E, Verhoeff, A, de Leeuw, M, Roskam, M, Benninga, M and Lindauer, R (2017) 'Psychosocial symptoms in very young children assessed for sexual abuse: A qualitative analysis from the ASAC study' Child Abuse and Neglect, volume 73, pages 8-23.

22 Jones, L, Bellis, MA, Wood, S, Hughes, K, McCoy, E, Eckley, L, Bates, G, Mikton, C, Shakespeare, T and Officer, A (2012) 'Prevalence and risk of violence against children with disabilities: A systematic review and meta-analysis of observational studies' Lancet, volume 380(9845), pages 899 to 907l, Office for National Statistics (2020).

2.11 Over half of children who are sexually abused are also subject to other forms of child abuse, most frequently emotional abuse or experiencing domestic abuse.[23] Children who are being neglected by their primary caregivers are 5 times more likely to be sexually abused than those with no experience of neglect.[24]

2.12 Furthermore, children who live in a household with someone misusing alcohol or drugs, or with mental health difficulties are 3 times more likely to be sexually abused than children not exposed to parental substance misuse or mental health issues.

Reporting abuse

There are many barriers faced by children in telling someone they are being or have been sexually abused. These involve a complex interplay of individual, familial, contextual, societal and cultural issues.[25] Fear of disrupting family relationships or breaking up the family, possibly being placed in foster care or involving their family with the criminal justice system, also prevents children from reporting abuse.[26]

2.13 Cultural stereotypes and racism can lead to failures on the part of agencies and practitioners to identify and respond appropriately to child sexual abuse. They can also make it more difficult for individuals in from Black and other minoritised communities to report child sexual abuse.[27]

2.14 The Independent Inquiry into Child Sexual Abuse undertook research to explore the experiences of people from Black and other minoritised communities in reporting and accessing support for child sexual abuse, particularly in terms of their interactions with institutions. They found that for people from Black and other minoritised communities, the response and support they received was influenced by systemic factors relating, on the one hand, to wider society and institutions, and on the other, to their own communities and culture. This is illustrated in the following diagram.[28]

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23 Office for National Statistics (2020).

24 Office for National Statistics (2020).

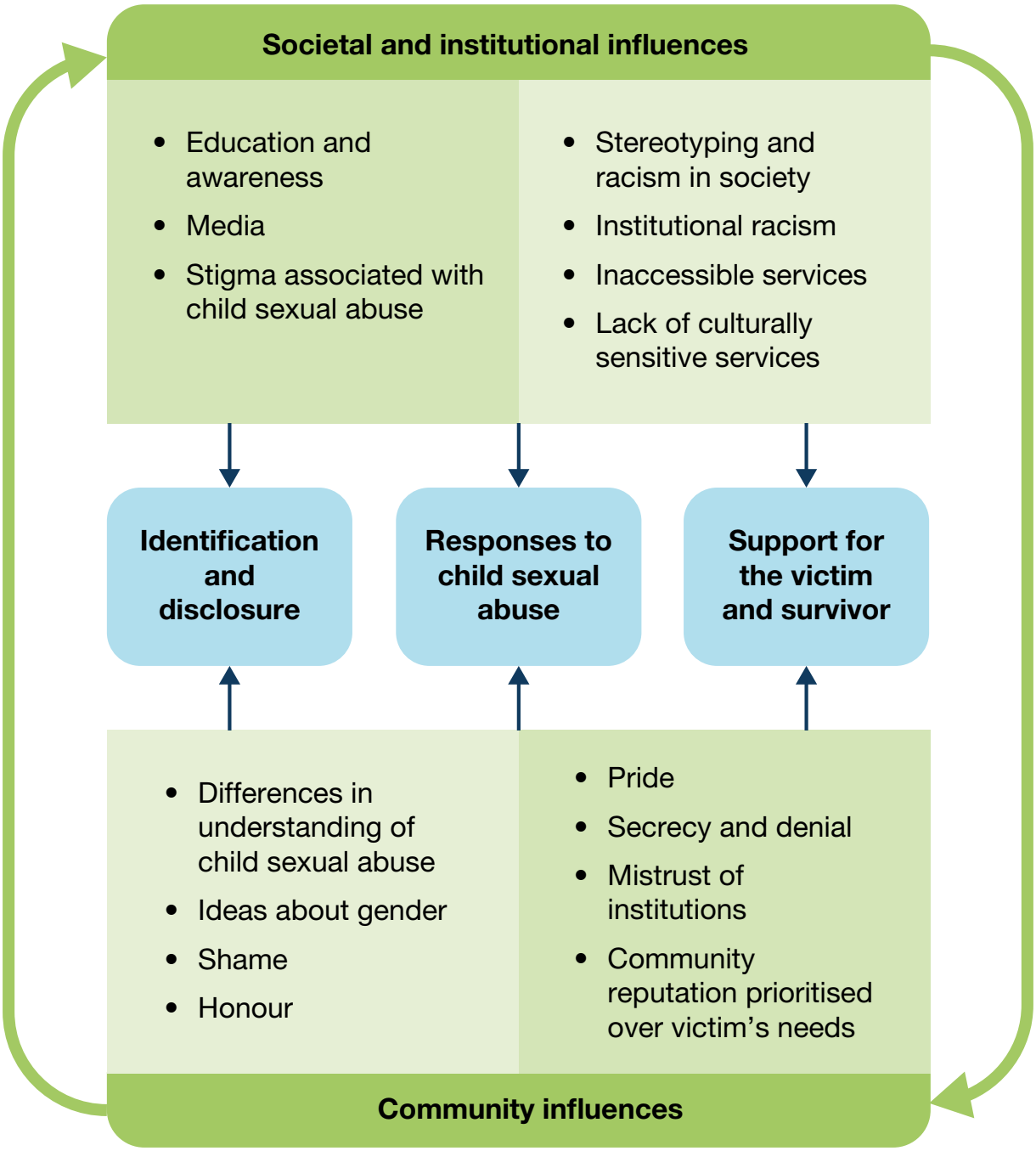
25 McPherson, L, Gatwiri, K, Graham, A, Rotumah, D, Hand, K, Modderman, C, Chubb, J and James, S (2024) 'What helps children and young people to disclose their experience of sexual abuse and what gets in the way? A systematic scoping review' Child Youth Care Forum.

26 Allnock, D (2017) 'Memorable life events and disclosure of child sexual abuse: Possibilities and challenges across diverse contexts' Families, Relationships and Societies, volume 6(2), pages 185-200.

27 Rodger, H, Hurcombe, R, Redmond T and George, R (2020) '"People don't talk about it": Child sexual abuse in ethnic minority communities', Independent Inquiry into Child Sexual Abuse.

28 Rodger, H, Hurcombe, R, Redmond T and George, R (2020) '"People don't talk about it": Child sexual abuse in ethnic minority communities', Independent Inquiry into Child Sexual Abuse.

Figure 1: Influences on child sexual abuse disclosure, responses and support



2.15 Children of African, Asian or Caribbean heritage may find it more difficult to report their abuse. For example, feelings of shame and embarrassment, and fears about the stigma associated with abuse were linked, for some Asian children, to an expectation that they must uphold their family reputation and 'honour', or that reporting the abuse would cause further stigma to their community.[29] For some, simply being able to talk about relationships and sex was impossible, with some languages having no neutral words for sexual abuse.[30] Research with African and Caribbean victims and survivors highlights the expectation that they should stay silent about abuse within the home to protect the family unit in the face of racism, sexism and socio-economic poverty.[31] [32]

2.16 There is also evidence that other groups of children – for example, boys and young men and care experienced children – are likely to face additional barriers to being identified or being able to tell someone about the abuse.[33] Boys and young men, for example, face barriers linked to societal understandings of masculinity and victimhood.[34] While children in care may be reluctant to report abuse to authorities if they fear reprisals from those around them.[35]

2.17 How practitioners perceive families' socio-economic status can also influence the response provided. We know from research into social workers' management of concerns of neglect that practitioners face particular challenges in intervening in families from affluent backgrounds.[36]

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29 Warrington, C, Beckett, H, Ackerley, E, Walker, M and Allnock, D (2017) 'Making noise: Children's voices for positive change after sexual abuse' University of Bedfordshire/Office of Children's Commissioner; Harrison, K and Gill, A (2018) 'Breaking down barriers: Recommendations for improving sexual abuse reporting rates in British South Asian communities' The British Journal of Criminology, volume 58(2), pages 273-290.

30 Gilligan, P and Akhtar, S (2005) 'Child sexual abuse among Asian communities: Developing materials to raise awareness in Bradford', Practice: Social Work in Action, volume 17(4), pages 267 to 284.; Pande, S (2012) 'Lost for words: Difficulties naming and disclosing sexual violence in Hindi'. In Rehman, Y, Kelly, L and Siddiqui, H (eds.) 'Moving in the Shadows: Violence in the Lives of Minority Women and Children' Routledge.

31 Bernard, C (2016) 'Child sexual abuse in the lives of black children' Bernard, C and Harris, P (eds.) 'Safeguarding black children: Good practice in child protection' London: Jessica Kingsley.

32 Home Office (2022) 'Country Policy and Information Note Pakistan: Women fearing gender-based violence'.

33 Allnock, D, Miller, P and Baker, H (2023) 'Key messages from research on identifying and responding to disclosures of child sexual abuse' CSA Centre.

34 Bonner-Thompson, C, McGregor, K and Preston, J (2023) 'Men's Unwanted Sexual Experiences: Barriers to timely and appropriate support in England' The MUSE project.

35 Evans, J (2019) 'Key messages from research on looked-after children and child sexual abuse' CSA Centre.

36 Bernard, C and Greenwood, T (2019) ''We're giving you the sack'- Social workers' perspectives of intervening in affluent families when there are concerns about child neglect', British Journal of Social Work, volume 0, pages 1-17.

The impact of child sexual abuse

Research suggests that the physical and emotional impact on children who are abused by someone within their family is greater than for those who are abused by someone external to their family.[37] This may be due to intrafamilial sexual abuse often occurring over a longer period of time and involving a greater level of intrusion, with children also reporting higher levels of mistrust, insecurity and self-blame.[38] However, the impact of child sexual abuse on victims and survivors is influenced by a range of factors, including its duration, the age that the abuse started, and the relationship between the child and the person who abused them.[39]

2.18 Child sexual abuse is strongly associated with adverse physical and mental health outcomes, relationship difficulties, socio-economic impacts and further victimisation.[40]

2.19 The impact of abuse by someone in their family environment on a child's sense of powerlessness, betrayal and confusion can make the abuse particularly damaging.[41]

37 Gekoski, A, Davidson, JC and Horvath, MAH (2016) 'The prevalence, nature, and impact of intrafamilial child sexual abuse: Findings from a rapid evidence assessment' Journal of Criminological Research, Policy and Practice, volume 2(4), pages 231-243.

38 Perdahli Fis N, Arman, A, Sakaya S and Berkem, M (2010) 'Psychiatric evaluation of sexual abuse cases: A clinical representative sample from Turkey' Children and Youth Services Review, volume 32(10), pages 1285-1290.

39 Scott, S (2023) 'Key messages from research on intra-familial child sexual abuse', CSA Centre.

40 Fisher, C, Goldsmith, A, Hurcombe, R and Soares, C (2017) 'The impacts of child sexual abuse: a rapid evidence assessment', Independent Inquiry into Child Sex Abuse; Vera-Gray, F (2023) 'Key messages from research on the impacts of child sexual abuse', CSA Centre.

41 Gekoski, and others (2016).

2.20 Furthermore, the harm of intrafamilial sexual abuse tends to be compounded when the sexual abuse is combined with other adversities or multiple forms of maltreatment, where it involves multiple abusers or organised networks, or when experiences of interpersonal violence and abuse are cumulative across the life course.[42] [43] [44]

2.21 Given the challenges involved for agencies in identifying and responding to child sexual abuse of all forms, it is therefore not surprising that the economic cost to the NHS alone as a result of delayed reporting and responses was estimated at over £3 billion in 2012.[45]

2.22 More widely it has been estimated that, across England and Wales, the economic and social cost of contact child sexual abuse in the year ending 31 March 2019 (for all victims who began to experience sexual abuse or continued to experience sexual abuse in that period), was at least £10.1 billion.[46]

2.23 However, calculating the economic cost of child sexual abuse is fraught with uncertainty and limitations. This is because so much child sexual abuse is unknown, or at least remains unrecorded in official data sets. But we do know that most of these costs fall to victims of child sexual abuse, mainly in lost productivity across the life course, with additional costs to health, criminal and welfare agencies.[47]

2.24 Finally, there is a large body of evidence including academic research, programme evaluation, learning from SCRs, LCSPRs and statutory guidance highlighting the importance of swift and appropriate agency responses to child sexual abuse in minimising further harm and distress to children as victims and survivors.[48]

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42 Finkelhor, D, Ormrod, RK., and Turner, HA (2007) 'Poly-victimization and trauma in a national longitudinal cohort' Development and Psychopathology, volume 19(1), pages 149-166; Finkelhor, D, Ormrod, RK, and Turner, HA (2009) 'Lifetime assessment of polyvictimization in a national sample of children and youth' Child Abuse and Neglect, volume 33, pages 403-411.

43 Scott, S (2001) 'The politics and experience of ritual abuse' Open University Press; Pacheco, ELM, Buanaventura, AE, Miles, GM (2022) '"She was willing to send me there": Intrafamilial child sexual abuse, exploitation and trafficking of boys' Child Abuse and Neglect, 2023 Aug, volume 142 (Part 2).

44 Salter, D, McMillan, D, Richards, M, Talbot, T, Hodges, J, Bentovim, A, Hastings, R, Stevenson, J and Skuse, D (2003) 'Development of sexually abusive behaviour in sexually victimised males: a longitudinal study', The Lancet, volume 361, pages 471-476.

45 Adisa, O, Hermolle, M and Ellis, F (2023) 'Denial, disbelief and delays', Survivors in Transition.

46 Radakin, F, Scholes, A, Soloman, K, Thomas-Lacroix, C and Davies, A (2021) 'The economic and social cost of contact child sexual abuse', Home Office.

47 Radakin and others (2021).

48 Scott, S (2023) 'Key messages from research on intra-familial child sexual abuse', CSA Centre; Smith, L (2017) 'Child sexual abuse and good practice for social workers', Outlines.

2.25 We also know that responding to child sexual abuse in a timely and effective manner can provide economic benefits. In one example, an analysis of the provision of a therapeutic service for children who had been sexually abused found for every £1 invested at least £4.17 was realised in social value.[49]

How agencies respond

The statutory safeguarding response to child abuse in England and Wales is enshrined within law, supported by agency-specific policies and guidance. However, it is not specific to child sexual abuse or intrafamilial child sexual abuse.

2.26 The Children Act 1989 sets out the specific duties of local authorities, partner agencies and organisations to safeguard and promote the welfare of children. The Children and Social Work Act 2017 and Children Act 2004 set out additional duties for statutory safeguarding partners – the police, integrated care boards and local authorities – to share information, responsibility and decision making, placing the welfare of the child as the paramount consideration in all decisions as outlined in the most recent statutory guidance, 'Working Together to Safeguard Children' (2023).[50]

2.27 'Keeping Children Safe in Education' sets out guidance for schools and colleges in England to fulfil their duties to safeguard and promote the welfare of children.[51] Additional non-statutory guidance offers advice on the legal framework and how it supports information sharing for the purposes of safeguarding children from abuse and neglect.[52]

2.28 In addition, HM Inspectorate of Probation has developed a 'Collective Safeguarding Responsibility Model', which is seeking to shift the culture from safeguarding being 'everyone's responsibility' to an accountable 'collective responsibility' and which specifies the need for agencies to work in partnership with families.[53]

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49 Edwards, J (2018) '"A light in the dark" Impact evaluation and social return on investment analysis of the green house therapeutic service for children and young people who have experienced sexual abuse', The Foundation for Social Improvement.

50 Department for Education (2023) 'Working Together to Safeguard Children: A guide to multi-agency working to help, protect and promote the welfare of children'.

51 Department for Education (2023) 'Keeping children safe in education: Statutory guidance for schools and colleges'.

52 Department for Education (2024) 'Information sharing advice for practitioners providing safeguarding services for children, young people, parents and carers'.

53 Ball, E and McManus, M (2024) 'Collective Safeguarding Responsibility Model' HM Inspectorate of Probation.

2.29 In relation to health services, National Institute for Health and Care Excellence guidelines include recommendations that health practitioners must follow the guidance in 'Working Together' (2023) for managing individual cases.[54] This includes providing early emotional support, assessing physical health needs and supporting children in order to reduce the risk of future abuse, for example sexual exploitation. The recommendations also highlight the importance of age-appropriate therapeutic interventions for children who have been sexually abused.

There is a lack of official data that provides sufficient information about statutory agencies' response to child sexual abuse.[55]

2.30 However, we do know that there was a significant drop in 2022/23 in the number of children placed on child protection plans under the category of child sexual abuse in England, continuing a long-term downward trend.[56]

2.31 In fact, the number of child protection plans under the primary category of sexual abuse fell to its lowest level in 14 years and in 2022/23 child sexual abuse was the reason for just 3.6% of all child protection plans, the lowest proportion ever recorded. The 2,290 children placed on child protection plans under the primary category of sexual abuse equated to only 5% of the children across England whose initial assessments recorded sexual abuse or sexual exploitation as concerns in 2022/23.

2.32 Meanwhile, in 2022, police recorded 107,000 child sexual abuse offences.[57] Of these, 29% – including one-third of all contact child sexual abuse offences – were intrafamilial. The report notes that police-recorded crime data is likely to under-estimate the relative scale of intrafamilial child sexual abuse and "reflects the general under-reporting of child sexual abuse in the family environment to the police" (page 19). Parents and siblings accounted for the highest numbers of people recorded in police data as those who had abused children.

54 National Institute for Health and Care Excellence (2017) 'Child abuse and neglect (NG76)'.

55 Karsna, K and Bromley, P (2024) 'Child sexual abuse in 2022/23: Trends in official data', CSA Centre.

56 Karsna, K and Bromley, P (2024) 'Child sexual abuse in 2022/23: Trends in official data', CSA Centre.

57 Neighbours and family friends are included in the definition of intrafamilial in this report: Vulnerability Knowledge and Practice Programme (2024) 'National analysis of police recorded child sexual abuse and exploitation (CSAE) Crimes Report: January 2022 to December 2022'.

2.33 Numbers of police recorded child sexual abuse offences have increased further in the latest reports as has the number of people prosecuted for child sexual abuse offences.[58]

2.34 Nonetheless, this increase has coincided with a decline in the proportion of child sexual abuse investigations ending with a charge. In 2022/23, 89% of cases involving child sexual abuse ended without a charge or summons.[59]

2.35 Criminal justice timescales are also significant. In 2022/23, the average time taken between recording a sexual offence and the investigation reaching an outcome was an average of 72 days, with rape offences taking 104 days.

2.36 Investigations resulting in a charge or summons take far longer to conclude – sexual offences take on average 271 days to complete. Once charged, the average time to completion in the Crown Court was 170 days for child sexual abuse image offences, but 331 days for other child sexual abuse offences.[60]

Previous reviews have already highlighted a range of concerns regarding statutory responses to child sexual abuse within the family environment.

2.37 In 2015, the Children's Commissioner's report, 'Protecting children from harm', highlighted a range of concerns, including criminal justice and child protection systems being heavily reliant on children telling.[61]

2.38 In 2020, a joint targeted area inspection (JTAI) looking into the multi-agency response to child sexual abuse in the family environment also revealed a lack of priority given to intrafamilial sexual abuse compared to other forms of harm, such as child sexual exploitation and child criminal exploitation.[62]

2.39 The inspection found responses were often heavily police-led and insufficiently child-focused, and that the quality of criminal investigations of child sexual abuse in the family environment was sometimes poor, with complex cases managed by less experienced officers and with considerable delays that left children at risk of further abuse. Furthermore, when police investigations ended with no further action, other practitioners 'retreated' and the child was left without support.

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58 Karsna, K and Bromley, P (2024) 'Child sexual abuse in 2022/23: Trends in official data', CSA Centre.

59 Karsna, K and Bromley, P (2024) 'Child sexual abuse in 2022/23: Trends in official data', CSA Centre.

60 Karsna, K and Bromley, P (2024) 'Child sexual abuse in 2022/23: Trends in official data', CSA Centre.

61 Children's Commissioner (2015) 'Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action'.

62 Children's Commissioner (2015); Ofsted, CQC, HMICFRS and HMIP (2020) 'The multi-agency response to child sexual abuse in the family environment: Joint targeted area inspections (JTAIs)'.

2.40 While both the JTAI and the Children's Commissioner's report noted considerable cross-agency commitment to tackle systemic issues, they also found many practitioners had received inadequate training on child sexual abuse, and on intrafamilial abuse specifically, leaving them lacking in confidence in responding to concerns of child sexual abuse within the family environment.

2.41 In particular, practitioners were hesitant to seek clarifying information and were worried about 'leading' the child in a way that might compromise future criminal justice responses.[63]

2.42 While the Independent Inquiry into Child Sexual Abuse did not have intrafamilial abuse within its remit, despite voices urging that it should be included, nearly half of the over 6,000 people who gave evidence to its Truth Project were victims and survivors of abuse within the family environment. The Truth Project's final research report, 'I will be heard', summarised participants' suggestions for change. Most commonly, these focused on increasing awareness of child sexual abuse, and on the need for strategies to prevent it, identify it quickly and respond effectively to it. Many recommended more and better training for professionals. 'Not having anyone to disclose to' was the most common reason given for not having reported abuse. Victims and survivors wanted to see wider societal awareness of child sexual abuse, and highlighted the importance of children being believed. The Inquiry's final report made more focused recommendations, and government continues to consider how it will act on them.[64]

2.43 Numerous studies, including the Independent Inquiry into Child Sexual Abuse's own report into child sexual abuse in Black and other minoritised communities, have also highlighted poor statutory practice in response to the intrafamilial child sexual abuse of Black and other minoritised children. Concerns have been raised about social workers' deficit-based approaches to safeguarding and to interactions with parents and the reliance on intermediaries or translators and interpreters linked to the community.[65]

63 Ofsted, CQC, HMICFRS and HMIP (2020) 'The multi-agency response to child sexual abuse in the family environment: Joint targeted area inspections (JTAIs)'.

64 Truth Project (2023) 'I will be heard': Victims and survivors' experiences of child sexual abuse in institutional contexts in England and Wales', Independent Inquiry into Child Sexual Abuse.

65 Gill, A and Begum H (eds.) (2023), 'Child sexual abuse in black and minoritised communities: Improving legal, policy and practical responses'.

Responding to children

A large body of research, including national reviews of evidence such as for the Independent Inquiry into Child Sexual Abuse, highlights an enduring tendency to disbelieve reports of child sexual abuse and the profound effect this has on both the multi-agency response to children and, crucially, the likelihood that a child will tell someone what has happened to them.[66]

2.44 There is also evidence to suggest that practitioners' fears around acting on concerns of intrafamilial child sexual abuse can be linked to the impact of the Cleveland Inquiry (1988) which has left a continuing, dominating and false belief that the children at the centre of the Inquiry were not sexually abused, and that the crisis was the result of over-zealous and incompetent practice.

In 1987, over the course of a few months, 121 children were removed from their families in Cleveland because of concerns of sexual abuse highlighted through medical examinations and wider assessment. A public outcry followed, involving local politicians, local and national media, parents, and practitioners from different agencies with safeguarding responsibilities, who could not accept that so many children had been sexually abused. The result was local and national hysteria and panic that over-zealous practitioners were wrongly identifying child sexual abuse. Then the professional judgement of those working with the children was challenged. An Inquiry was commissioned by the government and a report was published in 1988. The Inquiry made no assessment of whether or not the children were sexually abused, though clearly this would have been helpful. Evidence has subsequently been uncovered through documents now released in the National Archive that indicate most of the children were sexually abused, and that the diagnoses by medical professionals were correct.[67]

2.45 The Cleveland scandal had a huge impact on public attitudes towards child sexual abuse and led to calls at the time to address social workers' 'misuse' of their powers, founded on a perception that practitioners were intervening inappropriately in families' private lives.

66 Lovett, J, Coy, M and Kelly, L (2018) 'Deflection, denial and disbelief: Social and political discourses about child sexual abuse and their influence on institutional responses: A rapid evidence assessment', London Metropolitan University; Jay, A, Evans, M, Frank, I and Sharpling, D (2023) 'The Report of the Independent Inquiry into Child Sexual Abuse'.

67 See Campbell, B (2024) 'Secrets and Silence: Uncovering the Legacy of the Cleveland Child Sexual Abuse Case', Bristol University Press.

2.46 Despite research evidence indicating that children rarely make false allegations, that they are not easily 'led' by practitioners, and that sexual abuse by a family member is considerably more common than is often believed, practitioners, including most influentially the judiciary in family courts, are urged to beware the 'lessons' of Cleveland.[68] [69]

2.47 As a result, a culture of blame and fear has developed where practitioners, often under pressure to act speedily, are reluctant to make decisions that expose them to criticism and challenge.[70]

2.48 At the same time, children face significant barriers in getting help, due to the fear of not being believed or of not being taken seriously by practitioners or other family members, along with fear of the consequences of telling.[71] We also know from research that children are much more likely to show us in their behaviour rather than tell us in words what is going on for them.[72]

2.49 In addition, when some children subsequently retract what they have said, practitioners often assume that the retraction means the initial report was unfounded, without taking account of the variety of reasons why a report might be withdrawn.[73] Indeed, research suggests that a retraction does not often receive the same careful attention as the investigation of the original report and, inevitably, leaves children at greater risk of further harm.[74]

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68 See Jay, A, Evans, M, Frank, I and Sharpling, D (2023), 'Recommendations for change, section C6'.

69 Cromer, L and Goldsmith, R (2010) 'Child sexual abuse myths: attitudes, beliefs, and individual differences', Journal of Child Sexual Abuse, volume 19(6), pages 618-47; Oates, R K, Jones, D P, Denson, D, Sirotnak, A, Gary, N, and Krugman, RD (2000) 'Erroneous concerns about child sexual abuse', Child Abuse and Neglect, volume 24, pages 149-57.

70 Leigh, J (2017) 'Blame, Culture and Child Protection', Springer Link.

71 Allnock, D, Miller, P and Baker, H (2019) 'Key messages from research on identifying and responding to disclosures of child sexual abuse', CSA Centre.

72 Allnock, D and Miller, P (2013) 'No one noticed, no one heard: A study of disclosures of childhood abuse', National Society for the Prevention of Cruelty to Children.

73 Petherick, W (2020) 'Recantations and retractions in child sexual abuse', In Bryce, I and Petherick, W (eds.), 'Child Sexual Abuse: Forensic Issues in Evidence, Impact, and Management', pages 435-443.

74 Tully, B (2002) 'The evaluation of retractions in child sexual abuse cases', Child Abuse Review, volume 11(2), pages 94-102.

The impact of the Cleveland Inquiry on the response to intrafamilial child sexual abuse has been further compounded by a shift in focus towards specific forms of harm outside the home, notably child sexual exploitation and, most recently child criminal exploitation.

2.50 In 2014, the report from Professor Alexis Jay's Independent Inquiry into Child Sexual Exploitation in Rotherham was published.[75] Covering the period 1997 to 2009, the report found shocking evidence of sexual exploitation of at least 1,400 children. The public and media reactions to this had a profound impact on the professional response to child sexual abuse, with a shift in both national and local focus towards child sexual exploitation and, more recently, an increasing concern and focus on children at risk of criminal exploitation.[76] There was an undoubted need to focus on these forms of extrafamilial harm but this may have, albeit unintentionally, exacerbated reluctance to identify and respond to sexual abuse within the family environment. It is important to note too that evidence indicates that many children who have been sexually exploited were previously sexually abused within their families (see chapter 4).

Supporting parents and carers

We also know from research that the support a child receives from their main caregivers and wider family will have a significant influence on how they understand and respond to what has happened to them. However, parents themselves need support as they often experience high levels of distress and increased isolation following discovery of their child's abuse.

2.51 Parents can play a key role in mitigating the impact of the sexual abuse on their child, as good support from parents is linked to better long-term outcomes for children.[77] One study defined 8 elements that were key to the support sexually abused children need from their parents: meeting their basic needs ("I can provide for our family"), safety and protection ("I will not let harm come to you"), decision-making ("I will make a wise decision"), active parenting ("I can take care of you and me"), instrumental support ("I can find the help you need"), availability ("I am here for you"), sensitivity to child ("I understand you"), and, affirmation ("you are a wonderful child").[78]

75 Jay, A (2014) 'Independent Inquiry into Child Sexual Exploitation in Rotherham 1997-2013'.

76 Jay, A (2024) 'Shattered lives, stolen futures', Action for Children.

77 Scott, S (2023) 'Key messages from research on intra-familial child sexual abuse', CSA Centre.

78 Bolen, R, Dessel, A and Sutter, J (2015) 'Parents will be parents: Conceptualizing and measuring nonoffending parent and other caregiver support following disclosure of sexual abuse', Journal of Aggression, Maltreatment & Trauma, volume 24(1), pages 41-67.

2.52 Supporting family members, particularly parents, so that they better understand and respond to children, has been shown to help reduce feelings of guilt and increase feelings of confidence in children to talk about what had happened to them.[79]

2.53 Parents also play a vital role in protecting children from harm when the person suspected of abusing them remains in contact with them.[80] Once abuse is recognised, they are usually the best protectors of their children.[81]

2.54 However, parents are also likely to be experiencing significant trauma and shock following the discovery of harm to their child and may face additional challenges in effectively protecting their child, due to factors such as coercive control or domestic abuse, poor mental health, learning disabilities or substance use.[82]

2.55 Parents can feel judged by practitioners, often perceiving that they are being held responsible for not protecting their child.[83]

2.56 Support for parents from practitioners who are supportive, empathetic and knowledgeable about intrafamilial child sexual abuse is therefore highly valued.[84] Yet statutory services tend to focus wholly on the need for parents to safeguard their children without recognising the professional support that they will often require to do so.[85]

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79 Warrington, C, Beckett, H, Ackerley, E, Walker, M and Allnock, D (2017) 'Making noise: Children's voices for positive change after sexual abuse'.

80 Duff, S, Wakefield, N, Croft, A, Perry, L, Valavanis, S and Wright, L (2017), 'A service for non-offending partners of male sexual offenders', The Journal of Forensic Practice, volume 19(4), pages 288-295.

81 Bacon, H (2008) 'Cleveland 20 years on: What have we learned about intervening in child sexual abuse?', Child Abuse Review, volume 17(4), pages 215-229.

82 Assink, M, van der Put, CE, Meeuwsen, MWCM, de Jong, NM, Oort FJ, Stams, GJJM and Hoeve, M (2019) 'Risk factors for child sexual abuse victimisation: A meta-analytic review', Psychological Bulletin, volume 145(5), pages 459-489; Pusch, AS, Ross, T and Fontao, IM (2021) 'The environment of intrafamilial offenders – A systematic review of dynamics in incestuous families', Sexual Offending: Theory, Research, and Prevention, volume 16, pages 1-20.

83 Stitt, S (2007) 'Non-offending mothers of sexually abused children: The hidden victims', The ITB Journal, volume 81, Article 3.

84 Scott, S (2023) 'Key messages from research on intra-familial child sexual abuse', CSA Centre.

85 Wager, NM, Wager, AR and Wilson, C (2015) 'Circles South East's programme for non-offending partners of child sex offenders: A preliminary outcome evaluation', Probation Journal, volume 62(4), pages 357-373.

Responding to people who sexually abuse children

Understanding what leads someone to sexually abuse a child in their family is also important in considering the response to intrafamilial child sexual abuse. Although existing research does not focus specifically on those who sexually abuse children in the family environment, there are several factors relevant to the risk of abuse and offending in this context.

2.57 We know there are multiple pathways and risk factors related to sexual offending. Developing an understanding of a person's early life experiences, possible motivations for offending and facilitating risk factors will help to formulate an assessment of risk. [86]

2.58 While some sexual offending is motivated by sexual interest, not everyone who sexually abuses a child does so because they have a sexual interest in children. Furthermore, having a sexual interest in children does not necessarily mean the person will sexually abuse a child.[87]

2.59 Those who have sexually abused a child are more likely than other adults to have experienced multiple forms of abuse including physical abuse, neglect, domestic abuse and, in some cases, sexual abuse.[88]

2.60 Understanding the factors that have contributed to the offence, and how these are relevant for each person of concern, will help to develop an understanding of how they can be effectively managed. Such risk factors include emotional and sexual self-regulation problems, anti-social cognition, stress factors (such as relationship difficulties or financial problems), and situational elements (for example, the absence of a protective parent/guardian), as well as access to children.[89] [90]

86 Brown, S (2020) 'Key messages from research on child sexual abuse perpetrated by adults', CSA Centre.

87 Brown, S (2020) 'Key messages from research on child sexual abuse perpetrated by adults', CSA Centre.

88 Leach, C, Stewart, A and Smallbone, S (2016) 'Testing the sexually abused-sexual abuser hypothesis: A prospective longitudinal birth cohort study', Child Abuse & Neglect, volume 51(1), pages:144-153; Levenson, J and Grady, M (2016) 'The influence of childhood trauma on sexual violence and sexual deviance in adulthood', Traumatology, volume 22(2), pages 94-103; Levenson, J and Socia, K (2016) 'Adverse childhood experiences and arrest patterns in a sample of sexual offenders', Journal of Interpersonal Violence, volume 31(10), pages 1883-1911.

89 Antisocial cognition refers to attitudes, beliefs, and thoughts that support crime.

90 Seto, M, Augustyn, C, Roche, KM and Hilkes, G (2023) 'Empirically-based dynamic risk and protective factors for sexual offending', Clinical Psychology Review, Volume 108, March 2024.

2.61 The pathways that lead to sibling abuse are different to adult pathways to offending. These need to be understood as specific to children and young people and should not be conflated with our understanding of adults.[91] The majority of children and young people displaying harmful sexual behaviour, which includes sibling sexual abuse, do not go on to commit sexual offences as adults.[92]

2.62 Viewing harmful sexual behaviour through the lens of trauma is important, to identify vulnerabilities and areas of unmet need.[93] There is therefore general support for the use of holistic assessment tools which, alongside looking at specific risks of the young person's behaviour (including online), also consider the specific risks of the child or young person's behaviour (including online) and motivations, and their needs and strengths at individual, family and community levels.[94]

2.63 We also know that not all people with sexual convictions are equally likely to re-offend. Some people will present a higher risk of re-offending than others. Although recidivism data suggests most people do not go on to re-offend, some caution is needed as re-offending rates are based only on official criminal justice data and child sexual abuse is far more prevalent than official records indicate. Assessment of sexual risk within the family environment should include consideration of previous allegations or concerns of a sexual nature and other related intelligence, investigations and arrests.[95]

91 Yates, P and Allardyce, S (2021) 'Sibling sexual abuse: A knowledge and practice overview', CSA Centre.

92 Yates, P and Allardyce, S (2021) 'Sibling sexual abuse: A knowledge and practice overview', CSA Centre.

93 McNeish, D and Scott, S (2023) 'Key messages from research on children and young people who display harmful sexual behaviour', CSA Centre.

94 McNeish, D and Scott, S (2023) 'Key messages from research on children and young people who display harmful sexual behaviour', CSA Centre.

95 Hanson, RK, Harris, AJR, Letourneau, E, Helmus, LM and Thornton, D (2018) 'Reductions in risk based on time offense-free in the community: Once a sexual offender, not always a sexual offender', Psychology, Public Policy, and Law, volume 24(1), pages 48-63.

2.64 Evidence indicates that to provide the most effective treatment programmes for people convicted of a sexual offence, it is necessary to pay attention to several key programme, individual and study design variables.[96] These include: the context in which the treatment programme is delivered, the effectiveness of staff delivering the programme, and that interventions match the person's level of risk, target factors related to their pattern of offending and are delivered in a way that meets their individual needs.[97] [98]

2.65 Challenges for people accessing these programmes in the community were noted in the 2019 Inspection of the management and supervision of men convicted of sexual offences.[99] This showed that the programmes did not fully address the needs of people taking part and there was a lack of alternative one-to-one provision to help reduce the risk of re-offending of those who did not take part in the group programmes.

2.66 Some researchers have highlighted the need to consider that there is always some risk of sexual re-offending:

> **"The risk cannot be null given that offenders have committed at least one sexual offense in the past and past behaviours are the best predictor of future behaviours."**[100]

96 Tyler, N, Gannon, TA and Olver, ME (2021) 'Does treatment for sexual offending work?' Current Psychiatry Reports, volume 23, article 51.

97 Gannon, TA, Olver, ME, Mallion, JS and James, M (2019) 'Does specialized psychological treatment for offending reduce recidivism? A meta-analysis examining staff and program variables as predictors of treatment effectiveness', Clinical Psychology Review, Volume 73, 101752.

98 Ministry of Justice and HM Prison and Probation Service (2022) 'Offending behaviour programmes and interventions currently available for offenders in England and Wales'.

99 HM Inspectorate of Probation (2019) 'Management and supervision of men convicted of sexual offences'.

100 Lussier, P, Chouinard Thivierge, S, Fréchette, J, and Proulx, J (2023) 'Sex Offender Recidivism: Some Lessons Learned from Over 70 Years of Research', Criminal Justice Review, 0(0).

Multi-Agency Public Protection Arrangements (MAPPA) is a multi-agency approach that manages people convicted of violent and sexual offences. Legislated by the Criminal Justice Act 2003, responsible authorities include police, prisons, and probation. Other agencies that have a duty to co-operate include housing, education and health services.

2.67 Most Category 1 MAPPA offenders are case managed by the police as a single agency lead and by specialist police offender managers.[101] [102]

2.68 For those managed by probation, people with sexual convictions are required to adhere to conditions and undertake court ordered requirements as outlined in the Criminal Justice Act 2003. Some of these include the following: polygraph testing, Global Positioning System (GPS) tracking and electronic monitoring, and offender behaviour programmes. They may also have notification requirements to the Police.

2.69 In addition to requirements noted above, the police have a range of civil orders at their disposal including Sexual Harm Prevention Orders which restrict the behaviour of a person convicted of a sexual offence (such as their access to the internet). In addition, Sexual Risk Orders can be issued to any individual who has not been convicted of a sexual offence but who is thought to pose a risk of sexual harm.[103]

2.70 Finally, the Child Sexual Offender Disclosure Scheme allows the police to protect potential victims under the 'right to know' and gives the general public the 'right to ask' for information about a person they have concerns about.[104]

101 Category 1 MAPPA offenders are sexual offenders subject to notification requirements (often called registered sex offenders).

102 College of Policing (2017) 'Managing sexual offenders and violent offenders'.

103 A Sexual Risk Order is a civil order that allow authorities to apply for a set of restrictions on individuals without them being convicted of a crime.

104 Anyone can apply to the Child Sex Offender Disclosure Scheme, also known as Sarah's Law, if they are concerned about someone's behaviour towards a child. This includes parents, carers, guardians, grandparents, neighbours, or friends.

In relation to the management of people with sexual convictions, a national review of MAPPA highlighted concerns around the management of all types of sexual offenders, including those who committed offences within the family environment.[105]

2.71 The review revealed challenges when young people who sexually offend transfer from the Youth Offending Service to probation. There was an under-resourcing of rehabilitation programmes, that risk management plans did not provide opportunities to support, and there was insufficient staff training.

2.72 An analysis of Serious Further Offence reviews was also undertaken as part of the MAPPA national review and highlighted poor identification of risk and risk assessments, outdated risk plans, poor information sharing and disclosure to third parties, lack of collaboration and understanding of multi-agency roles and a lack of professional curiosity.[106] Though this review also found that MAPPA is a well-respected process, that seems to have a positive effect on re-offending rates. This highlights the potential for the MAPPA process to be used more effectively in alignment with the child protection system.

2.73 Another recent review highlights the challenging landscape and resource constraints within the police service, such as the increased volume of registered sex offenders due to the proliferation of online abuse, increased social awareness, new offences and changes to sentencing.[107] The review calls for police and partners to provide more effective and efficient public protection for all sexual abuse including child sexual abuse within the family environment.

105 Lundrigan, S and Mann, N (2023) 'Research briefing: The national MAPPA research', The Policing Institute for the Eastern Region, Anglia Ruskin University.

106 HM Inspectorate of Probation (2023) 'Independent Serious Further Offence review of Jordan McSweeney'.

107 Creedon, M (2022) 'Independent review into the police-led management of registered sex offenders in the community: Executive Summary'.

2.74 Not only have sexual offence convictions continued to grow over the last decade,[108] but the average sentence length received has also increased, placing greater demand on criminal justice systems and services to effectively manage this population.[109] This increase places significant pressure on prisons, which face a crisis regarding capacity, and on a Probation Service that has faced several organisational reforms in recent years, resulting in both organisations now facing a staffing crisis.[110] [111]

108 Office for National Statistics (2023) 'Sexual offences in England and Wales overview: year ending March 2022'.

109 Ministry of Justice (2020) 'Serious violent and sexual offenders to spend longer in prison'.

110 Mahmood, S (2024) 'New Lord Chancellor sets out measures to avert prison capacity crisis'.

111 HM Inspectorate of Probation (2021) 'Probation reforms broadly on track but some concerns persist around staffing and services'.

3. Methods

This chapter describes how the review was carried out, summarising the various data collection activities involved as well as the strengths and limitations of the approach we have used.

Our team of reviewers

3.1 The work for this review was undertaken by the Centre of expertise on child sexual abuse (the CSA Centre). The CSA Centre's core focus is on driving evidence-informed practice improvement across agencies working with children and families. Their team includes experienced practice improvement advisers from a range of agency backgrounds, researchers and policy professionals, ensuring a strong understanding of what is needed to drive improvements in practice.

3.2 The review process provided an opportunity for the CSA Centre to build on this foundation of expertise by engaging with stakeholders at both local and national levels to identify strategic levers for change in policy and practice affecting the identification of and response to intrafamilial child sexual abuse.

Research and engagement

3.3 The research involved a number of inter-related strands of work which were carried out concurrently.

- A review of relevant research and practice guidance, summarising what is known about intrafamilial child sexual abuse and the response to it.
- Analysis of 136 rapid reviews, 40 related serious case reviews (SCRs) or local child safeguarding practice reviews (LCSPRs), and one local thematic review relating to intrafamilial child sexual abuse received by the Panel between June 2018 and November 2023.[112]

112 Rapid reviews, SCRs and LCSPRs are processes used to review serious child safeguarding incidents and identify ways to improve the safety of children. The purpose of the rapid review is to identify and act on immediate learning and consider if there is additional learning which could be identified through a wider LCSPR (previously known as SCRs).

- 10 online reflective group discussions involving 107 practitioners and managers in 9 local safeguarding partnerships who had been involved in 10 of these reviews. These reviews were chosen to provide a broad geographical spread across the country as well as a range of factors (such as age, sex and ethnicity of victims and perpetrators, and relationships between victims and perpetrators). A list of the areas selected can be found in Appendix A.
- One-to-one interviews with 2 children who had been sexually abused by someone in their family environment.
- One-to-one interviews with 5 people who had sexually abused a child to explore the experiences and perspectives of this group of people.
- A series of roundtable discussions involving experts by experience and senior leaders from a range of agencies including policing, probation, universal health and specialist health services.

Ethical review

3.4 Given the highly sensitive nature of the work, the CSA Centre applied for and was granted ethical approval from its Research Ethics Committee and from the Department for Education's Research Ethics Committee. In addition, they sought and were granted ethical approval for the interviews with people who had harmed from the Ministry of Justice's National Research Committee.

Strengths and limitations

3.5 The 136 local reviews studied as part of this national review were only notified to the Panel because they had met the criteria for triggering a rapid review. However, there is considerable variation in how local safeguarding children partnerships (LSCPs) interpret the criteria for serious harm and in the frequency with which different local areas notify the Panel of incidents.[113] In addition, reviews focusing on intrafamilial child sexual abuse represent only a small proportion of the reviews received by the Panel since 2018 when reporting became mandatory. It made up 15.7% of the incidents reported to Panel from April 2022 to March 2023.[114]

113 The independent Child Safeguarding Practice Review Panel (2021) 'Annual Report 2020: Patterns in practice, key messages and 2021 work programme'.

114 The independent Child Safeguarding Practice Review Panel (2024) 'Annual Report 2022/23: Patterns in practice, key messages and 2023/24 work programme'.

3.6 It is therefore important not to generalise from the findings in this report, particularly in terms of demographic factors, as the patterns seen here do not necessarily reflect wider prevalence and may instead reflect the factors that led to these situations being taken to rapid review, which are many and complex. In addition, within the children described in the reviews there have been limitations on the extent to which we can disaggregate experiences, related to specific ethnic minoritised groups or disability. Furthermore, as we know, far more children are sexually abused than services identify.[115]

3.7 It is also likely that intrafamilial child sexual abuse was present in other reviews received by the Panel in this period but that these reviews were not selected because intrafamilial child sexual abuse had not been highlighted as a significant issue.

3.8 The local reviews we looked at as part of this study had to have reached a sufficient threshold of concern about harm to trigger a formal review.[116] But it is notable that many of the issues identified have been highlighted in national studies and inspections over a number of years, as well as surfacing in our reflective discussions.[117] We do not therefore consider that these reviews present an atypical picture of current issues in practice. Nonetheless, we fully recognise that this is a complex area of work and there will also be many examples of effective multi-agency working in response to intrafamilial child sexual abuse.

3.9 This review has also enabled us to speak directly to children who have been sexually abused by someone in their family and to people who have sexually abused a child in their family. We had also hoped to interview parents and carers of children but were not successful in doing so. One parent, who was not willing to be interviewed, offered to send a written statement instead but this was not forthcoming.

115 Karsna, K and Kelly, L (2021) 'The scale and nature of child sexual abuse: Review of evidence', CSA Centre.

116 A serious incident notification is triggered when a child dies or is seriously harmed, and abuse or neglect is known or suspected. See www.gov.uk/guidance/report-a-serious-child-safeguarding-incident

117 Children's Commissioner (2015) 'Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action'; Ofsted, CQC, HMICFRS and HMIP (2020) 'The multi-agency response to child sexual abuse in the family environment: Joint targeted area inspections (JTAIs)'.

3.10 Furthermore, while the researchers had hoped to carry out a larger number of interviews, the number they could approach was limited by the fact that many of the reviews were subject to either criminal or care proceedings, that children were too young, or that practitioners were concerned that being interviewed might cause children further distress. However, although the interviews proved challenging to arrange, the researchers felt it was important to explore the potential insights that speaking directly both to children who had been sexually abused and those who had abused children might bring in understanding what practitioners could be doing differently when identifying and responding to the sexual abuse of children by someone in their family environment.

3.11 Our fieldwork provided a rich base of evidence that has allowed us to explore the factors involved in this form of abuse, understand the challenges that practitioners face in identifying and responding to it, and develop recommendations that will transform how children are protected and supported from sexual abuse by someone in their family environment.

The report cites examples from LCSPRs where these have been published. In these reviews, children's names were changed to prevent children from being identified. Where LSCPs were concerned that a child might be identified, the review was not published and so has not been directly cited in this report.

4. The children at the heart of the reviews

This chapter describes the children at the heart of the 136 local reviews which were selected from those received by the Panel between June 2018 and November 2023 where there had been concerns of intrafamilial child sexual abuse.

Overview of children's circumstances

We analysed 136 local reviews, and 32 related local child safeguarding practice reviews (LCSPRs) and 9 serious case reviews (SCRs).[118]

4.1 Nearly three-quarters (100, 74%) of the 136 reviews focused on a single child but 36 reviews (26%) described sexual abuse of multiple children. Thirty-four reviews (25%) featured abuse by more than one person. Our analysis therefore took in a total of 193 children who had been sexually abused and 167 people who had sexually abused children.

4.2 As Table 1: Geographical region of referring LSCP shows, nearly a quarter of these reviews were sent in by local safeguarding children partnerships (LSCPs) in the North West of England. This distribution largely reflects the overall pattern of notifications made to the Panel in the latest published data for the period covered by this review. The Panel's annual report for 2022 to 2023 shows that the North West region had the highest rate of submissions of serious incident notifications with 6 notifications per 100,000 child population (CSPRP, 2024).[119] Further work is being undertaken by the Panel to understand factors behind this geographical variation.

118 At the time of writing this report, 41 SCRs or LCSPRs had been completed in relation to the 136 rapid reviews which were available for analysis and had sufficient focus on intrafamilial child sexual abuse.

119 The independent Child Safeguarding Practice Review Panel (2024) 'Annual Report 2022/23: Patterns in practice, key messages and 2023/24 work programme'.

Table 1: Geographical region of referring LSCP

Region	Reviewed (R) / Selected for fieldwork (F)
North West	32
London	20
West Midlands	18
Yorkshire and the Humber	8
North East	8
South West	16
South East	17
East Midlands	8
East of England	9
Total	136

The children who had been sexually abused

Sex

4.3 Information was available on the sex of all 193 children. 145 (75%) were girls and 48 (25%) were boys. Two children were reported as identifying as non-binary.

Ethnicity

Information was available on the ethnicity of 151 children (but missing for 42 children in 16 reviews). Nearly three-quarters of these children (100, 73%) were White British, while over a quarter (41, 27%) were from Black and other minoritised communities.

4.4 Seven children (5%) were from Black African/Caribbean/Black British ethnicities and another 7 (5%) were from mixed Black African/Caribbean/Black British and White ethnic groups.

4.5 Five children (3%) were from Indian/Pakistani/Bangladeshi/British Asian ethnicities and another 11 (7%) were from mixed Indian/Pakistani/Bangladeshi/British Asian and White ethnic groups.

4.6 Six children (4%) were from other White ethnicities, 2 were from other mixed ethnic groups, 1 was from a Gypsy/Irish Traveller ethnicity and 2 were from another ethnic group.

Age

Information on the age when children appeared to have first been sexually abused was available in 111 reviews (but missing for 35 children).

4.7 Thirty-two reviews – over a quarter (29%) of these reviews – featured a child under 6 years old, 51 – nearly half (46%) – featured a child aged between 6 and 12, while 28 – a quarter (25%) – featured a child aged between 13 and 17.

Additional vulnerabilities

Thirty-two reviews (29%) featured the abuse of a disabled child, although their disability was sometimes still in the process of being formally diagnosed.

4.8 This included 36 reviews where a child had a learning disability, 25 reviews where a child was autistic or with attention deficit hyperactivity disorder (ADHD) and 5 reviews where a child had a physical disability.[120]

How children had been abused

Children in over half of the reviews (56%) had been abused in more than one way and, in over a third of reviews (40%), over a period of multiple years.

4.9 In nearly half of the reviews (47%), children had also been subject to neglect. Nearly a third (32%) had experienced physical abuse, over a quarter (29%) had experienced domestic abuse and nearly a quarter (23%) had experienced emotional abuse. In nearly a fifth of reviews (17%), children had been abused in 3 or more different ways in addition to the sexual abuse.

4.10 Around three-quarters (73%) of the 127 reviews where this information was available featured a child being sexually abused by one person. A fifth (25 reviews) featured abuse by 2 people, and 9 reviews featured abuse by 3 or more people. 12 reviews (9%) featured multi-generational child sexual abuse.

120 We use the term 'autism' in place of autism spectrum disorder in line with Community-Preferred Terminology around Autism: Glossary & Rationale.

4.11 Where information was available on the type of abuse involved, 74 reviews (54%) featured rape or penetration, 26 reviews (19%) featured images of sexual abuse being taken and/or shared, and 14 reviews (10%) featured sexual abuse by a child sibling.

The person who abused the child

Our analysis took in a total of 177 people who had sexually abused children as 34 reviews (25%) featured abuse by more than one person. However, information on the person who had abused the child was not always available in the reviews.

4.12 In nearly half of the reviews where this information was available (66, 45%), the person abusing the child was their birth father (25%), stepfather (8%) or mother's boyfriend or partner (12%). Other reviews featured brothers, stepbrothers and half-brothers (18%), foster carers (9%), mothers (5%) and uncles (4%).

4.13 However, family links between the person who had abused and the children they abused were sometimes complex and also included a mother's partner's uncle, an aunt's partner, a foster carer's partner and, in other reviews, a foster carer's son.

4.14 In four-fifths of reviews (80%), the person who had abused the child was an adult, while 17 reviews (13%) featured abuse by someone aged under 18 and 9 reviews (7%) featured abuse by both an adult and someone aged under 18.[121]

4.15 In 14 reviews, the person who abused the child was a child sibling (including brothers, stepbrothers and half-brothers).

4.16 In the vast majority of reviews (132, 97%) the person who had abused the child was male. This included 9 reviews where a female adult had also abused the child. In just 4 reviews, the only person who had abused the child was female.

4.17 Information on the ethnicity of people who had sexually abused children was only available for 54 people (and missing for 113). Nearly three-quarters of these (74%) were White British. Seven were from Asian ethnicities, 2 were from Black ethnicities, 2 were from other White ethnicities and 3 were from other ethnic groups.

4.18 Although not systematically recorded or explored, many of the people featured in these reviews who had abused children were reported to have poor mental health, alcohol or substance misuse issues, and/or be victims and survivors of child sexual abuse.

121 Information on the age of the person who had abused the child was not available in 5 reviews.

Family situations

Complex family situations were noted in reviews for many, though not all, of these children.

4.19 Some families had long histories of specialist agency involvement, had a level of instability which saw them move across local authority boundary areas, or were living in overcrowded or poor housing. In some families, children had experienced trauma, such as the suicide or terminal illness of a parent.[122] However, this information was not systematically recorded so is likely to be under-reported, particularly in terms of families' socio-economic status.

4.20 In addition, 21 reviews (15%) featured children who were being electively home educated or who were out of education.[123] [124]

4.21 Parents also faced many challenges in their lives, particularly in terms of domestic abuse (recorded in 48% of reviews), poor mental health (39% of reviews), alcohol or substance misuse (26% of reviews), and being victims and survivors of child sexual abuse (15% of reviews). However, this information was not systematically recorded so is also likely to be under-reported.

4.22 There were 10 reviews where family courts had had a role before the serious incident was reported. There were 3 reviews where involvement from public law proceedings was described, 3 involving private law and 4 involving both types of proceedings. Cafcass were noted to have been involved in at least 7 reviews.

4.23 In addition, some children were abused in kinship arrangements, including a special guardianship order and a family assistance order.

122 Note that when referring to parents and carers, we have avoided terms such as 'non-abusing' and 'safe'. Instead, we refer simply to parents and carers, and make it clear when the parent or carer is the person who has sexually abused the child.

123 The latest Department for Education data estimates that there were 92,000 children electively home educated on a given day in 2022/23 and 9,073,781 children attended state schools in the same year. Department for Education (2024) 'Elective home education, 2022/23', and Department for Education (2024) 'Schools, pupils and their education, 2022/23'. This suggests that about 1.1% of children were electively home educated in that year. However, the data from the Department for Education excludes the number of children in private schools so it somewhat over-estimates the percentage of electively home educated children.

124 The Child Safeguarding Practice Review Panel have also published a briefing focused on 'Safeguarding children in Elective Home Education' (2024).

Reporting the abuse

In 98 (72%) of reviews, there was evidence that children had told someone about the abuse, sometimes on multiple occasions, although it was not always clear who they had told.

4.24 When this information was clear, it seemed that:

- 26 children had told a family member (often their mother, but sometimes a brother, father, grandparent, aunt or uncle)
- 12 had told a friend (either a peer or an adult family friend)
- 10 had told a residential worker or foster carer
- 9 had told a teacher or nursery worker
- 4 had told a health professional (such as hospital staff, or a therapist)
- 3 had told a social worker or student social worker

4.25 In addition, in over a third (40%) of reviews, another child or adult had reported the abuse of the child to someone.

The impact of the abuse

Some reviews highlighted the significant impact on children of sexual abuse by someone in their family environment.

4.26 Ten children in the reviews were known to have become pregnant and at least 6 had gone on to give birth as a result of the sexual abuse. This included reviews featuring an 11-year-old child who had given birth as well as a child who had been given an illegal abortion agent procured over the internet who had nearly died as a result.

4.27 In nearly half of the reviews, children were recorded as having mental health concerns, 6 of whom had been sectioned under the Mental Health Act 1983 or subject to deprivation of liberty orders.[125] In one review, a child was reported to have been so distressed that she had been kept in a hospital emergency department and needed 8 staff to look after her while a suitable residential placement was sought.

4.28 Tragically, 7 children in the reviews we looked at had died by suicide and a further 14 children had talked about or attempted suicide. One of these children was aged 7 when she talked about hanging herself.

4.29 Many children had self-harmed, developed an eating disorder, been diagnosed with depression or post-traumatic stress disorder, or were misusing substances or alcohol. One child described how she misused substances to numb the pain of what she had gone through.

4.30 Some of the children who had turned 18 by the time the serious incident was notified were recorded as showing extreme depression and self-harming.

4.31 The abuse was reported to have impacted children's education in nearly a third of reviews. This included children who were unable to attend school or engage in learning due to the emotional distress or physical harm resulting from the sexual abuse. There were also children who displayed distressed behaviours in school as a result of the abuse, which was not identified and sometimes resulted in them being excluded from school.

4.32 In nearly a fifth of reviews, children who had been abused by someone in their family environment had also been sexually exploited by someone outside their family.

125 A deprivation of liberty order is a procedure used to deprive children of their liberty for reasons of criminal justice (punishment), welfare (risks to their safety) or mental health. In these circumstances, children can be detained in secure children's homes, the youth custodial estate or mental health settings, provided statutory criteria are met.

Reflections

4.33 Although these reviews do not provide a representative sample of the circumstances and experiences of children who are sexually abused by someone in their family environment, some of their features reflect what is seen more widely. This is particularly so in terms of the child's sex (with around three-quarters being female), the perpetrator's sex (with the vast majority being male), and their connection to the perpetrator (with the largest proportion being a father, stepfather or mother's partner).

4.34 The reviews included children from a range of ages when they appeared to have first been sexually abused, with over a quarter featuring children under 6 years old. As official data suggests that around 4% of police reports of child sexual abuse feature children under 5 years old, the high proportion of reviews with children in this age group is likely to be a reflection of practitioners' increased levels of concern generated by the discovery of sexual abuse of very young children.[126]

4.35 On the other hand, while less than a fifth of reviews described images being taken or shared, we know from research that family members are often involved in producing images of child sexual abuse that are shared online.[127]

4.36 We saw a high proportion – over a quarter of reviews – featuring a disabled child. However, as is discussed later (see Chapter 5), it is important to be aware that the traumatic impact of the sexual abuse itself may be the cause of the disability or lead to diagnoses or assumptions of disability that may not take account of the child's traumatic and distressing experiences. The overlap between behaviours that suggest a possible diagnosis of autism or ADHD and those resulting from trauma linked to abuse has been noted in a systematic review by the Royal College of Paediatrics and Child Health.

> **"Many features described in neglected / emotionally abused children overlap with those found in children suffering from autistic spectrum disorder or attention deficit hyperactivity disorder."**[128]

126 Office for National Statistics (2023) 'Sexual offences prevalence and victim characteristics, England and Wales'.

127 Scott, S (2023) 'Key messages from research on intra-familial child sexual abuse', CSA Centre.

128 Royal College of Paediatrics and Child Health (2022) 'Child Protection Evidence Systematic Review on Early Years Neglect'.

4.37 While it is important to consider the professional response to children's needs in terms of their race, ethnicity, culture or disability, the extent to which the children may have had multiple and overlapping experiences of discrimination and marginalisation was not something that had been recognised in any of the reviews we considered.

4.38 Many children in these reviews had been subjected to multiple forms of abuse and had been sexually abused by more than one person within their family environment. We know from previous research that many sexually exploited children have previously experienced other forms of sexual abuse in their childhood, often in the family environment. In one study, sexually abused children were more than 5 times more likely to go on to be sexually exploited in teenage years than those who had not been sexually abused before.[129] Other, international studies, have reached similar conclusions.[130]

4.39 As we will discuss later in this report, other forms of abuse suffered by children often hindered the identification of and response to the sexual abuse as well as intensifying the impact on children.

4.40 A high proportion of parents were victims and survivors of domestic abuse. This is significant because the fear of violence and/or being subject to coercive control impacted parents' ability to protect children. We explore this further in Chapter 6.

4.41 Although it is widely suggested that children rarely tell anyone at the time that they are being sexually abused, it was striking that the majority of children had tried to tell someone what was happening to them, as reported in these reviews.[131]

129 Hallett, S, Verbruggen, J, Buckley, K, and Robinson, A (2019) 'Keeping safe? An analysis of the outcomes of work with sexually exploited young people in Wales', Cardiff University.

130 See Naramore, R, Bright, MA, Epps, N, and Hardt, NS (2017) 'Youth arrested for trading sex have the highest rates of childhood adversity: A statewide study of juvenile offenders', SexualAbuse, volume 29(4), pages 396-410; Widom, CS, Czaja, SJ, and Dutton, MA (2008) 'Childhood victimization and lifetime revictimization', Child Abuse & Neglect, volume 32(8), pages 785-796; Fortier MA, DiLillo D, Messman-Moore TL, Peugh J, DeNardi KA, Gaffey KJ (2009) 'Child sexual abuse and revictimization: The mediating role of coping and trauma symptoms', Psychology of Women Quarterly, volume 33, pages 308-320.

131 Allnock, D, Miller P and Baker H (2020) 'Key messages from research on identifying and responding to disclosures of child sexual abuse', CSA Centre.

4.42 This chapter has provided insight into the significant harm to children's emotional and physical health resulting from intrafamilial sexual abuse, with some children having taken their own lives and others having given birth to a baby conceived through the abuse. However, the symptoms and signs of child sexual abuse had often not been recognised until the incident that led to the local review of the child's situation.

Implications for practice

4.43 While many of the issues that have emerged here are discussed in more detail in subsequent chapters of this report, the number of very young children featured in these reviews highlights the importance of practitioners being able to identify signs and indicators of abuse in children of all ages, something which is particularly important for pre-verbal or non-verbal children.

4.44 Similarly, the likelihood that practitioners are not always exploring or recording whether concerns related to intrafamilial child sexual abuse also involve the creation and sharing of images online suggests a need for greater awareness of the risks of this taking place.

4.45 Equally, it is essential that practitioners are provided with training to enable them to understand the link between the impact of sexual abuse and the signs of distress that children then show in their behaviour or health.

4.46 It is important to apply an intersectional lens to consider the way in which inequalities linked to gender, disability, race and class are intertwined facets of some children's lives and can create a context of increased levels of risks for children.[132]

132 Barnard, C (2021) 'Using an intersectional lens to examine the child sexual exploitation of black adolescents' in Pearce, J (ed.) 'Child sexual exploitation: Why theory matters' Bristol University Press.

Key findings

5. Hearing children's voices and understanding their needs

A number of themes emerged from our analysis of local reviews and fieldwork in relation to the response to children who had been sexually abused by someone in their family environment. These centred around practitioners not believing they should talk to children about sexual abuse and give children a voice in decisions about them. There was evidence of practitioners not taking sufficient account of the needs of disabled children and children from Black and other minoritised communities, as well as a lack of appropriate support for children following the abuse. As is evident in Chapter 4, this lack of a response to children had a significant impact on children's lives and their future lives.

Not relying on children to tell

A consistent theme that emerged in our analysis and discussions with practitioners was an over-reliance on children to verbally report their abuse, despite research which indicates that there are multiple barriers to them doing so.

5.1 Practitioners spoke of how they had been told or understood through messages conveyed in safeguarding training, or more generally in their organisations, that they needed to wait for children to approach them to speak about sexual abuse rather than proactively talking to children when they had concerns that a child was being sexually abused. As a result, opportunities were not provided which could have enabled a child to tell practitioners what was happening. This created a barrier to children speaking about sexual abuse.

One of the children who was interviewed as part of this review said that she had been told by social workers and police officers that unless she made a direct report of sexual abuse there was nothing they could do to help her. One practitioner said, "If only they had told us what was going on", leaving the onus on children.

5.2 An overriding fear of interfering with any possible future criminal investigation meant practitioners felt they should not talk to children directly about the possible abuse.

> **"You just can't ask children questions in case you are leading them to tell you something." (Practitioner in reflective discussion)**

5.3 Some children in the reviews described waiting for someone to ask them what was happening so that they could tell them.

> **"I couldn't talk about the sexual abuse. It was too difficult. I wanted them all to notice and to ask me what was going on." (Interview with child who had been sexually abused)**

Not having opportunities to talk to a trusted adult also prevented children from telling someone what was happening.

5.4 One child aged 14 told the independent reviewer that she might have felt able to tell someone if they had taken time to establish a relationship of trust with her.

> **She spoke of her fear and of crouching in agony behind the bins near her home whilst she lost the child. This was clearly extremely traumatic for Kate and, for her, formed a major part of the abuse. She explained that if at that time, "just one person I trusted had taken the time to sit with me and ask, it might have taken a while, but I would have told them". (LCSPR)**

5.5 This child explained that she was finally able to tell a police officer when they said to her, "We know what this is." She said she had been trying to tell people for a long time but had needed someone to explicitly recognise and openly name what was happening to her.

> Health appointments presented missed opportunities for a child to be asked what was happening to them. For example, a 10-year-old girl who presented with a urinary tract infection (UTI), despite a history of previous UTIs, was not seen in person or tested before antibiotics were prescribed (counter to National Institute for Health and Care Excellence guidance).[133]

5.6 This evident fear of asking explicitly about child sexual abuse then prevented practitioners from exploring concerns in more detail. For example, in the context of known concerns about the child's father, one review described how practitioners knew that a child was sleeping in their jeans and wanted to harm their father, but they never asked the child what might be making them act and feel in this way.

Talking to or listening to children

As well as relying on children to tell them they were being abused, it appeared that practitioners were also not giving them information and not hearing what children said, which meant children were not helped to understand what was happening.

5.7 In one review, a child had reported sexual abuse by her father to practitioners in mental health services on 3 separate occasions over the course of a year but did not repeat her report to police or children's social care and there was no further investigation. She was subsequently admitted to a Children and Adolescent Mental Health Service (CAMHS) inpatient unit having made several attempts to take her own life. This was not seen as connected to the reports of sexual abuse but as a worsening of her mental health. Consequently the mental health needs were addressed in isolation from the abuse, leaving this child confused and sad.

5.8 Another child was asked as part of the local review process whether she had tried to tell practitioners what was happening. She replied, "Yes, all the time", and said she had been surprised that practitioners did not ask her more questions when she presented at the emergency department believing she was in labour, aged 14.

5.9 Another child emphasised the importance of being spoken to on her own and in a safe place.

133 National Institute for Health and Care Excellence (2022) 'Urinary tract infection in under 16s: diagnosis and management'.

When asked how the support they had offered could have been improved, Ruby said that it would have helped if they had spoken to her alone and away from the family home. Ruby explained that she was always conscious that someone could overhear their conversations. (LCSPR)

Practitioners did not provide children with the information they needed or consult them about decisions affecting their safety and wellbeing.

5.10 In some reviews, practitioners were uncertain whether they could provide children with the information they needed about adults in their life who were known to present risk of potential sexual harm. This would have helped children make sense of the coercive and controlling behaviour that had led to them being sexually abused.

Amy feels that had she been provided more information regarding her father's previous offending, and at an earlier stage, she would have been better equipped to identify the similarities in his behaviour. (LCSPR)

5.11 Children were also not kept informed about ongoing police investigations or child protection enquiries or assessments. This meant they were uncertain about what was happening which led to them feeling unsafe and unheard, as if the sexual abuse had not happened.

One child who had reported being sexually abused by an older brother was not aware that a police investigation had been stopped some months earlier and that children's social care had decided there was no need for any further action to be taken, including support or counselling.

5.12 Another child emphasised the need for practitioners to be proactive in maintaining direct communication with children.

When Amy was asked what single thing would have made the biggest difference for her, she said: "For people to make more checks and not to close the case. If someone had just checked up on me once a month, that would have helped. There needs to be more precautions." (LCSPR)

5.13 Clearly, given the scope of this review, the COVID-19 pandemic had a significant impact on children's ability to tell someone about their abuse. Much learning has already been drawn from this, summarised in our practice review, 'Supporting vulnerable children and families during COVID-19' (CSPRP, 2020). However, the following comment from one of the children in the reviews we looked at provides a powerful illustration of how the lack of a policy and practice framework enabling practitioners to make proactive contact with vulnerable children deprived them of their ability to tell anyone what was happening.

Ruby has told this review that when lockdown was first announced she thought it would be okay and that it would just be for a few weeks, but in time she began to feel trapped, and her mental health began to suffer. Ruby explained that Matthew did not allow her contact with anyone, and she had no way of communicating. (LCSPR)

5.14 Children who had been identified in images of child sexual abuse had felt unable to say what had happened to them, and there did not appear to have been any response to the needs or safety of these children. This highlighted the importance of practitioners being skilled in knowing how to speak to children in these circumstances and how to create supportive opportunities for them to talk about their abuse and/or take part in an achieving best evidence (ABE) interview or a video recorded interview (VRI) when they were ready.[134]

5.15 We found reviews where practitioners had responded to children's distress/trauma with a referral for a mental health diagnosis, which tended to shut down opportunities for children to tell someone what was happening to them and without an exploration of the meaning of the distress.

134 An achieving best evidence (ABE) interview is a video recording of a police interview with a victim or witness as part of a criminal investigation. ABE interviews are also known as video recorded interviews (VRI) by some police forces.

Believing children when they do tell

Although research has found that children do not generally tell anyone they are being sexually abused while it is happening, children actually had told someone about the abuse in nearly three-quarters of reviews considered. In some, they had repeatedly attempted to tell someone what was happening. However, when children did tell someone, they were often disbelieved, or subsequent retractions were taken at face value.

5.16 We saw many situations where children had directly told practitioners they were being sexually abused and were not believed.

> One review described a child who, on learning she was going to live with her stepfather, had told the family support worker that her stepfather had sexually abused her in the past. A child protection enquiry was initiated. The stepfather denied the report, and the child's previous reports had been recorded as "unsubstantiated concerns", with no further action needed by police or children's social care. The child's mother said that the child often got confused and misinterpreted rough and tumble play. A narrative then developed that she was a child who 'made up stories'. It was concluded that the child had not been sexually abused and she moved to live with the stepfather who subsequently went on to sexually abuse her.

5.17 When some children retracted what they had said, practitioners had often taken this at face value without attempting to explore the reasons for the retraction, which might have been due to fear, shame, embarrassment, intimidation or concern about the effects of the statutory response on their lives. For example, when a child retracted her report that her stepfather was sexually abusing her, this was not challenged despite documented concerns that it was likely she had been pressurised into retracting her report.

5.18 More worryingly, the retractions were often treated more seriously than the original report of abuse and taken as evidence that the abuse had not happened, leaving children at greater risk of further harm.

One review described how a child whose father had previously served a prison sentence for sexually abusing other children had told a neighbour that she was being abused by her father. However, when she verbally retracted what she had said, the investigation was ceased without any consideration of the factors that might have led her to retract her report and a conclusion was drawn that she had not been sexually abused. The impact of this on the child was never discussed with them or analysed further.

5.19 As a result of not hearing children's reports that they were being abused, practitioners did not take appropriate steps to protect children. One child told the local reviewer how the lack of action following a medical examination had left her feeling abandoned and hopeless:

Kate explained that she agreed to an internal examination on the understanding that it would provide evidence that she was being abused. She was aware he [the adult who was abusing her] followed her to that examination and explained during conversations with the reviewer how frightened she was of repercussions from him, but also relieved. She believed this would be a turning point, because everyone would know she was being abused and so what happened next would be out of her hands. So when nothing happened, the results of the tests were not reported back and an investigation wasn't taken forward, she lost faith that she would be protected from his abuse. (LCSPR)

5.20 When this child subsequently attempted suicide, the psychotherapist who saw her spoke of seeing a child in notable distress who 'did not feel believed', as her earlier experiences were of services having 'walked away'.

5.21 Another child said that they had wanted to report the abuse but were trying to get evidence to ensure they would be believed by practitioners. Meanwhile, a younger child in the same family said that they would have said what was happening if they had been asked by a practitioner they trusted.

5.22 The 2 children we interviewed offered the following advice for practitioners:

- If a social worker notices signs that something might be wrong, they should arrange more unannounced visits.
- If the parents or carers are in the same room or nearby, it is difficult for children to speak freely, so make every effort to find a safe space to talk to the child.
- When practitioners talk to a child on their own, reassure them that they can say anything and that they will not get told off for it.
- Ask more direct questions and keep children informed.
- Be more attuned to children's mental health needs and the reasons behind these.

Exploring or taking account of children's race, ethnicity and culture

Our analysis showed that practitioners did not sufficiently consider or respond to children's individual needs in relation to their race, ethnicity and culture.

5.23 Although over a quarter of the children in the reviews were from Black and other minoritised communities, in only 13 of these reviews was there any specific reference to children's race, ethnicity or culture and how practitioners had taken this into account in responding to children. None recognised the impact of racism, including bias and wider systemic experiences of discrimination including on people from Black and other minoritised communities. As a result, there was little learning available from these local reviews, other than highlighting how practice is failing in this respect and the need for this to be addressed.

5.24 For example, one review described how practitioners had not recognised or explored the potential impact of a child's Indian heritage and how this may have silenced her and left her without support when reporting her abuse. It was suggested that the child might have benefitted from support from culturally matched practitioners who understood her cultural, community and family dynamics.

5.25 In another review there was evidence of forced marriage being arranged for a 14-year-old Black African child from a Muslim family to her adult cousin. The review found that practitioners had shown a lack of understanding regarding forced marriage and the signs of this being planned, leaving the child unprotected from her cousin who went on to rape her.

5.26 In other reviews, there was a conclusion that while practitioners had discussed a child's ethnicity or culture, they had not taken this into account sufficiently in their actions to understand the lived experience of the child. Further discussion of this issue is considered in paragraph 5.78.

> **The cultural identity needs of Hatty and Jen were discussed in several of the assessments completed but ultimately no action was planned or taken. (LCSPR)**

5.27 The needs of children who had English as a second language were not sufficiently taken into account, which meant those children had no 'voice' in the assessment and investigative process.

> Reviewers acknowledged that using an appropriate translator or interpreter at some points in the investigations, and in a location away from the family, would have helped to create a safer space for the child to speak openly.

5.28 In another review, there was recognition by reviewers of the way in which some practitioners had displayed adultification bias towards a child from a mixed White and Asian ethnicity, treating him as older than his actual age and blaming him for his behaviour.[135] The risks he faced had therefore not been recognised or responded to.

Assumptions and bias could deflect practitioners from recognising signs of child sexual abuse in children from some minoritised communities.[136]

5.29 For example, in one review, the child's relative had explained marks on the body of the child who was from a mixed White and Asian ethnicity as being due to skin pigmentation. This was accepted by practitioners without challenge or triangulation of other known information.

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135 For more on adultification bias see Davis, J (2022) 'Adultification bias within child protection and safeguarding' HMI Probation.

136 Davis, J. (2019). 'Where are the Black girls in our CSA services, studies and statistics?', Community Care.

Our analysis and fieldwork did, however, identify some occasions where practitioners had given consideration to children's needs relating to their race, ethnicity or culture.

5.30 For example, in one review, practitioners found that a child of Black African heritage with a history of trauma and abuse was pregnant. They recognised that this particular child might be at risk of 'honour-based' violence or ostracisation and recommended appropriate support.

5.31 Practitioners reviewing the circumstances of an 11-year-old girl of Pakistani heritage who had become pregnant as a result of sexual abuse by her much-older brother recognised that she might receive a negative response from others within her community and would need additional support if this occurred.

5.32 However, there was a risk that this was sometimes based on assumptions that children from Black and other minoritised communities all faced similar risks, no matter which particular ethnic group they belonged to.

In our roundtable discussions, experts by experience who were from Black and other minoritised communities described how practitioners did not recognise and explore family structures within different cultures. One person with South Asian heritage explained how, when they were growing up, their family consisted of 6 inter-connected households, which had given the person who abused them access to children in all 6 households. They also described how biases and stereotypes could prevent practitioners from identifying intrafamilial child sexual abuse due to wrongly held beliefs that, for example, Asian men do not abuse Asian children.

Exploring or taking account of the needs of disabled children

Our analysis highlighted the need for practitioners to improve their response to disabled children when there are concerns of intrafamilial child sexual abuse.

5.33 While only 5 children in the reviews we looked at were noted as having a physical disability, 32 reviews (24%) featured a child who was recorded as having a learning difficulty or disability, autism or ADHD. However, few of these reviews provided any evidence that practitioners working with the child had taken account of the child's disability in responding to the abuse.

5.34 In one review where practitioners had sought to take account of the child's disability, school staff had used their understanding of the child's cognitive and learning abilities to inform other practitioners' response to the child's sexualised behaviours:

> **It was the school that was able to describe how Daniel's understanding of what was socially appropriate behaviour which was neither age appropriate nor in line with his abilities and how this had probably been affected by his early childhood abuse and adversity. (LCSPR)**

5.35 In another review, school staff recognised that disabled children are at increased risk of sexual abuse. They tried to adapt the relationships, sex and health education curriculum to enable the child to access it as well as engaging the child in regular structured conversations around healthy relationships.

However, a quarter of the 35 reviews involving a disabled child did not include any discussion of the child's impairment or give consideration to how this might affect them, what the implications were for communication and engagement with these children and what this would mean for effective practice for those working with them.

5.36 Issues in practice that were picked up in the local reviews were around signs and indicators of sexual abuse, such as a child's distressed behaviour being attributed to their disability rather than to potential sexual abuse. For example, in one review, practitioners had incorrectly attributed a child's behaviours to their diagnosis of autism or ADHD rather than seeking to understand those behaviours and link them to potential concerns about child sexual abuse.

5.37 There were times when signs and indicators of potential sexual abuse in physically disabled children had gone unrecognised or had been dismissed as being part of their impairment, even when there was no relation between the two.

5.38 Signs of abuse in children who were non-verbal, or pre-verbal, were also missed. In the context of a system which relies so heavily on verbal reports, these children were therefore left without any response to their abuse. In addition, practitioners did not see or pursue signs of possible sexual abuse in children with learning disabilities or difficulties as they were uncertain how to establish effective communication with children with different cognitive skills.

5.39 There was little evidence that practitioners considered why children were behaving as they were and there was a tendency to look for causes within the child. This was evident in responses to disabled children engaging in harmful sexual behaviour, where practitioners tended to focus on changing the behaviour itself rather than understanding the causes.

5.40 Overall, practitioners displayed a lack of knowledge around children's specific impairments or their implications, as well sometimes making inappropriate and ill-informed descriptions of children's cognitive abilities, for example, stating that "the child has a mental age of 4" or calling a child "quirky".

5.41 Practitioners' assumptions around disabled children's abilities prevented children being given opportunities to share what was happening to them.

In one review, practitioners had assumed that a child with selective mutism could not communicate, without providing any alternative ways for them to tell what was happening to them or seeking advice from those who knew this child well. The link between the child's mutism and increasing debilitating physical and emotional needs and their siblings' reports of sexual abuse by their parent was not made. The child was subsequently responded to as a disabled child, rather than a child who may have been sexually abused.

5.42 Practitioners working with disabled children had often not sought advice from those who knew the child well and could have informed them about each child's abilities and preferred communication style.

There was something of a separation between the work of professionals seeking to address the children's disability and health needs and the actions of the safeguarding professionals. There was a wide range of expertise available to safeguarding professionals to help them understand the children's needs, understand their communication style and to advise on the best way of maximising this. This opportunity was not taken. (LCSPR)

5.43 Some reviews recommended actions to address this lack of understanding and response to the child's needs, including the need for training on working with disabled children and the development of tools to assist in communication and support following sexual abuse.

Listening to children's wishes around VRI or ABE interviews

We were concerned about how poorly children had been informed about ABE or VRI interviews and saw some evidence that, when children expressed uncertainty about whether they wished to take part, they were told that this would impede the police investigation, leaving them feeling blamed and responsible.[137]

5.44 Some children had expressed concerns and uncertainties about taking part in an ABE or VRI interview and these understandable worries were not acted upon. In one review, a child had wanted her mother to be with her. When this proved difficult to arrange, the ABE or VRI interview did not take place and there was no further response to the sexual abuse the child had reported.

A child declined to take part in a second ABE or VRI interview as they could not face doing it. This was characterised as the child not co-operating, which was cited as the reason why no criminal action could be taken. This issue of blaming children and inappropriately holding them responsible for not taking forward the investigative process was a common theme.

5.45 There were also instances where ABE or VRI interviews had not been conducted in line with the ABE guidance, and had to be redone, causing trauma to the children involved. This included a lack of planning to take account of the needs of the child in terms of their age, communication style or language/s spoken. One of the children we interviewed told us:

> **The ABEs were horrendous. No support. I did not know what to do. The questions they asked me. One lasted for 4 and a half hours. All those questions. Like I was on trial. (Interview with child who had been sexually abused)**

137 An achieving best evidence (ABE) interview is a video recording of a police interview with a victim or witness as part of a criminal investigation. ABE interviews are also known as video recorded interviews (VRI) by some police forces.

5.46 We also found inconsistencies in the use of intermediaries for children, as outlined within the ABE guidance.[138] [139] One review described how an intermediary had met with a child who had experienced multiple forms of abuse and harm and had advised that, because of the impact of trauma, the child would need support in future ABE or VRI interviews. This advice was disregarded, and no intermediary was provided. This meant the next ABE or VRI interview had to be stopped because the child had become too distressed, leaving her feeling that she had failed in the process. There was no recognition of this, and the message was that no further action could be taken because of the lack of evidence, rather than a lack of due process.

Across the reviews we looked at, practitioners assumed that police officers would undertake and lead the ABE or VRI interview, with social workers who knew the child not being considered as possible better choices to lead or play a supportive role. This is despite the most recent ABE guidance making clear the need to consider who was the most appropriate ABE-trained practitioner to lead the interview, grounded in the best interests of the child. However, our fieldwork suggested that these choices were often limited by the availability of suitably trained practitioners.

5.47 There was little consideration that social workers would have an ongoing role with the child regardless of the outcome of the ABE or VRI interview, and would need to understand what the child had spoken about to be able to support them in the future. There was a consistent lack of clarity about whether the transcripts or recording of ABE or VRI interviews could be shared, leaving those who had an ongoing support role with the child uncertain about what the child had reported. This had inevitably left children feeling unsupported and unheard.

138 A registered intermediary is an impartial, self-employed, communication specialist who enables vulnerable witnesses and complainants to give evidence to the police and to the court in criminal trials.

139 Ministry of Justice (2023) 'Achieving best evidence in criminal proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures'.

5.48 There was also some rigidity in the ABE process, with an emphasis on verbal interviews. A child who had told a friend that she had been sexually abused from a young age agreed to an ABE or VRI interview but because of the long-term trauma was selectively mute. She communicated that she wished to write her answers down with support from a friend but was told this was not allowed. However, another review described how a child who had reported sexual abuse from the age of 5 years was facilitated to provide written answers because she could not speak about what had happened to her at a young age. Again, this highlights inconsistencies in approaches to supporting children to communicate effectively.

We found that, in many of these situations, the police investigation had either ended with 'evidential difficulties', with no further police action being taken, or the information from the investigation was passed to the Crown Prosecution Service and they decided there was insufficient evidence to pursue a charge. None of the children in these reviews appeared to have been informed about the victim right to review or criminal injuries compensation processes.[140] [141]

5.49 These decisions often took several years to be reached. We found that children and their parents were not kept sufficiently informed of the slow progress of investigations, or that a police investigation had ended. Children expressed concern about the adults who had harmed them remaining in their communities during this period, despite being subject to bail conditions. Children and their families did not always know about or understand these conditions and expressed not feeling safe. The police investigative process was not woven into ongoing support such as early help, child in need or child protection processes.

140 Crown Prosecution Service (2021) 'Victims' Right to Review Scheme'.

141 Criminal Injuries Compensation Authority (2024) 'A guide to applying for compensation under the Criminal Injuries Compensation Scheme'.

Responding to children in extreme distress as a result of sexual abuse

Our analysis revealed that children in extreme distress were not always getting appropriate support or being listened to, and that concerns of abuse were not always being escalated or attended to.

5.50 We saw situations where children had made repeated suicide attempts or been referred to CAMHS on multiple occasions within a short period of time, yet despite concerns of sexual abuse having previously surfaced, no further enquiry was made.

5.51 In many reviews, the impact of the abuse on children had been interpreted by practitioners as children needing to be assessed for autism or ADHD, taking the focus away from concerns about possible sexual abuse. For example, a 13-year-old child who had been sexually abused was understandably showing signs of distress and trauma. Practitioners responded by seeking a diagnosis of autism rather than seeking to understand her distress and respond to it. She eventually died by suicide.

5.52 Another review featured a child who had been sexually abused and who had been discharged into their mother's care, despite the mental health triage team indicating this was against the child's wishes and concerns about safety, as well as the child stating they were planning to die by suicide (which they subsequently did).

A child who was actively suicidal for over a year (including having been seen twice at the emergency department due to suicidal thoughts) was supposed to be receiving fortnightly virtual check-ins from the youth justice team – which her grandmother responded to on her behalf and without including her – and was on a waiting list to be seen by CAMHS. Not one practitioner had spoken directly to the child for 5 months at the point at which she died by suicide.

Children having access to appropriate support following abuse

Following the identification of the sexual abuse, practitioners often appeared to be unclear about what constituted an appropriate response for the child and their family.

5.53 Some reviews highlighted the lack of adequate support available for children. For example, in one review, it was stated that there was no service available to support a child who was saying that she felt "outside her body at times".

5.54 There was a sense that practitioners in their routine roles were unable to talk to children about their abuse, which meant there was a reliance on referring to specialist services that often held long waiting lists or were not available where the child lived. This left the children with little support.

5.55 In other reviews, it seemed that a child's complex needs, both arising from and compounded by the abuse, meant they had not met the criteria for support or that service provision did not match the child's needs for support, despite these stemming from well-recognised traumatic experiences. One of the children we interviewed said:

> **"CAMHS thought there was something wrong with me. They ended up saying I was too difficult and unstable so they could not offer me a service."**

In one review, a child had repeatedly asked for therapeutic support but was never offered any, despite the fact that their presenting behaviours and needs were expected effects of child sexual abuse and childhood trauma which required a response.

5.56 We also noted situations where restrictions were imposed that impeded children's access to therapy, such as requiring the child to be 'stable'. This was particularly problematic for children in care who were often experiencing immense instability in their living arrangements. Another review raised the issues associated with finding care for a young person making the transition to adult services who was in extreme emotional distress as a consequence of sexual abuse.

5.57 Other reviews featured children being taken into care following the identification of the sexual abuse without foster carers being sufficiently informed and supported to look after children with significant behavioural and mental health needs that had resulted from the abuse or being enabled to understand their role in supporting children after the abuse.

5.58 We also saw situations where, after the sexual abuse had come to light, children were not given sufficient support to re-enter education or their living circumstances had changed, such as moving into or between local authority care placements.

Children's understandable distressed behaviours were not sufficiently recognised or responded to and this resulted in them being further harmed.

5.59 Alongside this, the impact of the intrafamilial abuse on children's mental health had other inter-linked consequences. One child described to local reviewers how she struggled with intrusive thoughts and felt the abuse had affected her own sexual behaviour, which was exploited by adults and peers.

5.60 In another review, a child who had been sexually abused by her father had been placed with a foster carer who took advantage of the child's vulnerability to coerce and sexually abuse her.

Among reviews featuring children who had sexually abused a sibling, reviewers had felt that a lack of appropriate therapeutic support had meant that some children who had themselves been victims of sexual abuse had gone on to abuse their siblings.

5.61 Furthermore, while some children were unable to access appropriate therapeutic support, others were provided with interventions that were inappropriate to their situation. Most commonly, this had taken the form of 'Keep Safe work', consisting of 'healthy relationships and consent advice', which, for a child who has been sexually abused by someone in their family, would appear to put the onus on them to protect themselves from further abuse. In addition, this work lacked an evidence-based framework.

5.62 On the other hand, when children could access therapeutic support, this was clearly helpful.

> **The sexual and emotional abuse she has experienced over many years has had an impact, and there are times when she feels sad, confused and angry. Therapeutic support is helping her make sense of the harm she has experienced. (LCSPR)**

5.63 Some other reviews highlighted the strong pastoral support provided to some children by schools and how important it was that school felt like a safe place for children.

Reflections

5.64 Single and multi-agency assessments, enquiries and investigations into concerns of child sexual abuse do not always keep the best interests of the child as the central consideration. Children's needs are not always adequately considered in strategy discussions, and the right information is not consistently shared. Children and their families are not adequately informed about risk, supported through the investigation process or updated on the progress of investigations, which are often lengthy.

5.65 Furthermore, the evidence we have seen here suggests that practitioners working with children and families have not been equipped with the knowledge, skills and practical guidance to respond confidently to children who have been sexually abused, or about whom there are concerns of sexual abuse by someone in their family environment. Overwhelmingly, practitioners are relying on children to verbally report their abuse before taking action, without creating opportunities for them to do so safely. This has been previously highlighted as a major barrier to child sexual abuse being identified and responded to.[142] Practitioners are also sometimes disbelieving them when they do tell, or consider that children's reports do not provide sufficient 'evidence' to act.

5.66 Our findings around children's ethnicity reflect the absence of focus on these issues seen in reviews more widely. Our annual report for 2022-23 found that ethnicity is sometimes not recorded in serious incident notifications and rapid reviews, and that the impact of race, racism, ethnicity and culture is often not explored in depth in rapid reviews and LCSPRs. The Panel's current project on race, racism and ethnicity is exploring how reviews can critically analyse the impact of race and racism on safeguarding practice.[143]

142 Allnock, D and Miller, P (2013) 'No one noticed, no one heard: A study of disclosures of childhood abuse' National Society for the Prevention of Cruelty to Children.

143 Child Safeguarding Practice Review Panel (2024) 'Annual Report 2022/23: Patterns in practice, key messages and 2023/24 work programme report'.

5.67 In addition, our findings around disability suggest that many practitioners lack training in child development, which affects their ability to identify and respond to signs of possible intrafamilial sexual abuse in disabled children. At the same time, a lack of understanding of how trauma manifests in disabled children can mean practitioners miss non-verbal cues and changes in behaviour resulting from abuse or neglect, falsely attributing them to the child's disability or health status. Previous reports published by the Panel have highlighted the need to develop the skills of the workforce to enable disabled children's communication and respond appropriately and effectively to behaviour that challenges.[144]

5.68 Particular concerns also emerged about ABE or VRI interviews, with police tending to lead these interviews without involving children's social care and not always providing appropriate support to enable children to communicate effectively in the interviews. Meanwhile other conversations where a child had told someone they trusted about what had happened to them appeared to be disregarded, with children expected to repeat what they had said in this formal setting to be taken seriously.

5.69 The need for practitioners to keep children informed about the progress of assessments and investigations and the outcome of these also emerged clearly, particularly in terms of making sure that children's wishes and needs are being considered in these processes.

5.70 The evidence provides some insight into the significant impact of the abuse on the children in local reviews received by the Panel. However, it should be noted that evidence of the effects of the abuse on children was not systematically captured in the reviews we looked at. At times, there was simply no information available relating to the impact on the children. In some of the reviews involving very young children, impact had not yet been seen.

5.71 The lack of appropriate support for children following abuse was particularly concerning and some reviews revealed how hard it was for children to access specialist therapeutic support. This was highlighted in the Independent Inquiry into Child Sexual Abuse's final report and formed the basis of their recommendation 16 that "The UK government and the Welsh government introduce a national guarantee that child victims of sexual abuse will be offered specialist and accredited therapeutic support".[145]

144 Child Safeguarding Practice Review Panel (2022) 'Safeguarding children with disabilities and complex health needs in residential settings: Phase 1 report' and (2023) 'Safeguarding children with disabilities and complex health needs in residential settings: Phase 2 report'.

145 Jay, A, Evans, M, Frank, I and Sharpling, D (2023) 'The Report of the Independent Inquiry into Child Sexual Abuse'.

5.72 'Keep Safe work' is often proposed for children who have been sexually abused when, in reality, this intervention is designed as a preventative programme to help children recognise abusive behaviour and change their own behaviour and attitudes to stay safe. There is a danger of Keep Safe work being experienced by children who have already been sexually abused as placing blame on them.

Implications for practice

5.73 This chapter has highlighted the importance of practitioners feeling confident and being proactive in talking to children when there are concerns about sexual abuse, opening up conversations and providing them with information. Subsequently, children should be given further opportunities to speak and be consulted about decisions that affected them. This, in essence, would give them back some of the control that had been stripped away by the abuse.

5.74 However, it would appear that there is an overarching fear and uncertainty regarding talking explicitly about child sexual abuse, which prevents practitioners from naming and sharing their concerns. Practitioners' fears and misunderstandings about talking to children need to be urgently addressed across the whole system, including those in universal services, such as in schools and other education settings and in community health services, as well as practitioners in safeguarding, law enforcement and other specialist services.

5.75 We also saw an over-reliance on children to verbally report their abuse, when research indicates that there are multiple barriers to them doing so. Practitioners need to be able to recognise and respond to the physical, emotional and behavioural signs and indicators of abuse.

5.76 In addition, stereotypes and assumptions around both victims and those who harm, and a lack of understanding of grooming and coercive control, were seen to impact on practitioners' ability to recognise signs of intrafamilial child sexual abuse while other harms such as neglect (often present alongside the sexual abuse) may distract from the concerns of sexual abuse. Safeguarding practitioners, in particular, would benefit from specific training to improve their understanding of grooming and coercive control and the way in which other forms of abuse intersect with child sexual abuse.

5.77 When children did tell, they were not always heard and responded to. It seems that a fear of getting it wrong, perhaps influenced by misunderstandings following the Cleveland Inquiry (see Chapter 2), results in a lack of action to protect and support children. As well as training, practitioners would benefit from clear guidance on responding to concerns of child sexual abuse, such as the CSA Centre's response pathway, as well as from supportive supervision.

5.78 Our analysis also highlights the need to ensure that strategy discussions always include someone who knows the child and how best to communicate with them, taking account of disability, ethnicity, race and racism, language and culture. It is also important that strategy discussions involve an appropriate health representative who either has clinical experience in health assessment where recent or non-recent child sexual abuse is suspected or, as a minimum, has consulted with a professional who has this expertise.

5.79 Practitioners need to recognise the impact of racism, including bias and wider systemic experiences of discrimination on how children and families perceive and experience barriers to disclosing and reporting child sexual abuse, their experiences of, and interactions with, institutions in relation to child sexual abuse, and the nature of support that victims and survivors receive. They need to be able to explore and understand children's ethnic and cultural contexts, including family structures, and how these may impact the harm they have suffered and their help-seeking. This would support practitioners in providing a considered and culturally sensitive response, taking account of other vulnerabilities or contexts that intersect with children's ethnicity or culture.

5.80 Crucially, practitioners need to have a better understanding of the profound impact of intrafamilial child sexual abuse on children's lives, development and wellbeing, and how this manifests in distress which can be evident in their behaviour. This needs to be understood as the impact of harm. Children in extreme emotional distress must have access to specialist support from practitioners who understand this, can talk to children about the abuse they have suffered and reassure them of the normality of this distress. In particular, this suggests that children who have been sexually abused by someone in their family environment need better access to CAMHS services, whose practitioners need to have had sufficient training in working with children who have been sexually abused.

5.81 Nonetheless, while all children should be able to access specialist support, they will also benefit immensely from receiving a therapeutic and supportive response from non-specialist practitioners who can reassure them of the normality of their responses and support them in understanding the abuse was not their fault. The World Health Organization's clinical guidelines for responding to children and adolescents who have been sexually abused emphasise that practitioners can provide an "empathetic response [which]…can go a long way in helping survivors recover from the trauma of sexual abuse".[146]

146 World Health Organization (2017) 'Responding to children and adolescents who have been sexually abused: WHO clinical guidelines'.

5.82 Supporting the child's physical health and wellbeing can also help to address any physical impacts of the abuse and to mitigate further potential impacts in the future. Again, this requires both universal and specialist health services to offer appropriate support to ensure that children of all ages who have been sexually abused (whether this was recent or non-recent) have access to local health services that meet their needs.

5.83 Above all, it is imperative that all agencies such as schools and other education settings are enabled to create safe and supportive contexts for children who have been sexually abused – in particular through staff training and support, access to resources to support their practice, and sensitive, proportionate information-sharing systems.[147]

147 Warrington, C, Beckett, H, Ackerley, E, Walker, M and Allnock, D (2017) 'Making noise: Children's voices for positive change after sexual abuse', University of Bedfordshire and Office of Children's Commissioner.

5.84 The following diagram shows what a whole-system response would look like.

5.85 This would mean that children receive an effective response from practitioners across the whole children's workforce, including those in universal and early help services and those supporting children and families in other capacities, for example in fostering and adoption services. If all practitioners, including those in schools who see children every day, feel equipped to listen to, talk with and support children who have been sexually abused, the silence surrounding sexual abuse could diminish and the corrosive impact of it could be reduced.

5.86 Practitioners, managers and senior leaders must be equipped according to their specific roles and responsibilities to play their part. Schools may identify concerns and support children who have been abused to access education, health may support children's physical and mental health needs, early help services may provide the child and family with advice, guidance and useful interventions, social care may assess and intervene, police may investigate, family law may protect and fostering and adoption services may support recovery.

5.87 Therefore, everyone needs the right professional development opportunities, supervision and access to guidance and resources to give them the knowledge, skills and confidence to do what they can within their role to support and protect children.

6. Understanding parents' and carers' needs and contexts

Another significant theme is the lack of an appropriate response to parents and carers.[148] This included practitioners not taking sufficient account of parents' contexts and vulnerabilities, particularly those who are subject to domestic abuse. We also found that practitioners placed an unrealistic burden on parents and carers to protect their children, without giving them the information or support they needed to do this. Alongside this, we saw evidence of the lack of support available for parents and carers, both in addressing their own needs and in parenting a child who had been sexually abused.

Understanding of parents' contexts and vulnerabilities

Of particular note here was the lack of understanding of parents' contexts, needs and vulnerabilities, and especially how a poor understanding of domestic abuse could result in the sexual abuse of a child being overlooked or not seen at all by practitioners. In addition, parents' behaviours were sometimes labelled as 'disguised compliance' without the meaning of this being clear or any exploration of why parents might be behaving in this way or what this meant for their children.

6.1 There was evidence across the reviews of practitioners lacking understanding of domestic abuse generally and, specifically, coercion and control and the direct impact that this was likely to have had on the parent's ability to keep their child safe.

One mother described how her experience of domestic abuse had prevented her from speaking out about her concerns that her child was being sexually abused. However, she had hoped that practitioners would notice "the fear in her eyes" and see the "red flags" that should have triggered help for her daughter and herself.

148 Note that when referring to parents and carers, we have avoided terms such as 'non-abusing' and 'safe'. Instead, we refer simply to parents and carers, and make it clear when the parent or carer is the person who has sexually abused the child.

6.2 Parents, particularly mothers, were sometimes seen as displaying 'disguised compliance' or being unwilling to protect their children, rather than being victims of domestic abuse who might be subject to coercive control or grooming.[149]

In one review, the mother appeared to social workers to be heeding advice to provide care, emotional support and wellbeing for her daughter but consistently failed to do so and was seen to make up excuses whenever challenged. The review also noted that the child had said she worried that her stepfather was hurting her mother but, despite this, practitioners concluded there was no evidence of domestic abuse or that this might have been impacting on the mother's ability to comply with the advice.

Exploring and taking account of parents' race, ethnicity and culture

Our analysis revealed that practitioners did not usually consider and respond to parents' needs in relation to their race, ethnicity and culture.

6.3 In 25 reviews, it was known that the parent was from a Black or other minoritised community, yet this was rarely discussed in the reviews we looked at nor raised by the practitioners we talked to in our discussions, despite our attempts to initiate reflections around this.[150]

6.4 Nonetheless, in 3 reviews, there was clear evidence that practitioners working with the family had attempted to take account of the parent's ethnicity or cultural needs, such as through providing translators or interpreters. Even so, practitioners in these reviews reflected on the difficulties of using translators or interpreters in the context of intrafamilial child sexual abuse. These included translators or interpreters not being prepared for the sensitive nature of these conversations, as well as the fact that there were situations where there was no direct translation possible to some of the words used, creating confusion about what had actually been said. Parents also worry that information from the interviews would be shared by the translator or interpreter within their communities.

149 'Disguised compliance' is a term used to describe the behaviour of an adult who appears to be trying to comply with plans to safeguard or promote the welfare of their child but does not follow this through with meaningful action.

150 Reviews featured parents from the following minoritised communities: Asian – unspecified (3); Bangladeshi (1); Indian (2); Pakistani (3); Thai (1); Black African (4); Black Caribbean (5); South American (2); Black British and Asian (1); Eastern European (2); Traveller (1).

Another review described the frustration that a mother felt in communicating with practitioners, who had resorted to using Google Translate when talking to her on the telephone.

6.5 While in another review, a mother had told practitioners that she had been trafficked to the UK from Africa but there had not been any discussion of the impact this might have had on her, or of the fact that her first language was not English and that she might not understand what was being discussed with her.

6.6 In another, police communications with a child's mother whose first language was not English were generally undertaken by officers who spoke the family's primary language but who did not have any training in translating. The review recognised that this would have impacted the mother's ability to seek support in protecting her child from the sexual abuse.

6.7 In yet another, the lack of understanding or recognition of a parent's ethnicity and how this might impact on their response to statutory services led reviewers to call for a national review, led by someone with insight into the experience of marginalised Black families with mental health issues who, it was recognised, might have good reason to be deeply mistrustful of services.

6.8 Another review commented that there was no evidence that agencies had understood the travelling community to which the family belonged and suggested that some may have held pre-conceived and unconsciously biased ideas that influenced their practice.

Relying on parents to protect their children

We saw an over-reliance on parents to protect their child, as well as a lack of support to enable them to do this, taking account of their own situation and needs.

6.9 Relying on parents to supervise contact between their child and the person suspected of the abuse was particularly problematic within the context of domestic abuse, which was a factor in nearly half of the reviews we analysed.

6.10 In such situations, practitioners had often not sought to explore or take account of the impact of physical violence and/or coercive control when assessing parents' ability to protect their children.[151]

151 An ability to protect assessment should explore the ability and capacity of a parent or carer to support and protect their child, identifying both strengths and areas in which additional intervention may be needed.

6.11 Linked to this, we saw an inappropriate use of working agreements and safety plans which often placed sole responsibility on parents to keep their children safe, without taking full account of parents' own situations and needs.[152]

One review described how a mother had been asked to sign a working agreement that she would not allow her partner, who had a conviction for child sexual abuse, to live in the family home and that any contact with the children would be supervised. It was subsequently noted that practitioners had placed too much trust in the mother's ability to uphold the requirements of the working agreement which, in reality, had enabled the perpetrator to continue sexually abusing the children.

6.12 This family was also involved in private law proceedings underway in relation to another man, an ex-partner who had perpetrated domestic abuse. The Cafcass officer was verbally told of this 'safety plan' relating to the partner living with the child, but was not sent it. The information about this plan was not reported to the court.

Another review described a working agreement which specified that the mother should purchase a door alarm so that her partner, who was on the sex offender register, would not be able to leave the room while she was asleep. In another, a 7-month pregnant mother was asked to sign a working agreement saying she would sleep on the floor in front of the door of the children's bedroom to ensure the sibling who was displaying harmful sexual behaviour could not enter.

The needs of parents with learning disabilities or difficulties were often not taken account of, particularly in making sure they had sufficient understanding of responsibilities placed on them for the safety of their children.

6.13 For example, practitioners in one of the reviews we looked at were reported as having been aware that the mother did not really understand what was being discussed but had not attempted to address her communication needs, despite the national guidance or requirements of the Equality Act 2010.[153]

152 A working agreement is a document which sets out the things that parents and children's social care have said they will or will not do.

153 See here for more information on The Equality Act 2010.

There was also a lack of recognition and exploration of parents' own support needs to enable them to protect their children, requiring practitioners to think more analytically about family dynamics.

6.14 For example, a mother was assessed as able to protect her child on the basis that she was able to complete the majority of basic care tasks for her children without any consideration of the impact of her own history of intrafamilial child sexual abuse and exploitation on her capacity to protect.

6.15 One social worker told us they felt the safeguarding system handed the responsibility to protect children back to their parents:

> **"You give all of that back to the mother to manage. Really. That's essentially what we do." (Practitioner in reflective discussion)**

Sharing information with and believing parents and carers

Practitioners did not always share information appropriately with parents, seek their views or listen appropriately.

6.16 A particular concern was that practitioners did not know they needed to advise parents about their rights to find out about a new partner's previous convictions for child sexual abuse or that they could proactively share this information under the 'right to know' procedure.

6.17 In only 2 reviews was there any evidence of parents making use of the Child Sex Offender Disclosure Scheme (CSODS or 'Sarah's Law') to find out about risks that their partner might present to their children. In one instance, this resulted in information being presented to the child's mother about their partner's convictions for sexual offences. However, in the other review, it seemed that practitioners had been confused about the difference between CSODS and the Domestic Violence Disclosure Scheme (or 'Clare's Law'), with the end result being that an application was never submitted under the CSODS and the mother was not made aware of the information that might have stopped the abuse.

We also read reviews where parents or carers had talked about feeling disbelieved by practitioners. For example, concerns raised by a mother who believed her ex-partner was sexually abusing their child were dismissed on the basis that these were 'malicious' as she was contesting custody in the family court.

6.18 Some parents also described how they felt practitioners were not listening to them or seeking their views which had led them to disengage from services. For example, one mother told reviewers that she had not understood why meetings were happening, that she had felt bullied when she had taken part, and that this had reminded her of her experiences of domestic abuse.

Support for parents and carers

Parents were also not offered appropriate support, particularly in parenting a child who had been sexually abused and in coping with the information about the abuse.

One mother with a learning disability whose partner had sexually abused her 3-year-old child was told that there were no specialist support services available and was instead offered a mental health support group where she was required to tell people the reason she was attending. Unsurprisingly, she did not feel able to do this and left. No further support was offered because she was described as not engaging with services.

6.19 Although there were often many practitioners involved with the family, parents did not often receive the support they needed to parent their children. One mother described how she would have valued further advice and guidance about how to be a more protective parent to her son:

> **During the time when Freddie was subject to a 2-year child protection plan the mother was unclear what it was achieving and often felt it to be very messy. During meetings, the mother expressed a view that she often felt intimidated by professionals, sometimes not knowing who people were or what they did. (Serious case review)**

6.20 Other parents told reviewers how hard it was to make sense of the various interventions available for their child and that navigating these, while caring for their child, required a level of financial and emotional resource that they did not have. Frequently, parents needed support with other challenges they were facing in their lives, such as mental ill-health or substance misuse.

6.21 Parents also spoke about the difficulty of responding to the needs of their different children after sibling sexual abuse had come to light and, particularly, in knowing whether and how they could keep their family together in a safe and appropriate way. They did not feel they had been provided with the right advice or support.

6.22 Foster carers of children who had been sexually abused also said they needed guidance and support in talking to the children about what had happened to them and the future risk that they might face from the person who had abused them.

6.23 Some key points about the support they would have liked from practitioners were made by family members in one local review and are outlined below.

- Consider visiting our home in twos so that observations can be made about the family dynamics and interactions.
- Consider the allocation of (the gender of) social workers in some family situations where misogyny and male power is highly dominant and controlling.
- Work with parents by listening to their views more and offer support to them.
- Share the actual reports and information at the time you receive them.
- Ask parents how meetings should be run and how participation feels safest for them – otherwise there is a risk it is more damaging, albeit non-intentionally.

Reflections

6.24 Reflecting on the response to parents, this review has highlighted that services place undue responsibility on parents to protect their children from abuse without offering the support or information they need to do this. Practitioners need to be sensitive to the shock and trauma that learning of their child's abuse causes parents and need to take this into account in their ongoing work with families. The CSA Centre has published a guide that outlines how practitioners can provide a supportive response for parents and carers whose children have been sexually abused.[154]

154 Parkinson, D (2022) 'Supporting parents and carers: A guide for those working with families affected by child sexual abuse', CSA Centre.

6.25 This was particularly concerning in relation to practitioners not considering the possibility of domestic abuse and how this might impact a parent's capacity to care for and keep their children safe. The Panel's briefing about domestic abuse highlights 4 core principles that should underpin practice approaches when working with children: domestic-abuse informed, trauma-informed, intersectional, and whole family.[155]

6.26 In addition, the lack of attention to parents' needs in relation to their race, ethnicity and culture was striking, with little attention paid to this by practitioners in the reviews we looked at or in our discussions. This meant that practitioners were giving little consideration to the role of racism and discrimination in these parents' lives and how this makes it more difficult for some parents to build trusting relationships with practitioners.

6.27 Many of the reviews also highlighted the lack of a specialist and tailored response when the parent had a learning disability, despite the Equality Act 2010 requiring reasonable adjustments to be made.

6.28 We also saw how parents were not being given guidance and support that would help them keep their children safe or were not listened to when raising concerns or seeking support. There was very little discussion of the need to ensure that parents were properly supported to participate in meetings concerning their child and an over-reliance on the use of working agreements and safety plans that did not take account of parents' own support needs.

6.29 Finally, we were concerned by the lack of support for parents in caring for a child who has been sexually abused.

Implications for practice

6.30 There is a need to improve practitioners' understanding of the dynamics associated with domestic abuse, the parallel risks to children, whether the alleged or known perpetrator is present or not in the family home and, particularly, the need to recognise and explore when parents are being controlled and coerced. This would help to improve the way in which safeguarding practitioners use working agreements to manage contact between family members. These working agreements need to be discussed and negotiated with the parent. They should be a shared document outlining clearly the concerns and expectations of the whole family and the support that will be provided. Too often, they are unclear and focused on telling the parents what to do rather than being collaborative and supportive.

155 Child Safeguarding Practice Review Panel (2022) 'Multi-agency safeguarding and domestic abuse: Panel Briefing 2'.

6.31 In assessing parents' ability to protect their children, practitioners need to be more aware of and responsive to parents' own support needs. In particular, safeguarding practitioners need training and resources that will support them in working with parents with learning disabilities or difficulties.

6.32 Practitioners also need to be more attentive to the needs of parents from Black and other minoritised communities, particularly in recognising and exploring the barriers that some parents may face in accessing support.

6.33 Our findings also emphasise the importance of police keeping parents and carers informed of the progress of their investigations, including the rationale for the outcome of the investigation. In addition, parents and carers should be informed by police when someone in their family environment presents a risk of child sexual abuse, whether or not the person of concern has received a conviction.

6.34 Family courts should also ensure that they do not place unrealistic requirements on mothers to protect children when the court grants contact in the context of concerns about sexual abuse, especially where risks are known.

6.35 Finally, practitioners need to be aware of the crucial role that parents and carers can play in mitigating the impact of the sexual abuse on their child, as research has shown that good support from parents is linked to better long-term outcomes for children.[156] Support for parents from practitioners who are empathetic and knowledgeable about intrafamilial child sexual abuse is highly valued.[157] This highlights, once again, the importance of providing training, effective supervision and support, and resources for all practitioners working with children and families.

156 Scott, S (2023) 'Key messages from research on intra-familial child sexual abuse', CSA Centre.

157 Scott, S (2023) 'Key messages from research on intra-familial child sexual abuse', CSA Centre.

7. Identifying signs, understanding risk and raising concerns

This chapter looks at the challenges for practitioners in identifying signs of intrafamilial child sexual abuse and understanding risk from family members who were known or suspected to pose sexual risk to children. It also explores the barriers that prevent practitioners from raising concerns of intrafamilial child sexual abuse, highlighting a systemic failure across all services to recognise and respond when children are at risk of, or are already, being sexually abused by someone in their family environment.

Identifying signs of intrafamilial child sexual abuse

Our analysis revealed that practitioners often lacked an understanding of intrafamilial child sexual abuse and particularly the signs and indicators that could indicate a child was being sexually abused by someone in their family.

7.1 We saw many situations where practitioners would seek other explanations for symptoms and behaviours in children that could indicate possible sexual abuse without seeking to establish a wider picture of the child and their family circumstances or build a picture of concern about child sexual abuse.

7.2 Practitioners often did not recognise potential signs of sexual abuse that manifested in the child's physical health, such as recurrent urinary tract infections, sexually transmitted infections, genital bleeding or pain. These health needs were often treated in isolation without further exploration of other possible causes or talking to the child about the cause.

7.3 Not recognising the signs of possible sexual abuse was sometimes because practitioners were unaware of information held by other agencies that might have helped them contextualise what they were seeing.

In a review featuring the sexual abuse of a baby, the health visitor was unaware that an adult in the family had downloaded images of child sexual abuse and was therefore not concerned when the mother reported that the child was "grinding the floor" (a form of sexualised behaviour), telling her that this was normal child development.

7.4 We also saw situations where children were being electively home educated – sometimes but not always linked to the COVID-19 pandemic – which meant that these children were not seen routinely by practitioners and signs of the abuse could not be identified, and opportunities to talk to children on their own were not available. This was identified as a key issue in the Panel's review of elective home education.[158]

Ten children in the reviews we studied were known to have become pregnant and at least 6 had gone on to give birth as a result of the sexual abuse.

7.5 In most of these reviews, it was the discovery of the pregnancy or the birth of the baby that had led to the sexual abuse being identified. In several of these reviews, practitioners had previously not seen children on their own and had therefore missed opportunities to establish more about the child's life or identify that they were being sexually abused.

7.6 In the review of the 11-year-old girl with Asian heritage who gave birth, it was noted that she had been seen by a GP 2 weeks earlier, but her pregnancy had not been noticed. Previously, the same child, aged 5, had been seen for genital warts, however a family member had acted as an interpreter for the child and her mother. It was unclear what was then discussed and no further investigation was carried out.

7.7 Another review described how a 17-year-old girl who had been placed in foster care following sexual abuse by her father had subsequently been groomed, sexually abused and made pregnant by the male foster carer. There had been several points when the behaviour of the male foster carer had been identified as problematic, but child sexual abuse had not been considered.

Practitioners did not sufficiently connect changes in children's behaviour with the possibility of child sexual abuse, even when this had previously been a concern.

7.8 For example, no one considered why a child might be going to the back of the queue and covering their head when the person (who was subsequently found to be sexually abusing them) came to pick them up from school.

158 Child Safeguarding Practice Review Panel (2024) 'Safeguarding children in Elective Home Education'.

"I took my son to the doctors as he scrubbed his hands continually which made them extremely sore. I was given E45 soap to help my son with his handwashing. The doctor did not ask any further questions as to the reasons why a young boy would have to wash his hands THAT many times." (Parent in roundtable discussion)

7.9 We saw earlier that not connecting changes in a child's behaviour with the possibility of child sexual abuse was particularly common when children were displaying distressed behaviours, which led practitioners to believe the child had autism or ADHD when it later became clear that the child's behaviour was manifesting the trauma caused by the abuse.

7.10 There were times when practitioners had not noticed signs of concern in children's behaviour, for example pre-adolescent children who had accessed adult sex chatrooms or sought emergency contraception without this being understood as a potential indicator of sexual abuse and without sufficient exploration of what this behaviour meant.

Assumptions and bias could deflect practitioners from recognising signs of child sexual abuse.

7.11 In some reviews, it seemed that practitioners had not considered the possibility of child sexual abuse when the sex of the potential victim or person of concern was less commonly identified with that group. Practitioners appeared particularly reluctant to consider that women might sexually abuse a child and were unclear about how to assess and respond to this.

The professionals involved did not consider the unthinkable – that the children's mother may be actively involved in allowing her father access to children for the purpose of abusing them. (LCSPR)

Bias was seen in one of the discussion groups where the adult children of a foster carer who had sexually abused a fostered child were seen as people who could vouch for him because they were "of good character and could be relied upon", against the word of the looked after child. This was given as one factor as to why the case was not pursued for prosecution. In this same example, police had previously dropped concerns they had about a man reported to be watching school children from his car when they discovered that he was a foster carer.

A lack of understanding of 'grooming' behaviours and/or the influence of coercive control also meant that practitioners did not identify that someone might be sexually abusing a child.

7.12 Some reviews revealed how practitioners had not understood or considered the influence of the person abusing the child on those around them. For example, practitioners had not considered the possibility that a mother with a learning disability and a history of being domestically abused by former partners and family members might be being coerced by her partner. When concerns were raised about her partner, a child protection enquiry was completed but this did not consider the mother's vulnerabilities or the role that her partner was playing in her life, leaving her and her child at ongoing risk.

7.13 Commonly, having a narrow focus on the presenting incident had prevented practitioners in many of these reviews from seeing child sexual abuse. There was a tendency to respond to issues in isolation rather than seeing the wider context or triangulating information from the chronology of concerns and interventions.

Quality of risk assessment for sexual offending

Our analysis found that over a third of reviews featured a family member with a known history of sexual offending or who was known to present some risk of sexual harm. However, practitioners appeared to lack knowledge and resources to support them in discovering and then understanding how a history of sexual violence or child sexual abuse offending might translate into risk for children in the family environment.

7.14 We saw reviews that featured convicted sex offenders and family members who had been previously prosecuted for sexual abuse, including rape of family members, moving into a home with young children without a risk assessment or an effective safeguarding response being put in place.

7.15 Similarly, there were situations where offenders had been released from prison without any requirement for ongoing contact with the Probation Service. When strategy discussions were held regarding the children of these individuals, the Probation Service was not asked to participate, and the discussion therefore lacked the insight that they could have brought regarding the risk presented by these individuals. Although the Probation Service may not currently be involved with the individual, they have expertise and historical knowledge/information which would be helpful for risk assessment and planning.

In another review, a parent with young children was known to have asked for information about a new partner under the Child Sex Offender Disclosure Scheme without this triggering any further safeguarding activity or curiosity about why and what this meant for her and her children.

7.16 Similarly, we saw situations where concerns raised by family members or members of the public about people posing a risk of harm to children who they had contact with had not been thoroughly investigated. This concern has been picked up in other national reviews, including that into the murders of Arthur Labinjo-Hughes and Star Hobson.[159]

7.17 It was clear that the assessment of risk posed by adults had been routinely undertaken by practitioners without sufficient training, knowledge or expertise and using tools not specifically designed for assessing sexual risk, with different terminology, thresholds and classifications. Consequently, what one agency might give as a medium risk classification could be a high risk in another agency's assessment. This led to an inconsistent response and provided an inaccurate picture of the risks posed to children.

7.18 There were reviews where the police were described as not 'sufficiently probing' when concerns of child sexual abuse had been raised and had not identified or shared information about known risk with children's social care, even when this indicated recent concerns about an adult family member's sexual offending.

In one review, the head teacher from the children's school had contacted their local police force using the provisions in the Child Sexual Offender Disclosure Scheme to establish whether the child's mother's partner posed a risk of sexual harm. However, the police did not extend their search to the national systems available which meant a previous sexual abuse conviction was not flagged and the children not effectively safeguarded.

7.19 In contrast, the difference made when prison staff and probation were able to share relevant information was highlighted in one review:

The presence at this meeting of probation and the prison offender manager … and the information they shared ensured that the risk grandfather posed, and the control he continued to have, even from prison, was recognised as significant. (LCSPR)

159 The Child Safeguarding Practice Review Panel (2022) 'Child Protection in England: National review into the murders of Arthur Labinjo-Hughes and Star Hobson'.

7.20 In some reviews, adults who had been investigated for or convicted of a sexual offence against another adult were not perceived as presenting any potential risk to children, based on a perception that offences against adults do not translate into offences against children. Adults with less recent concerns or sexual offences were particularly unlikely to be identified as posing a risk to children in their family environment. Sometimes this was because they were not known about, as it had not been considered necessary to check back beyond recent years, even where a residence order was involved.

7.21 In our sample evidence, there were weaknesses in assessments for kinship care. Three looked-after siblings were placed by the family court with step-grandparents under a special guardianship order, despite a negative assessment of the local authority, which only met with the step-grandmother. After the step-grandmother died, they remained with their step-grandfather as sole foster carer, without re-assessment, and the 2 girls later reported he had gone on to sexually abuse them for many years.

Practitioners made assumptions about adults who had sexually offended against children. In one review, practitioners did not consider that a family member, who was known to have accessed images of child sexual abuse online, posed any risk to their own children on the basis that the images they had accessed were of children of a different sex or age.

Where child and family assessments did take place, we found that these often lacked depth, did not focus sufficiently on sexual abuse and were not informed by contributions from the multi-agency network. It was particularly striking that those who knew the children best were often not invited to contribute, or practitioners' views were disregarded when these differed from those of the assessing social worker.

7.22 When specialist assessments were commissioned, the implications of these assessments were not always well understood by other practitioners with less knowledge of sexual offending.

A specialist assessment was commissioned to understand a mother's ability to protect her child from the potential risk presented by her partner about whom there were concerns regarding sexual abuse. The assessment mistakenly focused on the sexual risk that the mother herself might pose and when she was assessed as being low risk, this was taken to mean that she was able to protect her child from the adult of concern. The fact that this had not been assessed was not noticed.

7.23 Furthermore, we saw practitioners relying on outdated risk assessments, without appreciating that risk is dynamic and needs regular review.

> **Although no further action was taken by the police due to lack of evidence, the child protection case conference did not raise the need for an updated risk assessment to be undertaken of the father and also the mother to look at her ability to protect. (LCSPR)**

7.24 A narrow focus prevented a thorough assessment of the child's situation and the potential risks they were facing. We saw examples of multiple child and family assessments being carried out which did not take account of previous history of concerns related to the child or family. Each incident of concern was treated in isolation.

One review featured a child who had been subject to 8 assessments over a 9-year period. These started with concerns around neglect, but by the second assessment it was known that the child's stepfather had a conviction for sexual offences. However, information about these offences was not sought and the stepfather agreed to move out of the home permanently. Further assessments were initiated by referrals from friends and neighbours expressing concern that the child continued to have contact with this man, including spending time overnight in his home. Each incident was explored, and reassurance that the friends and neighbours were mistaken was accepted. It was only when the child herself reported that she had been sexually abused by this man for many years that action was taken.

7.25 We found practitioners were confused about the need for parental consent in the context of child in need and family assessments. A number of reviews described how parents had been asked to consent to an assessment of need and where this parental consent was not given, no assessment was undertaken – apparently in the belief that securing this consent was a legal requirement. This left practitioners without an understanding of children's circumstances and the children without any ongoing intervention or support.

A child was found to be living in the home of his mother's large extended family. Many of the adults in the home had known histories of concerns around harmful sexual behaviours as children and sexual harm as adults. The strategy discussion concluded that the child had been neglected and had witnessed inappropriate behaviour which was manifesting in his behaviour at home and school. The parents declined to give consent for an assessment of the child's needs and circumstances to go ahead. Rather than working authoritatively and challenging parents, children's social care made a referral to early help which focused on finding the family their own accommodation, rather than on addressing concerns about abuse.

7.26 Where assessments took place involving parents who did not have English as their first language, the identification of signs of potential abuse and exploration of the family circumstances were sometimes hampered by the lack of an appropriate translator or interpreter. There were reviews which described how, for example, the person who was abusing the child had been included in discussions because they spoke English more fluently than other family members.

7.27 Child and family assessments did not sufficiently analyse signs and indicators of child sexual abuse, despite this often being the impetus for them taking place. In one review, the school had reported to the social worker that a 5-year-old was exhibiting highly concerning sexualised behaviours. They provided records of the inappropriate language, drawings and behaviours displayed by this child, however the assessment concluded that there were no safeguarding concerns, and the referral was closed down with parents being provided with 'Keep Safe' information. The school's knowledge of the child was disregarded, leaving the school feeling de-skilled and that their concerns had been dismissed.

We also found that child and family assessments often did not focus on the adult about whom there were concerns of possible sexual abuse, even when the child had reported being sexually abused.

7.28 One review featured a child who said that her father had sexually abused her. The father was contacted and denied this was the case. The police concluded there was insufficient evidence to take forward an investigation, and it was agreed that a child and family assessment should be undertaken because the child was regularly missing from home and described as "poorly behaved" when in school. There was no exploration of family history, or the history of the father which would have shown allegations of sexual abuse in another family many years earlier. The child and family assessment focused on the child's behaviour and parenting by a single mother, and concluded there was no need for child in need services. An early help plan was proposed and declined by the mother. The child received no support or services.

We found that there was often a poor understanding of the whole family or what constituted family within an assessment. For example, our analysis of reviews revealed very little evidence of genograms and/or ecograms being used and shared with the agencies involved to consider children's relationships with their extended family members.

> **Agencies were not aware of the full family makeup, or at what point family members were on various plans or interventions. (LCSPR)**

We also noted that responding to concerns of sexual abuse appeared to be particularly challenging when physical abuse, neglect and/or domestic abuse were known to be occurring. Instead, practitioners tended to focus on addressing other forms of abuse, with the concerns of sexual abuse becoming lost from sight.

7.29 One review featured a sibling group of 4 children who had been subject to child protection planning for 2 years for neglect and concerns about domestic abuse. Concerns had emerged about an 11-year-old sharing sexualised images at school and another child aged 7 displaying significant sexualised behaviour. The existing child and family assessment was refreshed and focused on neglect and emerging concerns about physical abuse. The concerns about sexual abuse were subsumed under the complexity of the neglect and therefore not responded to. Instead, it was recommended that the mother attend parenting classes.

7.30 In another review featuring 6 children, there were concerns from school about sexualised behaviours for the children who had recently joined the school. Information was not sought from the 3 previous local authorities where the children had lived. This would have provided information about each area seeking care proceedings because of concerns about sexual abuse and neglect. This meant the assessment focused narrowly on the presenting issue and concluded that the children all had undiagnosed neurodiversity concerns. The conclusion was an urgent referral to the community paediatric service, and the concerns about significant sexualised behaviour were dismissed as being caused by neurodivergence and therefore not addressed.

There were a number of reviews where families had moved across local authority boundaries and new concerns had arisen in the area where they were now living. The assessment focused on the new concerns. Social workers undertaking the assessment did not seek information on previous concerns about the child's wellbeing and the circumstances of the child were therefore not understood.

We also saw family court decisions around child contact and residence arrangements which had taken insufficient account of the known history of sexual risk presented by the parent.

7.31 Several reviews described how the family court had granted fathers with a known sexual offending history the right to see their children through private law decisions without proper consideration of the risk that this might pose for the child.

7.32 Among this group, there were 4 reviews where the person found to have committed the intrafamilial sexual abuse that triggered the serious incident notification had been previously convicted of similar crimes. Family court private law proceedings had nonetheless later removed them from their mother's care and placed them with him. The information about their past records was not known to the court at the point that these crucial decisions were made – despite the fact police held this information.

7.33 We saw 6 situations where key information did not appear to have been sought by or provided to the family court. This included convictions that dated from some years previously and an impending prosecution. In other situations, no searches at all were reported to the court. Cases brought to the family court provide potential opportunities to protect children, but in these cases this did not happen.

7.34 One father had been convicted of sexually abusing the child's mother when she was underage herself, and a looked after child. He was cautioned and put on the Sex Offenders Register for 2 years. They had 2 daughters. He eventually sought and gained sole residency of the children and excluded the vulnerable mother entirely from their lives. Practitioners focused on the mother's 'abandonment' of the children to explain the distress they displayed through their behaviour. The court did not seek information in such a way as to discover his previous conviction which, it seemed, had become "vague and unclear" in local practitioners' minds. He went on to sexually abuse the girls for a number of years.

7.35 In another review, a mother had applied for a child arrangements order in order to formalise contact with her oldest child's father, but when she was told that a safeguarding assessment would be needed, she dropped her request.[160] She presumably knew that her current partner had a case outstanding against him for child abuse images. Again, an opportunity for practitioners to be curious and seek to protect children was missed. Images emerged later of sexual abuse of a two-year-old child and the man was sentenced to 15 years' imprisonment.

160 A 'child arrangements order' decides where a child will live, when the child will spend time with each parent, and when and what other types of contact take place. 'Child arrangements orders' replace 'residence orders' and 'contact orders'.

In one review, the man who sexually abused the child had previously served a custodial sentence for 4 counts of sexual abuse of boys. The mother had conceived the girl at the centre of concerns when aged 16 with a different man and then had 3 more children with the man who later abused her. When he sought sole custody of the 4 children through private law proceedings, the court ordered a Section 7 report, which seems not to have been informed of this man's record.[161] The case came to light when the eldest girl reported her pregnancy, and DNA was collected.

When the concerns related to a child's sibling, practitioners appeared to lack guidance and support in assessing and managing the risk.

7.36 For example, a sibling with a previous conviction for child sexual abuse was not supervised by probation under MAPPA, but was looked at as a potentially dangerous person, which meant that probation had no powers to play a role in managing the risk they posed and continued to present.

7.37 In another review, it seemed that the sibling sexual abuse might never have come to light if the child who had caused the harm had not told a practitioner what they had done. Practitioners had not considered the child's sexual thoughts and behaviours as problematic or harmful and had respected the parents' wishes to keep matters within the family, leaving the sibling to be abused for many years.

Reflections

7.38 The evidence we have seen in this review suggests that practitioners across all agencies are not routinely identifying and acting on signs of sexual abuse. This is due, primarily, to a lack of training and resources that support and empower them to recognise and respond to signs (both in the child and the adults around them) that a child may be being sexually abused by someone in their family environment.

7.39 The inability to identify children who were being sexually abused was particularly concerning when the abuse resulted in a pregnancy. Very little is known about the prevalence of, response to and impact of pregnancy resulting from intrafamilial child sexual abuse. Yet the lifelong impact on girls who become pregnant by a family member, on the children born from these pregnancies (when they go to completion), and on the family surrounding the girl is incalculable.

161 Section 7 reports (Children's Act, 1989) relate to private law proceedings when the court is wanting information about a child's welfare to determine what course of action will be best for the child.

7.40 Not noticing and acting on signs that a child might be at risk was particularly concerning where there was a known history of sexual offending by a family member. Yet in many of these cases this information had not been shared with those responsible for taking decisions about a child in this person's family.

7.41 Practitioners were also confused about the need for parental consent for intervening. While best practice, in accordance with the statutory guidance, is to work in partnership with parents and carers as far as possible, fears about sharing information should not stand in the way of safeguarding and promoting the welfare of children, particularly where a child is suffering or is at risk of suffering significant harm.[162]

7.42 There is also insufficient collaboration and information-sharing between children's social care, and both police and probation, who may hold relevant information on sexual offending. This means that concerns relating to adults who pose a risk of sexual harm are not always shared and effectively assessed, leaving children exposed to ongoing sexual harm. This issue of not joining up information relating to a child at risk of harm is a continuous theme in many previous reports by the Panel.[163]

7.43 The need to develop professional skills and knowledge about sexual offending (including abuse committed online) has not been consistently prioritised by LSCPs, meaning that investigations and assessments into concerns of sexual harm are not aways informed by knowledge, research or evidence. Therefore, even when information is shared appropriately, practitioners are often unable to make sense of it.

7.44 Equally, we have seen how a focus on other harms, such as neglect, may lead to failure to recognise or respond to the sexual abuse. For example, a mother may be required to attend a parenting course, with no concurrent enquiry or assessment into possible suspects of sexual harm.

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162 Practitioners should be aware of the UK GDPR legal basis for sharing personal information. It is not necessary to seek consent in the case of children in need or at risk of significant harm provided there is another lawful bases for sharing information under UK GDPR. If sharing information is likely to assist in safeguarding and promoting the welfare of a child, then information is likely to be shared without consent. See: Working together to safeguard children 2023: Statutory guidance (paragraphs 28-33); Information Commissioner's Office 'A guide to lawful basis'.

163 See, for example, the Child Safeguarding Practice Review Panel's 'Annual Report 2022/23: Patterns in practice, key messages and 2023/24 work programme report'; and the report published in 2022: 'Child Protection in England: National review into the murders of Arthur Labinjo-Hughes and Star Hobson'.

7.45 We also noted the siloed nature of assessments, with information not being shared across agencies, and each new incident being treated as unique rather than as part of a wider picture. Similarly, practitioners did not always have or seek access to relevant information when families had moved across local authority areas.

7.46 In addition, child and family assessments often lacked depth, did not focus sufficiently on sexual abuse or on the person suspected of abusing the child, and were not informed by contributions from the multi-agency network, including those with relevant knowledge of the child or their family. This is despite 'Working Together' (2023) making clear that:

> "Assessments should be multi-agency and multi-disciplinary, based on information gathered from relevant practitioners and agencies, and drawing in the relevant expertise."[164]

7.47 We were also particularly concerned about some of the family court decisions described in reviews – in both public and private law proceedings – where a lack of recognition of the risk presented by a parent or carer had resulted in children being placed with or having unsupervised contact with the person who was abusing them. It appeared that courts had at times failed to understand risks they had information about. At other times, there had been inadequate investigation of the history of those concerned through the commissioning of Section 7 reports, leaving children at risk of further harm.

7.48 Finally, despite this report highlighting multiple challenges in practitioners' identifying and raising concerns of child sexual abuse, the review has not identified evidence indicating that mandatory reporting would have benefitted children in these situations. As we have seen, the barriers to practitioners identifying and raising concerns arise primarily from a lack of understanding around child sexual abuse and a reliance on children to tell. Both are more effectively addressed through training, professional development and effective supervision and support.

164 Department for Education (2023) 'Working Together to Safeguard Children: A guide to multi-agency working to help, protect and promote the welfare of children', page 86.

Implications for practice

7.49 Improving initial identification requires that practitioners across all services are clear about the signs and indicators that a child may be being sexually abused by someone in their family environment. This is also important throughout any multi-agency response, as multiple confused ideas can prevent action being taken.

7.50 This section also highlights the importance of multi-agency working, drawing on the expertise of all practitioners, particularly those who know the child well and who have a comprehensive and clear picture of their needs. Others can bring essential expertise through their professional role, such as understanding health or development concerns, disability, the cultural context, or the dynamics of sexual offending. A whole picture of the child and their family is needed. This could include the use of ecomaps, culturagrams and genograms to better understand those around the child and the family history and dynamics.[165]

7.51 Service provision needs to be enhanced to ensure that sexually abused children have access to local health services that meet their needs. This includes universal health services being able to identify that a child may be being sexually abused and making appropriate referrals for investigation of these concerns, and specific local pathways with understood thresholds for specialist health assessments (of both recent and non-recent sexual abuse). Some children also require ongoing specialist therapeutic mental health support. In our sample, there was late identification of pregnancies resulting from intrafamilial child sexual abuse, particularly in children aged 12 and under.

7.52 Assessing risk of sexual harm to children involves consideration of everyone in the family environment – which could mean multiple households, where extended family is strongly interlinked. Practitioners should therefore be equipped with the necessary knowledge, and be able to access and make use of appropriate tools for assessing both risk and ability to protect. These latter assessments need to take account of concerns about domestic abuse, coercive control, previous child sexual abuse or other vulnerabilities, ethnicity and culture, the need for translators or interpreters, and any practical barriers to safeguarding children, among other factors.

165 Ecomaps, culturagrams and genograms are family assessment tools that are used to collect information with biological mothers, biological fathers, children, the kinship caregiver, other members of the kinship network, and/or the entire extended family as a whole.

7.53 It is also important that practitioners understand how stereotypes and assumptions around both victims and those who harm may impact on their ability to recognise signs of intrafamilial child sexual abuse. This highlights the need for practitioners to be supported in their work through good supervision, with time and space to reflect on this emotionally challenging and often uncomfortable area of practice.

7.54 It appeared that practitioners preparing Section 7 reports did not systematically investigate the backgrounds of the parties, nor routinely seek information on previous convictions. Considering that only 11% of cases reported to the police see criminal proceedings pursued, it is also essential that previous concerns or investigations are included.[166] This highlights the need for the findings of this review to be considered by the President of the Family Division and the Family Justice Board to determine what actions may be needed to support judicial decision making.

166 Karsna, K and Bromley, P (2024) 'Child sexual abuse in 2022/23: Trends in official data', CSA Centre.

8. Responding to concerns of intrafamilial child sexual abuse

This chapter looks at issues in practice around responding to concerns of intrafamilial child sexual abuse. It describes how, once concerns have been raised, there is often a lack of thorough investigation and effective action to safeguard and support children. This is partly due to inadequate multi-agency co-operation, exploration and sharing of concerns but also stems from confusion around thresholds and the way in which the incorrect use of criminal justice standards of proof prevents practitioners from taking effective action to safeguard and support children.

Exploration and recording of concerns

We noted confusion and uncertainty among practitioners in exploring concerns around the sexual abuse of children and in recording these concerns. This often meant that the concerns of child sexual abuse got lost and the subsequent involvement of practitioners did not take account of these previous concerns when fresh concerns of sexual abuse emerged.

8.1 We were concerned by an over-reliance on general health practitioners, including school nurses, GPs and non-specialist hospital clinicians, rather than those trained to undertake child protection medical assessments, to provide an assessment of concerns in the context of child sexual abuse. For example, social workers had sometimes relied on a GP's view, rather than referring the child for a child protection medical assessment undertaken by a specialist paediatrician. This included a child with abdominal pain and discharge who was already on a child protection plan for neglect.

8.2 Reviews revealed fundamental confusion around which health colleagues should be consulted and for what purpose, with some children receiving multiple health assessments to investigate health concerns relating to neglect and sexual abuse separately.

8.3 In another instance, a collective decision had been taken by multi-agency practitioners to record concerns as emotional abuse, despite clear evidence presented by the social worker who had urged other practitioners to record the concerns as child sexual abuse.

Evidential thresholds

Referrals were often rejected as not meeting the threshold for action because there was felt to be a lack of sufficient evidence of the abuse. It seemed that practitioners felt that the criminal justice standard of proof (beyond reasonable doubt) was needed to take action, rather than applying the safeguarding threshold where the 'balance of probabilities' should be used to determine what action is needed.

8.4 Even when there was a verbal report of sexual abuse, there appeared to be a perception that the evidence needed for concerns to be pursued required more than a child's report.

For example, a 12-year-old child had told a teacher that she had been sexually abused by her father. The father denied this was the case and said that they had argued, and the child was making the story up because of this. The child said she was too scared to complete an ABE or VRI interview and did not want to have a medical examination. The police concluded that they could take no action because of a lack of evidence.

8.5 In relation to other situations, without a clear verbal report from the child, practitioners concluded they did not have strong enough evidence of sexual abuse and that it would therefore be inappropriate to record this or share their concerns with other practitioners. This was illustrated in one discussion with practitioners involved in the review of a child who had been sexually abused by her father for multiple years, who had repeatedly attempted to tell practitioners that something was wrong, where a practitioner reflected on how not being heard must have felt for the child:

"The most powerful thing that I'm feeling is how awful it must have been for the child to repeatedly tell people these little bits, that to us felt like little bits, but probably to them felt like massive disclosures, and they might have been testing what would happen and nothing happened. And they got left in the same circumstance, and I think then their ability to pursue wanting things to be different for them got less and less. And I can only try and imagine what that must have felt like. I think it must have been horrendous." (Practitioner in reflective discussion)

8.6 Many of the practitioners we talked to in our discussions recognised that they felt less reluctant to record concerns of other kinds of harm such as neglect. When this was explored further, the focus was on the issue of "a lack of evidence" or what constituted sufficient evidence. One practitioner asked, "How can we record it if we don't have the evidence?"

> The brother of a 7-year-old child told a social worker that his sister was being sexually abused by her father and the whole family was ignoring it. Police and child protection enquiries were initiated. The family reported that both children had misunderstood the actions of the father. It was noted the brother had learning disabilities and this had caused the confusion. The 7-year-old confirmed she had been sexually abused by her father and 2 uncles however the adults denied what she had said. The 7-year-old was interviewed, but the police decided the ABE or VRI interview did not provide enough evidence and closed their investigation, with no further action taken by any other agencies.

8.7 We saw repeatedly that when the police had decided to take no further action, children's social care considered this meant that the child had not been sexually abused, and without evidence of other harm decided the threshold for any action was not met. This in turn resulted in other practitioners believing that children had not been sexually abused and that there were therefore no safeguarding concerns or other action needed. This meant that support was not provided to children who had indicated concerns, and further signs of abuse were then missed. This was particularly striking when further referrals to children's social care resulting from new concerns about sexual abuse of a child were discounted on the basis that a recent child and family assessment had been completed and found no concerns.

8.8 A child whose mother reported that she was being made to sleep in bed with her father and his new partner and who had a rash in her genital area was deemed too young to be able to give evidence, and the police decision to close the investigation meant that child protection proceedings were also concluded with no further action. Despite making further attempts to report the abuse as she grew older and further referrals to the police and social care, the abuse continued until the child was 14 years old and was discovered holding a knife at school and threatening to harm herself.

In our discussions with practitioners, we heard from education practitioners particularly, as well as other practitioners in the wider safeguarding network, about their frustration that their concerns relating to child sexual abuse were not always taken forwards. Some then felt there was nothing more they could do, not realising that the social care decision to take no further action could be challenged.

8.9 We also found that police investigations sometimes shaped the practice of other agencies in unhelpful ways. In situations where criminal justice proceedings had been halted due to the 'beyond reasonable doubt' evidential threshold not being reached, practitioners in other agencies then applied the same threshold to their own assessment of the safeguarding needs of the child. In addition, a lack of further police action meant that steps were not taken to disrupt the abuse, such as through the use of civil orders which might have presented an opportunity to stop the abuse.

In one review, where a child had told practitioners they had been sexually abused by someone in their family, the police had (incorrectly) told all agencies that they could not speak to the child about the sexual abuse until the police investigation was completed. This continued for a period of 14 months and meant that the school, social worker and the allocated family support worker did not acknowledge what had happened to the child or address their support needs.

The importance of information-sharing

Where referrals were accepted, agencies were often not informed of the outcome of their referral and did not know whether strategy discussions had been convened. Key information was also not shared between agencies.

8.10 There were occasions where no information was shared with the multi-agency group, and practitioners assumed that the concerns they had raised had been responded to. Not having sight of at least a summary of the child and family assessment meant these agencies were working without a knowledge of the history or family context and the focus became the child's behaviour, rather than harm they may have suffered. Without the assessment and the information and analysis which had informed the decision making, it was hard for agencies to challenge what was often a lack of investigation, services and support going forward.

8.11 We also found there were times when police investigations and child protection enquiries happened completely separately, without either process informing the other and with a lack of clarity around what information should be shared.

In one review, a father was found to have downloaded indecent images of children. However, the police had decided that he posed no risk to children as he had reportedly left the family home and the mother was believed to be ensuring that the children had no contact with their father. The police did not share information about discovery of the indecent images of children with children's social care and no strategy discussion was convened. This meant that practitioners did not have any opportunity to assess the children's safety. It was later found that the father was living at home and that the mother had not been able to prevent the children from being sexually abused by him.

8.12 There was often a rigid attitude towards the way in which a child's report of sexual abuse was understood. Practitioners sometimes appeared to assume that, unless a child agreed to undertake an ABE or VRI interview, what they had said in other contexts was not 'evidence'. Therefore, verbal reports by a child in ordinary contexts like school or home were disregarded.

There were other examples illustrating confusion around whether the police could share transcripts of ABE or VRI interviews with the wider safeguarding network.[167] This meant that, in many instances, the only feedback given to social workers or other practitioners about the ABE or VRI interview was that the child had not made a report of harm or that there was not enough evidence that the child had been harmed.

167 This information cannot be shared during a live investigation, but once over, and particularly where no further action is taken, they contain information which can critically enhance an understanding of a child's circumstances going forward and assist in protecting them. The guidance in 'Working Together' (2023) says that, "The police should…. make available to other practitioners any other relevant information gathered or known to inform discussions about the child's welfare." (HM Government, 2024, page 86).

8.13 Similarly, when child and family assessments were completed, there was significant confusion about whether they should be shared with members of the multi-agency group who were working with the child or their family. In some situations, an outcome that no further action was necessary was shared, suggesting no ongoing concerns. This often led to agencies such as schools continuing to respond to the child's presenting behaviour as supportively as they could as they remained concerned, but not feeling they had a legitimate role to do so.

8.14 There were reviews featuring sexual abuse by multiple perpetrators and where multiple children were suspected to have been harmed, where complex safeguarding strategy discussions, as indicated in 'Working Together' (2023) were not held. These would have been particularly valuable in allowing practitioners to share information about the different children and perpetrators involved.

Collaborative working

Practitioners were not always clear about the need for joint working, meaning that the right practitioners were not always invited to strategy discussions or involved in investigations which often then concluded that there was no need for further action.

8.15 In some reviews, we found that practitioners were not clear about the need for joint social work and /police child protection enquiries, despite there being strong evidence for criminal investigations as well as child protection enquiries to establish risk and safety for the children in line with 'Working Together' (2023). The confusion about what joint enquiries meant was articulated by one of the practitioners in our reflective discussions who commented that, "Police tend to lead the investigation without any involvement of children's social care."

8.16 There were also times when police acted on concerns before discussing these with children's social care or holding a strategy discussion, which then undermined the assessment of risk. In one situation, a child reported that he had been sexually abused by his older brother. This was shared by the school with the police and children's social care. However, there was a delay in the strategy discussion being convened and the police visited the child and conducted an interview without children's social care and without any joint planning taking place. The subsequent confusion resulted in the child being asked to repeat the interview as part of joint police and child protection enquiries, which he refused to do on the basis that he had already provided a witness statement. At this point, the joint enquiries faltered and ultimately led to no further action from the police.

Different working arrangements also made short-term crisis work difficult to accommodate. For example, the scheduling of strategy discussions often failed to take account of health colleagues' clinical duties or education colleagues' work patterns. Specialist health colleagues were very often not invited to strategy discussions.

8.17 As such, we saw a number of reviews where key meetings had happened during school holidays and specialist safeguarding education colleagues had not been included and their views had not been represented in the meetings. Their perspectives would sometimes have meant that child protection plans were maintained rather than stepped down.

The impact of drift and delay

There was considerable evidence of multiple assessments being completed about the same concerns over many years, each undertaken in isolation from the previous one, not drawing on history or building a picture of cumulative concerns.

8.18 As a result of all these issues, we saw significant drift and delay occurring in the majority of the reviews we looked at. This is illustrated by the following example based on our interview with one of the children whose situation had been subject to a local review.

Suzie first said she had been sexually abused by a peer in the community as she felt this was the only way of alerting others she was being sexually abused by her father. This led to a police investigation which took 6 months. She did not know when this ended or why it ended without any action. She was subject to a child in need assessment which took 5 months. This focused on self-harm and challenges with adolescence and she was not asked any questions about her home life. At the end of the assessment, her parents said they did not need support and she did not know what to say. The assessment was closed down without any support in place for Suzie.

Suzie then started to go missing and continued self-harming. She was on the waiting list for CAMHS services. Suzie then decided she needed to tell her college tutor that her father was touching her inappropriately. This led to a further police investigation and child protection enquiry which both took 6 months to complete without any ongoing support for the child. During this time, Suzie remained at home, having been re-referred to CAMHS and for specialist counselling. It was only when she was admitted to emergency departments for self-harm that these referrals were expedited. However, CAMHS decided they could not offer her a service as she was deemed too unstable. Suzie remained on the waiting list for specialist counselling for another 6 months until she was eventually hospitalised following an attempt to take her own life.

8.19 In some reviews, a lack of robust supervision and managerial oversight was highlighted, despite its importance in this particularly challenging area of practice, which is so often fraught with uncertainty and susceptible to denial and silence.

8.20 Finally, practitioners in our discussions highlighted the significant length of criminal justice processes, and the impact this has on children and their families.

Opportunities and interventions to address offending thoughts and behaviour

Our interviews with 5 people who had sexually abused a child in their family revealed the impact of trauma and a lack of opportunities and interventions throughout their lives to address this.

8.21 Four of the 5 people we interviewed described the impact of living with unresolved trauma linked to their childhood experiences – 3 talked explicitly about having been sexually abused as a child.

> **"I was scared to talk about it… I started to blank it all out…what he did to me. He probably turned me into what I was. Because of him I did what I did, because that urge has been there for all those years. I managed to control it all, but you know sometimes it can get too bad and you can't."**

8.22 He said his only opportunity, as a child, to tell someone that his father was sexually abusing him was when a social worker had talked to him. But they had done this in front of his father, and he had therefore denied anything was wrong.

> **"I've always wanted to tell someone about it [their own abuse] but… if I did, was he then going to go and hurt somebody else?"**

8.23 When asked to reflect on what might have led them to sexually offend, 3 interviewees indicated that being able to tell someone about their own abuse would have helped them get help:

> **"I wish I had spoken up about what happened beforehand because if I did, I reckon it wouldn't have happened, you know, if I was to speak about what happened to me and the urges I have, but controlling them, I could have got more help than what I did."**

Our interviews also revealed a lack of opportunities available to address sexual offending thoughts and behaviour.

8.24 One interviewee who had been arrested twice in connection with indecent images of children, said that he had been released from custody and was able to return to his family, with access to children:

> **"When I got arrested, the first thing I would have thought is that someone from social services would have come round. That's just logical. A guy's been done for that, living with a 6-year-old…I was expecting someone to knock on the door, or to phone us. But nothing, just crack on with life, get on as normal. You think that when you're put on bail there would be stricter procedures. All they said is I couldn't be unsupervised or sleep in the family home. OK. But I spent all day with my [now] ex-partner."**

8.25 Another interviewee, whose previous husband had been convicted for similar offences, felt that his arrest should have been a "huge red flag" for services to support her in protecting herself and her children. She described how she had had a family support worker who she trusted and who, she felt, might have been able to intervene.

8.26 Knowing where they could go to speak about their feelings might have helped prevent some of those we interviewed from further offending:

> **"You need people out there where people can go and talk… If there's nobody there for you to talk to, you're just dealing with your demons on your own."**

Reflecting on what would help reduce the risk of re-offending, interviewees highlighted unmet needs for support to address the impact of their childhood trauma.

8.27 Four interviewees told the researchers that they had not spoken to anyone before the interview about their own sexual abuse or sexual offending. One said to the researcher:

> **"You're the first person who's asked me about anything and I've been in prison for over 2 years. Every 6 months I get this thing that says [name] hasn't lowered his risks or addressed his offending behaviour. Well, how? Nobody has spoken to me."**

8.28 Two people wanted help with substance or alcohol misuse, and others suggested they would benefit from help with relationship skills, problem solving or thinking as well as more practical issues such as housing and employment.

8.29 One person felt more could be done specifically to tackle his sexual re-offending. He said that he had previously completed a sex offender programme but described this as "a quick one" at the end of his sentence which had not prepared him for release.

8.30 Another was aware that he would be able to access a programme before he was released but did not know when this would be, due to resource limitations. He also said he knew of people who had served their sentence and been released without any opportunity to discuss their offending:

> **"There's Horizon in here for sex offenders but a lot of people have been told that they might not fit it in before they get released… They are let out with no support, no programmes, and I think they're going to do it again."**

8.31 Several interviewees also described fears about their own release from prison and one interviewee felt there should be some post-release support in place which might reduce re-offending in the future:

> **"Somewhere on my system it must say something about alcohol problems… If something like that comes up, make it mandatory that someone from alcohol/drugs anonymous comes to speak to that person because it's obviously a part of their offending. Perhaps make that or an alcohol tag part of their condition when they're released."**

8.32 In addition, 2 interviewees highlighted the need to provide opportunities for people at risk of offending to seek help and information on where to go for help.

> **"It's not widely known out there that if you need support…there is nobody to talk to that I know of that is safe to talk about it. It's only when it's happened and it's too late when the support or help is there. There's no advertisements. I get society wants to keep things quiet but there needs to be something out there…that there is an alternative route before offending or re-offending."**

8.33 Similarly, in one of the reviews we considered, it was documented that, following his discharge from prison, following completion of a sentence for sexually abusing his stepsiblings, the individual (who had gone onto sexually abuse further children) had stated to professionals that he continued to be attracted to children and might abuse again. He had reportedly asked for therapeutic support, but this did not appear to have taken place.

Reflections

8.34 Above all, we noted confusion and uncertainty among practitioners in how to explore the sexual abuse of children by someone in their family environment and how to record these concerns. This seemed to be based on misconceptions around what constitutes sufficient evidence to act, resulting in a collective silence and paralysis and leaving children neither safeguarded nor supported.

8.35 This meant that practitioners appeared to have lost confidence in their professional judgment, something which was particularly significant among those who did not have routine safeguarding supervision.

8.36 We also saw a lack of robust supervision and managerial oversight, leaving practitioners lacking confidence in organisational support to take action. Good supervision is crucial in providing practitioners with emotional support as well as time and space to reflect on practice and work through uncertainties. Robust managerial oversight should ensure the pace is not lost when responding to concerns of intrafamilial child sexual abuse.

8.37 Throughout the review, we saw practitioners using the criminal standard of proof (which requires evidence 'beyond reasonable doubt') as the threshold for assessing whether a safeguarding response was required including in pre-proceedings and the family courts, instead of the safeguarding threshold of 'balance of probabilities' which includes an evaluation of likely or actual significant harm.[168]

8.38 As a result, referrals were either not made or were rejected on the basis that they did not meet the threshold for action, and investigations which resulted in no further police action led to all agencies ceasing their involvement.

8.39 This finding mirrors concerns raised in previous studies and inspections that practice in this area is too police-led.[169]

8.40 There was also confusion around the need to share information between agencies and work collaboratively. This meant that decision-making at all levels (from early identification to care proceedings) was not always based on correct and full information, suspect-focused nor child-centred and was often characterised by drift and delay.

8.41 Our interviews with people who had sexually abused children in their family revealed a lack of awareness of and access to services support that could help address and reduce the risks of offending and re-offending. As we have seen, opportunities for those who have abused to consider and change their behaviour post-conviction are too often being missed.

8.42 The lack of opportunities these adults had as children to talk about what was happening to them and the later offending they had engaged in, also highlights the vital importance of talking to children when there are concerns about them. Offering appropriate support can help them come to terms with what has happened to them, process difficult feelings and reduce the risk of further harm.

168 See The Children Act 1989, section 47.

169 Ofsted, CQC, HMICFRS and HMIP (2020) 'The multi-agency response to child sexual abuse in the family environment: Joint targeted area inspections (JTAIs)'; Children's Commissioner (2015) 'Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action.'

8.43 Opportunities were also lost for practitioners to disrupt further abuse through the use of civil orders, such as Sexual Risk Orders which can be issued to individuals who are thought to pose a risk of sexual harm.

8.44 In addition, guidance, policy, procedures and inspection frameworks are not sufficiently specific to the particular dynamics of intrafamilial child sexual abuse, meaning children are not always supported and safeguarded effectively.

Implications for practice

8.45 Our analysis has highlighted the importance of practitioners being supported to thoroughly explore and understand concerns around the sexual abuse of children by someone in their family environment and to record and share these concerns.

8.46 Practitioners need to work together to put in place robust, multi-agency plans to support and safeguard children during an investigation, and following any decisions made by the criminal justice system. In addition, lead practitioners should ensure the reasons for the police closing the investigation and agreed actions are clearly recorded on the child's file and shared with relevant agencies.

8.47 Similarly, LSCPs need to make sure that their threshold documents of need and risk take specific account of the particular dynamics of intrafamilial child sexual abuse and support practitioners in effective decision-making and response.

8.48 Meanwhile, in line with the recommendations from Operation Soteria, police should be able to seek early charging advice from the Crown Prosecution Service on whether the threshold is met for criminal proceedings to ensure that children are not kept waiting for long periods of time.

8.49 Although guidance is clear that multi-agency discussions should continue beyond the point at which police action ends, this review has found that this rarely happens in practice. Too often, this leaves the referring agency and other key agencies unclear about the outcome of investigations and enquiries, and what they need to do moving forward.

8.50 At the same time, practitioners need guidance on the meaning and implications of the term 'no further action', to understand that a 'no further action' decision does not mean that a child has not been abused. The child may have been sexually abused and still require safeguarding and support, despite the fact the police do not feel they have evidence 'beyond reasonable doubt' to take action at that time.

8.51 Children’s need for support and protection must therefore be considered whether or not the police have decided to pursue a prosecution, and families will also need advice and support. As sexual abuse can impact every aspect of a child’s development and their family and wider relationships, there is a role for all agencies in providing support and protection.

8.52 A formal, multi-agency planning meeting at the point at which police decide whether or not to take further action, and what that action will be, would enable agencies to consider together what measures should be put in place to respond to concerns about the alleged perpetrator, what support and protection the child needs from all agencies and what interventions will best help families to keep their children safe and supported.

8.53 Finally, it is vital that services are available to help prevent offending and re-offending, and that relevant practitioners can direct people who are at risk of offending, or who have offended, to them.

Moving forward

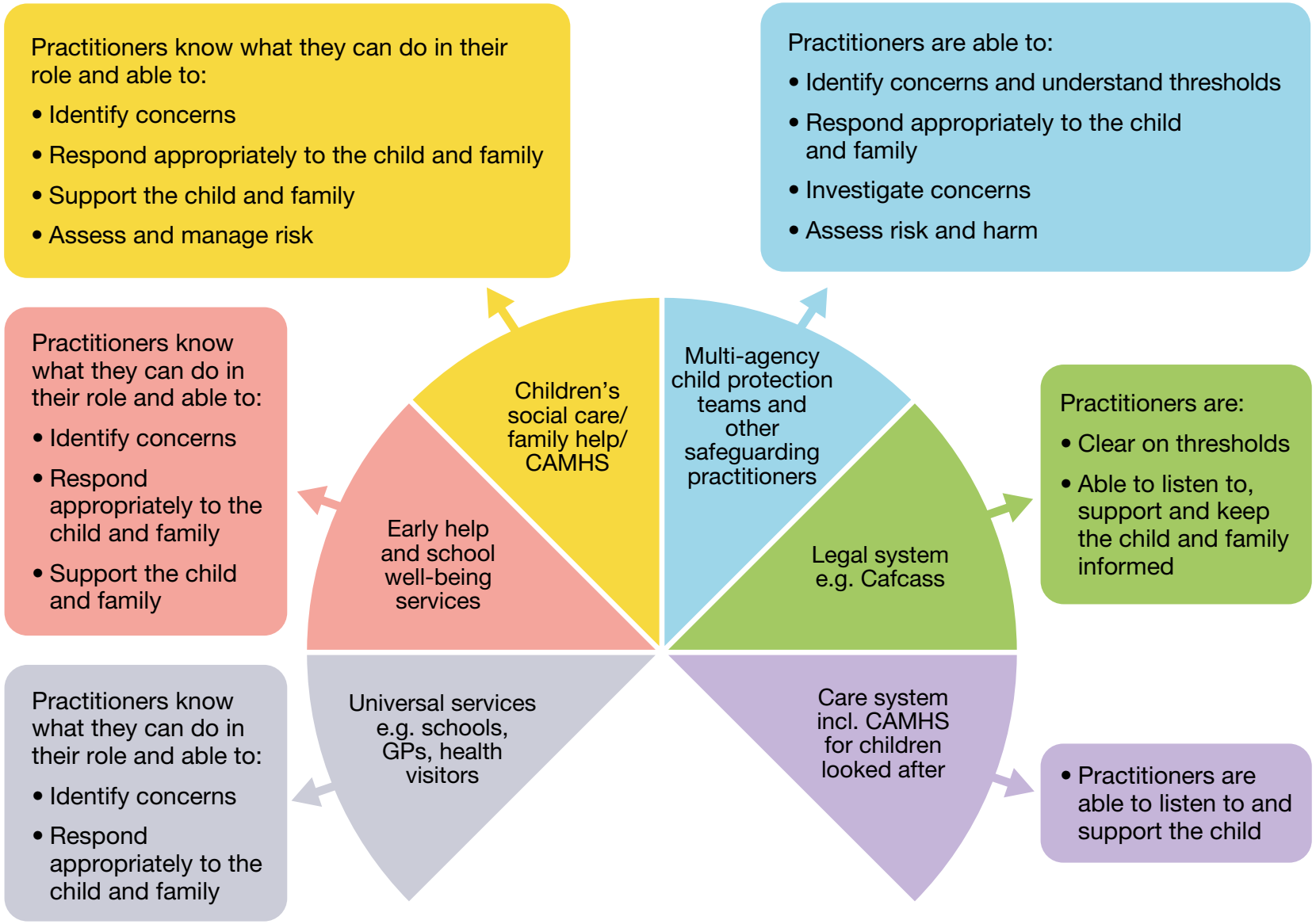
9. Conclusion

9.1 The findings of this national review powerfully illustrate the scale of the challenge facing practitioners, It is the case that this national review was naturally skewed towards a focus on situations where a serious incident notification had been made and where there had often been poor multi-agency practice. However, many of the issues identified in this report have been repeatedly highlighted in previous research and inspection reports and are strongly indicative of wider systemic problems[170]The response to the findings of this review must therefore be similarly systemic, driven through strong leadership and a sustained commitment across all parts of government and by senior leaders within all agencies working with children. National leaders, supported by the inspectorates, must set clear and unambiguous expectations of local multi-agency partnerships. They must articulate what an effective response to intrafamilial child sexual abuse looks like and equip local leaders with the guidance, resources and training they need to support their workforce in identifying and responding confidently and sensitively to children.

9.2 This report highlights the need for a child-centred system that recognises the challenges children face in verbally telling about their abuse and that does not rely on them doing so in order to take action. When sexual abuse is suspected or reported, including where children are non- and pre-verbal, where reports are retracted or where evidence has not yet reached the high threshold for a criminal justice intervention, practitioners at all levels of the system need to be empowered to act quickly and confidently to safeguard and support children.

9.3 Safeguarding actions must be determined by the balance of probabilities threshold and the best interests of the child. This will require the whole children's workforce, including those in universal and early help services and those working with children and families in other capacities, to be equipped with the knowledge, skills and practical guidance to identify and respond confidently to children whenever there are concerns of intrafamilial child sexual abuse, including online. The following diagram shows what the system response should look like:

170 Children's Commissioner (2015) 'Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action'; Ofsted, CQC, HMICFRS and HMIP (2020) 'The multi-agency response to child sexual abuse in the family environment: Joint targeted area inspections (JTAIs).'


Practitioners know what they can do in their role and able to:
• Identify concerns
• Respond appropriately to the child and family
• Support the child and family
• Assess and manage risk
Practitioners are able to:
• Identify concerns and understand thresholds
• Respond appropriately to the child and family
• Investigate concerns
• Assess risk and harm
Practitioners know what they can do in their role and able to:
• Identify concerns
• Respond appropriately to the child and family
• Support the child and family
Practitioners are:
• Clear on thresholds
• Able to listen to, support and keep the child and family informed
Practitioners know what they can do in their role and able to:
• Identify concerns
• Respond appropriately to the child and family
• Practitioners are able to listen to and support the child
Children's social care/ family help/ CAMHS
Multi-agency child protection teams and other safeguarding practitioners
Early help and school well-being services
Legal system e.g. Cafcass
Universal services e.g. schools, GPs, health visitors
Care system incl. CAMHS for children looked after

9.4 The more that practitioners in all services and across all agencies are skilled and confident in naming and responding to concerns of child sexual abuse within the family environment as well as elsewhere, the more that child sexual abuse will be talked about and the fewer places there will be for those who abuse children to hide. Normalising conversations about child sexual abuse, including with children themselves, will in itself and over time contribute to a cultural shift in the response that children and families receive.

9.5 Such a shift will require strong and determined leadership and a focused effort within and between all agencies. With the right knowledge and resources, practitioners can be given the confidence to talk sensitively about sexual abuse, and we can move to a more open and supportive whole-system response to concerns of intrafamilial child sexual abuse. Similar to the response to other forms of harm, such as domestic abuse or neglect, interventions need to be offered across the spectrum of need. This is not to suggest that specialist services for children who have been sexually abused are not required, rather that all children, whether or not they access specialist services, should be able to receive appropriate protection and support from all the adults around them.

9.6 This review has demonstrated how the presence of child sexual abuse in the family environment is seen as particularly difficult to accept and respond to, both by wider society and the organisations charged with protecting children. Intrafamilial child sexual abuse takes place across all parts of society, with some children being more at risk than others depending on their own vulnerabilities, backgrounds or life circumstances, yet data indicates that very few sexually abused children are identified or receive the support and protection they need, and few offenders are successfully prosecuted.

9.7 The recommendations presented in this report aim to support a safeguarding system where children and families are better protected and supported, and the overall costs to society are reduced, by:

1. Identifying the signs of sexual abuse in the family environment earlier, improving prevention and intervening earlier to minimise harm.

2. Providing timely, appropriate, holistic responses to all children who are sexually abused by someone in their family environment, with support tailored to their individual needs.

3. Creating a more consistently child-focused response that recognises and is responsive to the needs of victims and survivors from the point when concerns first come to light, so that fewer people require mental health and/or substance misuse services in adulthood, enter the criminal justice system or require ongoing social care intervention.

9.8 Through the findings and recommendations of this review, we seek to create a system in which all those working with children and families have access to the knowledge and resources required to confidently identify and respond to intrafamilial child sexual abuse. Supported by a robust system of strong leadership and accountability at national and local level, and sustained long-term focus on driving change, child sexual abuse within the family can be identified earlier, the risk of further harm prevented, and the impact of abuse reduced.

9.9 The new government's mission-led approach has potential to deliver the concerted effort required, through collaborative work across government and beyond, providing determined national leadership to the issues identified in this report. The focus on creating opportunity, reducing violence against women and children, and the Children's Wellbeing legislation all present good opportunities for delivering the changes that are so urgently needed.

9.10 This will require that government ministers and their officials work across government to address the systemic problems identified in this report. Government must signal in the strongest possible way their commitment to make sure that necessary improvements are secured and provide assurance that this will be fully translated into concrete actions to make a tangible difference to children's lives. For its part, the Panel will track and contribute to making progress in implementing the report's recommendations, working with all stakeholders, to ensure that this time the spotlight on child sexual abuse is not dimmed, as it has often been before.

9.11 Child sexual abuse in the family environment has been allowed to thrive in secrecy and silence for far too long. Having been sexually abused within their family can have a serious long-term effect on a child's life and vulnerability to further abuse. We hope that this review begins to break that silence by making clear the scale of the problem and the actions required in response, driving system and culture change that centres children's right to be protected, and empowers practitioners to respond confidently and sensitively to children's needs.

10. Recommendations

This review has uncovered significant and long-standing systemic issues in the response to child sexual abuse in the family environment. Children who are sexually abused are frequently not being identified by practitioners, nor are they receiving the response needed for their ongoing safety and recovery. Problems with identification are of particular concern for disabled children and those from Black and other minoritised communities.

The review provides the opportunity for real and lasting change to be enacted which will fundamentally transform the identification of abuse and the response that children and families receive. However, long-standing issues require long-term action with concerted cross-government activity and sustained commitment over the coming years. Enabling the very best and most effective multi-agency practice requires a fully joined-up approach from government departments, including but not limited to the Home Office, the Department for Education, the Ministry of Justice and the Department of Health and Social Care.

The government has recognised the need for a long-term approach in related areas, notably in its commitment to halve violence against women and children over the next 10 years. Meeting this target will necessarily require a strong focus on addressing sexual violence against children, who are the victims in 40% of all recorded sexual offences, despite accounting for only 20% of the population.[171] As we also know, a large proportion of child sexual abuse, committed both online and offline, takes place within families.[172]

The government's mission-led approach provides an opportunity to implement the recommendations from this review, with relevance across the missions on opportunity and safer streets. The 10-year timescale for delivery of its commitment to tackling violence against women and children fits well with the extent of commitment required to drive tangible change in the response to child sexual abuse in the family environment.

We need to create a system in which all those working with children and families are equipped to identify and respond confidently and sensitively to intrafamilial child sexual abuse (including abuse committed online). They must be supported by a robust system of strong leadership and accountability, clear guidance, supervision and support, ensuring that child sexual abuse within the family is identified early, the risk of further harm is prevented, and the impact of child sexual abuse is reduced.

171 Office for National Statistics (2023) 'Sexual offences prevalence and victim characteristics, England and Wales'

172 Office for National Statistics (2020) 'Child sexual abuse – Appendix tables'

National recommendations

Recommendation 1: National strategic plan

Government should develop and publish a strategic plan to secure the necessary practice improvements identified in this report.

This should include:

- identifying relevant data to evaluate progress, in improving how children are helped and protected in response to concerns about sexual abuse, and in how we are preventing harm from those who pose a risk.
- updating all relevant national guidance to take account of the findings of this and other relevant previous reviews.
- taking into account the findings throughout this report on the specific needs of children with a range of characteristics.
- considering the value of a national pathway approach to promote greater consistency and quality in multi-agency practice in identification and response to child sexual abuse.

Recommendation 2: Professional knowledge, skills and confidence

Government should take the necessary steps, working with professional bodies, to ensure that practitioners and managers have the necessary skills, knowledge and capabilities, including access to relevant guidance and multi-agency training.

This should include:

- reviewing and updating initial training, early career and ongoing professional development and supervision, so that practitioners can fulfil their roles and responsibilities in identifying and responding to child sexual abuse and sexual offending. This will involve ensuring that relevant resources and guidance are widely available.

This applies to practitioners and managers working in local authorities, police, health, schools and other education settings, probation, youth justice and Cafcass.

Recommendation 3: Enquiries and investigations

Government should take necessary steps to improve the quality of joint enquiries so that decisions are more consistently in children's interests.

This review reveals that the criminal standard of proof pervades decision making throughout the child protection system and beyond, which prevents many children who have suffered sexual abuse receiving the help and protection they need.

Responding to this should include:

- requiring safeguarding partners to audit and review local guidance and practice so that a clear distinction is made between thresholds about significant harm to a child and those influencing criminal investigations. Safeguarding decisions must be based on all indicators of sexual abuse and should not rely solely on verbal statements from children.
- make any necessary changes to Working Together guidance to clarify that a section 47 enquiry concludes when the multi-agency group who have led the enquiry decide together if there are outstanding concerns, and if so, to notify relevant agencies so that any necessary actions needed to safeguard the child and/or other children can be considered.
- when applicable, that the child's records should state 'no further police action at this time', with an appropriate explanation, instead of 'no further action'. Too often when the police record that they are taking no further action it is understood by other professionals to infer that the abuse did not happen.

Recommendation 4: Assessment of people presenting risk of sexual harm

Government should ensure that there is robust assessment and management of people who present a risk of sexual harm and who have contact with children.

This should include:

- government reviewing the application of the Child Sex Offender Disclosure Scheme to ensure the proactive application of the right to know when someone in the family environment has a conviction for sexual offending, previous allegations of a sexual nature have arisen, or intelligence related to sexual offending is held.

- improved information-sharing and closer working relationships between policing, probation, children's social care, youth justice and relevant statutory and voluntary organisations. The guidance and training provided by Government, the College of Policing and others should clearly inform practitioners about how and when to share this information.
- making sure that whenever information comes to light which indicates that someone in the family (adult or young person) has a previous allegation or conviction (spent or unspent) for any type of sexual offending, this should lead to a multi-agency discussion, which involves an up-to-date assessment of risk, how that risk will be managed, and when this should next be reviewed.

Recommendation 5: Talking to children

Government should ensure that practitioners understand that they can and should talk directly to children, and families, about concerns of sexual abuse.

This should include:

- making guidance and training available, on when and how to talk to children and families when child sexual abuse is suspected (including online), to practitioners and managers working in universal services such as schools, health services, police and early years settings, and practitioners in specialist safeguarding and child protection roles (including fostering and adoption).
- keeping children and families informed of the progress and outcome of investigations and enquiries.

Practitioners must sensitively manage the impact of any decision to close a criminal investigation on children and families. They must be advised on the rationale for decisions, their right to review requirements and about the Criminal Injuries Compensation Scheme, in line with the Victims' Code for Policing.

Recommendation 6: Health

Government should ask NHS England and public health commissioners to audit local commissioning arrangements to ensure that pathways and services are in place to identify and respond to the health needs of sexually abused children (recent and non-recent).

The audit should ensure that:

- universal and specialised health services are identifying the signs and indicators of possible child sexual abuse (including pregnancy) and making appropriate referrals for investigation of these concerns.
- suitably qualified and trained health professionals undertake paediatric forensic medical assessments.
- children of all ages must be able to access timely screening for sexually transmitted infection and receive follow-up for any physical health concerns identified.
- therapeutic mental health support services are sufficient to provide for the ongoing needs of children and families.

Recommendation 7: Criminal investigations and charging advice

Government should take action so that there is a clear and agreed process for ensuring that where cases cannot be considered against the threshold test, early charging advice is sought in cases of intrafamilial child sexual abuse.

This should include:

- the College of Policing, National Police Chiefs' Council and the Crown Prosecution Service working together to improve case progression to provide greater reassurance for children and their families.

This recommendation is in line with the learning from Operation Soteria, a national research and change programme led by the National Police Chiefs' Council, focused on the investigation of rape.

Recommendation 8: Family courts

The Panel invites the President of the Family Division to consider the findings of this review and determine what actions are needed to support judicial decision making when children may have been sexually abused.

Additionally, the learning from this report should be considered by the Family Justice Board, so that they can review its findings and determine what arrangements should be put in place to ensure that all reports in public and private proceedings include all relevant information held by police, on any current or past intelligence, investigations or convictions, for any sexual crime, committed by any party.

Recommendation 9: Cafcass

The Panel invites Cafcass to consider the findings of this review to determine what actions it needs to take.

This is to improve the arrangements to safeguard children in both private and public law proceedings, so that:

- assessments and advice provided to the family court about what is safe and in children's best interests, are always informed by a detailed understanding and analysis of information from current and previous safeguarding enquiries, previous proceedings and all current and previous police and local authority information.
- all applications ('spending time with' or 'live with', or in the case of public law proceedings, arrangements for family time), received by Cafcass and which involve an adult with a known conviction, a served prison sentence for a sexual offence or a current investigation of a sexual offence, involve a comprehensive and urgent assessment about the safety of any child in existing and future contact arrangements.

Recommendation 10: Inspectorates

The Panel invites the relevant inspectorates (Ofsted, the Care Quality Commission, HMI Constabulary and Fire and Rescue Services and HMI Probation) to consider the findings of this review.

These findings should be used to:

- inform learning and development programmes for inspectors.
- plan for undertaking a further Joint Targeted Area Inspection on the multi-agency response to child sexual abuse in the family environment.

Recommendations to safeguarding partners in England

Many of the changes identified by this review are already included in or permitted by current guidance. Local partnerships do not need to wait for government to act to begin making changes at a local level.

There are 6 specific recommendations to partnerships:

Recommendation 1: Strategic planning

Safeguarding partners should consider the findings of this national review and develop a local action plan to respond to its recommendations as it affects local multi-agency practice.

Recommendation 2: Professional knowledge, skills and confidence

Safeguarding partners should undertake a multi-agency training needs assessment, to ensure that their practitioners are able to fulfil their roles and responsibilities in this area. This should include the achieving best evidence joint training.

The response to this assessment may require multi-agency and single-agency training initiatives, in a range of formats, supported by evidence informed resources.

They should additionally give specific attention to the role of schools, early years and other education settings and how they can identify and help children affected by child sexual abuse.

Recommendation 3: Enquiries and investigations

Safeguarding partners should audit the quality of local multi-agency decision making when responding to concerns about child sexual abuse. This may include adoption of a pathway approach, use of guidance about signs and indicators of sexual abuse and reviewing threshold documents about assessment of need and risk.

Agencies should ensure that Working Together guidance is followed and that, at the conclusion of section 47 enquiries and police investigations, there is a multi-agency discussion to consider risk to the children and how they will be protected and supported.

The term 'no further action' should not be used in these circumstances as it is too often understood to mean the abuse did not happen. The term 'no further police action at this time' is more appropriate. There should be a clear record of why a criminal investigation has been closed and that this information has been shared with other relevant agencies.

Where the harm has been perpetrated by a sibling, plans must be made for all the children in the family, addressing the needs of the child who has harmed as well as the child who has been harmed, and any other siblings.

Recommendation 4: Assessment of people presenting risk of sexual harm

Safeguarding partners should, with all relevant agencies such as the Probation Service, review how people who present a risk of sexual harm and who have contact with children are assessed and managed, with information about risk shared across agencies in a timely way. Partners should consider the use of civil orders and other measures to effectively manage the risk from the person of concern.

There is evidence of a need for safeguarding partners and probation to work together to create single points of contact, have robust information sharing arrangements and promote effective learning across agencies.

Recommendation 5: Talking to children

Safeguarding partners should take necessary steps to ensure that all practitioners in their area (including foster carers) understand and are confident in talking directly to children, and families, about concerns of sexual abuse, taking due account of ethnicity, language and disability.

Safeguarding partners need to ensure that there are sensitive and effective plans to address the impact on children of any decision to end an investigation.

Recommendation 6: Health

Safeguarding partners should ensure that there are local pathways for referring children for appropriate forensic medical and other health assessments, for both recent and non-recent sexual abuse, and that safeguarding practitioners understand them.

It is also important that strategy discussions about children, where there are concerns about possible sexual abuse, involve an appropriate health representative who either has clinical experience in assessment where recent or non-recent child sexual abuse is suspected or, as a minimum, has consulted with a professional who has this expertise.

Annexes

Annex A: Review questions

The overarching review question, as agreed with the Secretary of State for Education, was:

What specific challenges feature in the identification, assessment, and response to child sexual abuse within the family environment and how can multi-agency local and national safeguarding practice change to better reflect evidence about how to protect children from intrafamilial child sexual abuse?

Within this, 3 key lines of enquiry were set to focus the review:

Strand 1: Early identification of risks, risk assessment and strategies to mitigate those risks

- How can safeguarding partners and multi-agency bodies (including probation services) work together to identify known sexual offenders in or entering a child's family and thus allowing practitioners to assess the impact and risk they can have on a child (including identification of new people in the lives of children at risk?
- How can the multi-agency safeguarding network better work together to improve the management of ongoing risks posed by known offenders?
- What changes in practice need to occur to enable practitioners and those working with children and families to acknowledge, identify and address abuse hidden by family members, including as a result of coercive control, or deception?
- What changes in practice need to occur to enable practitioners and those working with children and families to assess situations based on evidence (including the child's voice and changes in behaviour) rather than depending on children to tell them what is happening?

Strand 2: Robust responses to concerns of intrafamilial child sexual abuse to protect children from ongoing or recurrent harm

- What indicators do safeguarding practitioners consider as signs of child sexual abuse?
- What are the commonalities among practitioners in terms of the signs that first triggered suspicions and what then led to the point of reporting?
- What challenges and barriers exist that prevent or disempower multi-agency and practitioner-led work and interactions with children, thus creating blockers to recognising and responding to key indicators of intrafamilial child sexual abuse?
- What challenges and barriers exist that prevent or disempower multi-agency and practitioner-led work and interactions with children, thus creating blockers to sharing and appraising relevant historical information and context about families, which means that signs which could help identify intrafamilial child sexual abuse are missed?
- What challenges and barriers exist that prevent or disempower multi-agency and practitioner led work and interactions with children, thus creating blockers to having the right conditions in place to enable children to safely share that they have been sexually abused and for practitioners to hear children's voices and respond, without waiting for or relying on verbal disclosure?
- What are the challenges and barriers for safeguarding partnerships and practitioners in reporting general concerns of child sexual abuse and what considerations are factored into decisions about when to report possible abuse?
- What can the current system do to create the conditions for effective practice and build practitioner confidence when identifying, following up on suspicions of, and responding to intrafamilial child sexual abuse?

Strand 3: Cross-cutting themes and questions

- How does intrafamilial child sexual abuse, and practice to prevent it, interact with other vulnerabilities?
- How is intrafamilial child sexual abuse, and practice to prevent it, influenced by factors specific to families from particular communities or backgrounds (including race, ethnicity and faith backgrounds)?
- How does intrafamilial child sexual abuse, and practice to prevent it, interact with other types of abuse (particularly child neglect) and with other forms of child sexual abuse?
- Why is there a gap between research evidence and what is happening in practice across the spectrum of multi-agency working? Why has that gap persisted despite significant research on good practice?
- What masks child sexual abuse for practitioners when with hindsight there was evidence for concern?

Annex B: Fieldwork areas

Local safeguarding partnerships included in this review . This table shows a list of some of the local safeguarding children partnerships that had submitted local reviews to the Panel between January 2022 and November 2023 that we identified as featuring intrafamilial child sexual abuse. We included them in the sample for this review, from which the 9 fieldwork areas were chosen.

Table 2: Local safeguarding partnerships included in this review

Name of local safeguarding children partnership	Reviewed (R) /Selected for fieldwork (F)
Bolton Safeguarding Children Partnership	F
Bradford Safeguarding Children Partnership	F
Bristol Safeguarding Children Partnership	F
Buckinghamshire Safeguarding Children Partnership	R
Bury Safeguarding Children Partnership	R
Cambridgeshire Safeguarding Children Partnership	R
Cheshire East Safeguarding Children Partnership	R
Cornwall Safeguarding Children Partnership	F
Darlington Safeguarding Children Partnership	R
Dudley Safeguarding Children Partnership	R
Gloucestershire Safeguarding Children Partnership	F
Knowsley Safeguarding Children Partnership	R
Leeds Safeguarding Children Partnership	R
Leicester Safeguarding Children Partnership	F
London Borough of Barking and Dagenham Safeguarding Children Partnership	R
London Borough of Ealing Safeguarding Children Partnership	R
London Borough of Haringey Safeguarding Children Partnership	R

Name of local safeguarding children partnership	Reviewed (R) /Selected for fieldwork (F)
London Borough of Lambeth Safeguarding Children Partnership	R
Lincolnshire Safeguarding Children Partnership	R
Liverpool Safeguarding Children Partnership	R
Manchester Safeguarding Children Partnership	R
Newcastle Safeguarding Children Partnership	R
Nottinghamshire Safeguarding Children Partnership	F
Oldham Safeguarding Children Partnership	R
Oxfordshire Safeguarding Children Partnership	R
Pan-Dorset Safeguarding Children Partnership	R
Rochdale Safeguarding Children Partnership	R
Salford Safeguarding Children Partnership	R
Southampton Safeguarding Children Partnership	F
Staffordshire Safeguarding Children Partnership	F
South Tyneside Safeguarding Children Partnership	R
Tameside Safeguarding Children Partnership	R
Telford and Wrekin Safeguarding Children Partnership	R
Trafford Safeguarding Children Partnership	R
Wigan Safeguarding Children Partnership	R
Wiltshire Safeguarding Children Partnership	R
Worcestershire Safeguarding Children Partnership	R

In addition, the review also looked at a further 91 local reviews submitted to the Panel between June 2018 and January 2022 from a further 40 partnerships.