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Research and analysis

Multi-agency response to child sexual abuse in the family environment: joint targeted area inspections (JTAs)

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Introduction

The programme of joint targeted area inspections (JTAs) began in January 2016. Together, Ofsted, the Care Quality Commission (CQC), HMI Constabulary and Fire and Rescue Services (HMICFRS) and HMI Probation (HMIP) examine how well agencies are working together in a local area to help and protect children. Each set of JTAs focuses in depth on a particular issue. Issues so far have

abuse

Protection of children when
abuse has occurred

Support for children and
families

Conclusion

included:

- child sexual exploitation and children missing from home, school or care
- the response to children living with domestic abuse
- the response to older children experiencing neglect
- child exploitation (including sexual and criminal exploitation)

This report describes our findings from six JTAs carried out between September 2018 and May 2019. This included a deep dive into the experiences of children and young people who are at risk of, or subject to, child sexual abuse in the family environment.

The findings in this report consider the extent to which, in the local authorities inspected, children's social care, health professionals, youth offending services, the police and probation officers were effective in safeguarding these children. We review the practices of the individual agencies, as well as the effectiveness of multi-agency working arrangements.

Sexual abuse in the family environment may be perpetrated by a family member, including a child or adult sibling, or by a person close to, or known to, the family. For example, this could be a family friend, a partner of a parent or other trusted adult.

In order to put the findings from inspections in context, we also:

- carried out a literature review
- analysed national and local data, where available
- held focus groups with the multi-agency inspection teams that led the six inspections
- consulted stakeholders from a range of organisations that work in the field of child protection and sexual abuse

The six local authorities we visited were Bracknell Forest, Cornwall, Derby City, Islington, Shropshire and York.

Please note that children's names and personal information have been changed for all case studies included in the report to protect their identities.

Executive summary

Sexual abuse within the family environment needs to be talked about.

As a society, we find it difficult to talk about sexual abuse of children within the family environment. The consequence of this reluctance is to reduce our capability

and preparedness to protect children from it. Within families and communities, there remains a disbelief and denial about familial sexual abuse, which means it is less likely to be identified and discussed. When we do talk about sexual abuse, we use language that can minimise the abuse or imply consent.

Child sexual abuse in the family environment is not a high enough priority.

Child sexual abuse in the family environment should be just as much of a priority as child sexual exploitation and needs long-term national and local strategies to understand and reduce its prevalence. The knowledge that agencies have gained and the systems that have been put in place for dealing with child sexual exploitation are not being applied in the context of abuse within the family environment. As a result, frontline professionals are not equipped to know enough about perpetrators of child sexual abuse in the family environment: how to identify them, what their escalation patterns are and how to prevent them from abusing children.

Professionals find this area of practice very difficult. Local area leaders across all agencies must provide better training and support for frontline professionals on the issue of sexual abuse in the family environment.

In the absence of clear national and local strategies and approaches, professionals across all agencies lack the training and knowledge they need to identify and protect these children.

Although we saw pockets of good practice, this is not consistent, and these children are not helped and protected well enough. This is a complex area of work in which there are often multiple risks to children in addition to sexual abuse. Across our six inspections, we saw professionals working in a culture of a limited focus on, and knowledge of, this form of abuse.

Preventative work is absent or focused on known offenders.

Where we did see evidence of prevention work, this focused around managing risk related to known sex offenders. We saw limited evidence, in the areas we visited, of community or parent/child-focused prevention strategies being adopted to aid the identification or prevention of child sexual abuse in the family environment.

Professionals rely too heavily on children to verbally disclose abuse.

Children are unlikely to tell someone that they are being sexually abused, particularly when the perpetrator is known to them. Therefore, parents, professionals and the public must understand and know how to respond to the signs and symptoms of child sexual abuse. This includes recognising the signs of abusive relationships between an adult and a child, or between two children, and relationships that lack boundaries. Everyone in society needs to know how to recognise the signs of abuse of a child and how best to respond when they suspect a child is being abused.

When children have displayed harmful sexual behaviour, often it is solely their behaviour, not the cause, that professionals respond to.

Sometimes, the first sign that a child has been sexually abused is when they begin to exhibit harmful sexual behaviour towards others. This may be towards other children in the family, classmates or other children. In some cases, professionals treated these children as perpetrators of abuse, and focused solely on their harmful behaviours. Professionals did not consider, as they should have, that these children's harmful sexual behaviours may be a result of having been sexually abused themselves and that they, too, may be victims. The abused children are then re-victimised and their needs as victims of abuse are not addressed.

Practice in this area is too police-led and not sufficiently child-centred. Too often, health agencies are not involved at all.

Police often led decision-making in cases of sexual abuse in the family. This was because of a lack of confidence and ability to challenge within the rest of the partnership. We saw too much silo working and, in most of the work we saw with children, not enough involvement from health professionals due to children's social care and the police not consistently involving health partners in decision-making. This meant that decisions were made without all of the information and that children were then left at risk and/or without medical treatment.

The lack of appropriate professional challenge among agencies in relation to child sexual abuse was particularly evident. Local partnerships do not always work together to respond to child sexual abuse, information is not shared, and decisions are made that leave children at risk of further harm. Child protection enquiries were too often carried out by just one agency when police and social care agencies should have worked together, supported by health professionals.

The quality of criminal investigations of child sexual abuse in the family environment is sometimes poor.

Poor-quality criminal investigations are leaving too many victims at risk of further harm from suspected perpetrators and are failing to identify the full extent of the abuse. Investigations take too long and therefore impact on children's well-being for reasons that include:

- delays in arresting or questioning suspects of sexual abuse
- police accepting voluntary attendance of a potential perpetrator at a police station
- delays in the forensic examination of digital equipment

Children are put at further risk because of police removing bail conditions placed on suspects when the risk they pose to children has not decreased. Professionals do not always investigate whether there are further potential victims, such as brothers and sisters or children in the neighbourhood.

What was striking from our inspections was the difference in the quality of response from the police, which was very dependent on the level of training and experience of the police officers involved. Sometimes, complex cases were managed by less experienced officers, which in some cases led to suspected perpetrators of child abuse being allowed to remain in the community without restrictions, possibly still offending, for too long.

Children and non-perpetrating parents and family members are not supported well enough.

We are particularly concerned about misconceptions we saw around what support can be offered and when; for example, whether therapeutic support for victims is available during a police investigation or ongoing trial or not. The best interests of the child are the paramount consideration in decisions about the provision of therapy before the criminal trial.

We also found:

- significant delays in support being offered to children
- not all non-offending parents receiving support
- that when support was offered, it was not offered for long enough

When children did receive support, it was often of good quality, which is positive.

Context

Child sexual abuse in the family environment is a very complex area. Our findings highlight significant challenges for agencies, professionals and the government.

As such, it is important for professionals working in this area to be well trained and appropriately resourced in order to prevent abuse happening and to identify and protect children at risk.

The deep dive specifically focused on children and young people who children's social care services had identified as being subject to, or at risk of, child sexual abuse in the family environment. While some children displayed harmful sexual behaviour, the inspections did not look at peer-on-peer abuse, other than when it occurred in a family environment (such as between brothers and sisters).

There is very little reliable data available on the prevalence of child sexual abuse. Latest estimates, for 2017–18, suggest that there were an average of eight recorded offences of child sexual abuse (including rape, assault, grooming and other non-contact abuse) per 1,000 children in England and Wales. The most recent prevalence surveys suggest that around 15–20% of girls and 7–8% of boys have been victim of sexual abuse.¹ Furthermore, the 2019 Crime Survey for England and Wales (CSEW) estimates that around 8% of all adults aged 18 to 74 experienced child sexual abuse before the age of 16.²

Estimates are calculated using available administrative data, such as crime survey and police recorded crime statistics, but these cover different time periods and different collection methodologies. A further complication is the hidden nature of sexual abuse, and the fact that when disclosures are made, it is often a long time after the abuse took place. We have tried to reflect the most comprehensive studies in this report.

The CSEW estimates fill an important evidence gap, but only of adults' past experiences of sexual abuse. The Office for National Statistics is currently carrying out a feasibility study to determine whether a new survey could effectively measure the current scale and nature of child abuse and neglect. It plans to publish the findings from this feasibility study later in 2020.

In 2015, the Children's Commissioner carried out an inquiry into child sexual abuse in the family environment.³ Some of the findings from that report are listed below:

- The proportion of children who suffer sexual abuse, in the family environment or otherwise, is estimated at around 11%.⁴
- Two thirds of child sexual abuse takes place within the family environment.
- It is estimated that only one in eight children in England who are sexually abused come to the attention of statutory authorities.
- Children often do not recognise that they have been abused until they are older.
- Professionals working with children need additional training and support to help them identify victims of sexual abuse.
- Child sexual abuse in the family environment often comes to the attention of statutory and non-statutory agencies as a result of a secondary presenting factor, for example self-harm, which becomes the focus of the intervention. In many cases, the underlying issue of sexual abuse may not be identified until

much later on.

We are using the Department for Education's (DfE) definition of child sexual abuse⁵:

“ [Child sexual abuse] involves 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 (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.”

There is no single agreed definition of child sexual abuse within the family environment. We are therefore using the Children's Commissioner's inquiry's definition:

“ Child sexual abuse in the family environment is defined as sexual abuse perpetrated or facilitated in or out of the home, against a child under the age of 18, by a family member, or someone otherwise linked to the family context or environment, whether or not they are a family member.”

Within this definition, perpetrators may be close to the victim (for example, father, uncle, stepfather, sibling) or less familiar (family friend, neighbour, babysitter). Less commonly, perpetrators can also be female, such as mother, aunt, cousin or stepmother, which is often overlooked.

The Children's Commissioner inquiry discussed three aspects to the impact of sexual abuse within a familial setting:

- Sexual abuse of a child can lead to problems with mental and physical health, relationship breakdowns and problems with behaviour.
- The disclosure or discovery of sexual abuse within a family is likely to have a significant impact on the family and the victim's relationship with other family members.
- Statutory and non-statutory services and intervention, such as being removed from the family or giving evidence, may further traumatise the victim even when it is in their best interests.

Apart from the psychological and social impact of sexual abuse, the Children's Commissioner's inquiry reported the following:

- Some children reported experiencing physical violence and nearly half of children had injuries that required attendance at an accident and emergency department.⁶

- Some children have contracted sexually transmitted infections or had unwanted pregnancies as a consequence.
- Between half to four fifths of children and young people who report sexual abuse have some symptoms of post-traumatic stress disorder (PTSD), anxiety or depression.
- Many exhibit self-destructive behaviours and/or experience substance abuse.
- Many report feelings of isolation, stigma and difficulty in trusting others.
- Some display sexualised behaviour, low self-esteem, withdrawal, anger/aggression and disruptive behaviours.

Limitations of the report

There are some important limitations to this project that are useful context for the reader.

First, we were only able to review cases of child sexual abuse in the family environment that the local authorities (LAs) we visited were aware of. In most cases we saw, there were co-existing vulnerabilities such as neglect or other abuse in the home, and sexual abuse was often not the primary factor identified for the child.

Second, we cannot be confident that children from all backgrounds who experience sexual abuse in the family are coming to the attention of statutory authorities. If they do not have co-existing vulnerabilities, they are less likely to be identified.

Third, we were only able to sample from cases that were open to children's social care at the time of the inspection. Even then, some LAs had difficulty identifying all of their child sexual abuse cases on file, because many were recorded under another primary need, such as neglect. The implications of this are discussed later in the report.

Finally, our sample sizes are not big enough to draw any conclusions about the protection of children who are minority ethnic or living with special educational needs and/or disabilities (SEND). Disclosure of sexual abuse by these children is thought to be even less common. We believe that further research into the prevalence, experiences and outcomes for these children is crucial.

Report findings

The findings in this report consider the extent to which, in the local authorities inspected, children's social care, health professionals, youth offending services, the police and probation officers were effective in safeguarding these children,

and how well they worked together. The visits identified four themes, which are presented below: prevention, identification, protection and support.

Prevention

In this section, we have discussed our findings relating to the prevention strategies used in the areas we visited. However, local areas were unable to give inspectors enough evidence of the prevention strategies they were using. We have therefore also drawn on research findings to outline what can be done to try to prevent child sexual abuse in the family environment.

Prevention is the most fundamental form of protection from child sexual abuse. To prevent sexual abuse of children, in the family environment or otherwise, policy-makers, professionals, parents and adults in local communities need to understand enough about it and what preventative methods work.

In our inspections, we saw very little work being done in local areas to raise awareness of, or educate the public about, risks relating to the sexual abuse of children. It was also clear that, possibly due to a reluctance to discuss the topic, local areas did not prioritise prevention strategies around sexual abuse in the family environment.

Understanding what child sexual abuse is

Although research into perpetration and perpetrators of child sexual abuse has increased in the last decade or two, the knowledge in this area is still too limited. We will struggle to prevent sexual abuse until we understand fully:

- why and how perpetrators abuse children
- what works in stopping perpetrators
- what the most effective ways are of informing children and adults about healthy relationships, including sexual relationships

In England, the law on consent to sexual activity in adolescence can be difficult for parents, adults and children to understand, and it is not always clear what an appropriate relationship is.

Legally, the age of consent for sexual activity is 16. However, the Sexual Offences Act 2003 identifies three categories of offences against children of different ages.⁷ They are:

- offences against those under 13
- offences against those under 16
- offences against those under 18

Sections 5 to 8 of the Act apply the main non-consensual offences to children under 13 (rape, assault by penetration, sexual assault, causing or inciting a child to engage in sexual activity). Consent in these offences is impossible – a child under 13 does not, under any circumstances, have the legal capacity to consent to any form of sexual activity.

In relation to children who are 13 and over, but under 16, the 2003 Act makes clear that the age of consent for sexual activity is 16 (except that a defence in relation to a child who is 13 or over but under 16 is that the suspect reasonably believed the victim to be 16 or over and consenting).

As well as the main non-consensual offences, sections 9 to 15 include offences such as sexual activity with a child, causing or inciting a child to engage in sexual activity, engaging in sexual activity in the presence of a child, causing a child to watch a sexual act, child sex offences committed by children or young persons, arranging and facilitating a child sex offence and meeting a child following sexual grooming. These sections are designed to protect children under 16, the intention being that anyone who engages in sexual activity with a child under 13 should be prosecuted under sections 5 to 8 to ensure the availability of the higher maximum penalties for the under-13 offences.

The legislation also covers familial child sex offences and offences against those with a mental disorder.

There is increasing understanding of child sexual exploitation among professionals and agencies, evidenced, and aided, by the DfE's guidance issued in February 2017. Child sexual exploitation occurs when an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual.⁸

Home Office guidance states that there is no intention to criminalise adolescents who engage in consensual sexual activity under the age of 16 if they are a similar age. It is not always clear what a 'similar age' means in this context and there are difficulties about what constitutes 'peer-on-peer' abuse.⁹ We have recently published a blog about what it is, what schools should be doing when it happens and how we've trained our inspectors to recognise it.¹⁰

Particularly where adolescents are concerned, language used about sexual abuse can minimise it or imply consent where there was no consent. For example, the BBC reported on 29 July 2019, 'A teacher who had sex with [rather than 'abused'] four of his pupils, including one who became pregnant, has been jailed for 12 years'. In our inspections, we noted similar misleading language about children. For example, medical case notes stated that a young adolescent was 'sexually active', when in fact they were being sexually abused by a middle-aged adult.

Until we are clear as a society about what constitutes sexual abuse of children, parents and other adults in those children's lives will not have the knowledge and

information they need to protect them as well as they could, whether the abuse occurs inside or outside of the family environment.

Understanding how and why perpetrators sexually abuse children

It was clear from our inspections that professionals working in this area do not have a good enough understanding of:

- how and why perpetrators sexually abuse children
- what the signs of an abuser are
- the risk that perpetrators present to their own or other children

Evidence from our JTAs suggests that, sometimes, when professionals assess the risk to children in a household in which a parent has been accessing online child abuse images, the focus is on neglect or other abuse that they are more confident in assessing risk for. Professionals, as in society generally, do not understand well enough the relationship between perpetrators viewing child abuse images and the abuse of children directly.

Several research studies have tried to understand this relationship by looking at the characteristics and motivations of sexual offenders. One study looked at three groups of offenders (offenders who view sexual images, non-contact offenders and contact offenders). It found that these groups were more similar than they were different.¹¹ Another study identified differences in the backgrounds and/or psychological characteristics between offenders who solely view images of child sexual abuse and other offenders.¹² There is a lack of research into why some abusers will target their own children or family members, while others will abuse children they are not directly related to.

Patterns of escalation of abuse are not well understood by professionals, although research suggests that a sexual attraction to children develops in adolescence.¹³ In most cultures, more men than women abuse children, with the NSPCC estimating that two thirds of sexual abuse by parents, guardians or other adults in the home (including step parents, parent's partners, grown-up brothers or sisters and relatives) was perpetrated by males.¹⁴ Research also indicates that girls are at a higher risk of being abused by a family member than boys, while boys are more likely to be abused by someone in a position of trust.¹⁵ Overall, studies agreed that girls were more likely to experience sexual abuse than boys, and men were more likely to perpetrate abuse than women.

Getting accurate estimates of the prevalence of sexual abuse from research is a challenge, due to the varied nature of data collection methods around this topic and the specific cohorts or circumstances that are the focus of the research. Many studies rely, for example, on self-reports of abuse, either by children themselves or by adults who have experienced sexual abuse in childhood. Other studies rely

on parents or guardians to answer questions about their child. These variations all contribute to the significant differences found in prevalence and incidence rates from study to study. Some of these differences were summarised by Lalor and McElvaney and include the following¹⁶:

- The age and gender of the study group – this varied from children of all ages (from infancy) to only women aged 20 to 40. Commonly, sexual abuse under the age of 16 or under 18 was used.
- The population of interest – some studies are of children living in private households, others focus on children living in residential care homes and some concern high school or university students.
- The definition of sexual abuse – this varied from the broad ‘any sexual interaction’ or ‘any sexual abuse in the home’, to very specific acts such as ‘someone touched their private parts in a way they did not like’.
- The perpetrators – there was a varying level of detail about the relationship, from family member and stranger to more detailed friend, acquaintance, person from the broad family circle and similar.

Because of the differences highlighted above, direct comparisons between studies are not possible. However, using a broad definition of contact sexual abuse, rates ranged from 10% of females in the UK to 40% in Switzerland. For males, rates ranged from 6% in the UK to 16% in Ireland.

Of all the studies we looked at, there were wide ranges in prevalence by type of abuse (such as contact versus non-contact), age of the victim, relationship with the perpetrator and where the abuse took place. But if the picture from the research is not clear, it will be very difficult to understand the scale of the problem for professionals working in this area.

Frontline professionals cannot develop effective prevention programmes and strategies unless they understand:

- how a desire to abuse children emerges
- the different ways in which it manifests itself
- how perpetrators organise themselves and their access to children
- how perpetrators hide their abuse
- what their escalation patterns are

Although some experts understand some of these issues within discrete disciplines, for example in clinical psychology and criminology, not enough of this work has been brought together in an accessible way that frontline professionals can use. More recent work, by the Independent Inquiry into Child Sexual Abuse (IICSA) and the Centre of Expertise for Child Sexual Abuse (CSA Centre), is attempting to do this, which is a positive step.¹⁷

Prevention strategies

Regardless of this lack of information and knowledge, academics and public health experts recommend that prevention should target factors at both an individual level and a macro level, such as community groups and the wider society.¹⁸

Programmes may be targeted at the perpetrator, child, parent, family, school or community, or can be applied at multiple levels, depending on factors such as the identification pathway, the developmental stage and age of the child, and the mental health and ability of the parent.¹⁹ These different strategies are discussed below.

Community- or place-based prevention programmes

The CSA Centre has a long-term research programme aimed at improving understanding of the scale and nature of child sexual abuse. Its work is centred around the view that, in order to make better decisions, target responses effectively and best protect children, professionals need better data about both the prevalence and contexts of child sexual abuse, nationally and at a local level.²⁰

Despite this work happening in discrete organisations, what was notable through our inspections of the six local areas was that, although many had implemented some prevention strategies for child sexual exploitation, strategic work for child sexual abuse in the family environment was absent. This report will discuss some of these elements that were missing.

Local areas are not prioritising prevention of child sexual abuse to the same extent that they now do with child sexual exploitation. They are failing to:

- identify families of concern
- understand the problem at a local level
- develop locally informed prevention plans
- work with local partners to develop preventative strategies

Managing known sexual offenders in the community

A crucial element in preventing further sexual abuse of children in the family environment is managing effectively the risks from known sexual offenders in the community.

In our inspections, we saw significant variation in how well risks were managed,

including those relating to known sexual offenders.

We saw a lack of timely and adequate planning when adult offenders were due to be released from prison. Agencies missed opportunities to work with families or put plans in place before the offender was released. In some areas, the lack of suitable accommodation for released perpetrators added an additional challenge to agencies' ability to manage offenders in the community and limit their contact with children.

Police and other agencies do not always use sexual harm prevention orders or sexual risk orders to restrict the suspect's harmful sexual behaviour. In one area, public protection officers did not always carry out home visits as part of the risk management of convicted offenders. Professionals could not therefore be sure where offenders were living. Clearly, this presents a huge risk to children with whom these offenders may have contact.

Mark

Mark's father is a registered sex offender. He was due to be released from prison. The LA had been informed by another LA that Mark and his mother were moving into the area and that Mark's father was likely to move back in with Mark and his mother. The LA took no further action at this time. Mark's father moved into the family home after his release from prison.

Assessments had taken place but there were delays. The assessments were overly-optimistic, and over-reliant on a probation service from another area.

Despite concerns raised by health services, a strategy meeting was not convened until a month after the father's release. Eventually, the LA identified risks and took action to safeguard Mark. His father is no longer able to live with him.

Accredited sexual offending behaviour programmes are available through the National Probation Service for people who are on current sentences or have recently been released, although this does not include those under the age of 18. In Shropshire, for example, the probation service delivers Horizon, a research-based, accredited group work programme for offenders. It has a separate, but similar, programme for sexual offenders with learning difficulties. In addition, a multi-agency panel reviews the risks presented by the offenders in the programmes. All relevant agencies are involved. As such, we saw good coordination between probation officers and police offender managers. This coordination helped them to understand the wider risks that offenders may pose within the family and their wider communities.

This example of collaborative working is significant because, while studies have found some programmes to be effective, other studies have shown that some

programmes aimed at reducing offending in prisons have had no significant effect, or have even increased re-offending.²¹ It has been suggested that this recidivism is higher among offenders with learning disabilities.²²

In general, there is a real lack of services, including specific programmes to support rehabilitation and prevent further offending outside of those offered by the National Probation Service. As it stands, local partnerships are not doing enough to manage the risk posed by known sexual offenders.

The role of education in the prevention of abuse

Educational programmes can play an important role in the prevention of abuse because they can be targeted at a large number of people at one time (for example, through schools or health services) and they can focus on children and/or their parents. As well as raising awareness about the risks of sexual abuse, and how to spot the signs, educating families about what are appropriate relationships can help people to recognise abuse in their family environment.

Although education and awareness campaigns can reach a wide audience, they are by no means the only, or indeed the most effective, means of prevention. As previously noted, academics and public health experts recommend that prevention measures should target factors at both an individual level and a community or societal level. It is essential to remember that even though these interventions are beneficial for children, the responsibility for children's protection lies with adults.

Child-focused strategies

Typically, child-oriented approaches to prevention focus on increasing the child's knowledge around sexual abuse. This is often supplemented by other concepts related to child sexual abuse, such as the fact that abuse is never the victim's fault or that perpetrators can also be well-known people. These programmes are usually carried out in schools, which can reach a large number of children without stigmatising a particular population.²³ In the UK, the NSPCC introduced the PANTS Campaign (the 'underwear rule') to help encourage and support parents to talk to children aged four to 11 about staying safe from sexual abuse. The campaign also includes teaching resources for schools and early years settings.²⁴

A variety of reviews of child-focused prevention strategies have been carried out. One review of 24 school-based prevention programmes identified significant positive effects from children's participation in programmes, such as increased self-protective behaviours.²⁵ Another review identified the range of outcomes of these interventions, including building children's knowledge and self-protective skills without producing negative side-effects (for example, elevated anxiety, over-

sensitivity to appropriate touches) and additional positive effects such as increased parent–child communication.²⁶

In our inspections, we saw effective local authority work with schools, which had improved schools' understanding of the signs and indicators of sexual abuse and harmful sexual behaviour. We saw one example in which a school session for children about risks of child sexual exploitation had resulted in a disclosure of sexual abuse in the family environment. This led to a quick referral to children's social care and sensitive support for the child, as well as a successful prosecution of the perpetrator.

York has an ongoing 'It's not ok' campaign that has led to a significant increase in schools' uptake of preventative services, such as the 'Speak out, stay safe' assemblies, and an increase in disclosures by children and young people.

Parent or family-focused strategies

Despite the fact that most sexual abuse is carried out by someone known to the child and their family, research shows that the majority of parents (around 80% to 95%) focus their sexual abuse prevention discussions on 'stranger-danger' warnings.²⁷ Many interventions therefore tend to focus on either increasing parent knowledge or enhancing parent –child communication about child sexual abuse. However, research has also shown that recruiting and retaining parents for educational programmes can be challenging and attendance rates at training and meetings tend to be quite low, especially among fathers.

In one of the areas visited, women who had registered sex offender partners or family members being released from prison were able to access the NSPCC's Women as Protectors programme. This is aimed specifically at mothers and carers who are in contact with a man who poses a risk of sexual harm to children. An evaluation of the service found some evidence of positive results in terms of the women's capacity to keep their children safe.²⁸

Improving practice

This JTAI identified that all local areas need to assess local need and employ a range of preventative strategies, combined with educational programmes, to address sexual abuse in the family environment.

We did see some recent work to understand current practice and prevalence. For example, Bracknell Forest has carried out its own multi-agency audit to understand the experiences of children at risk of sexual abuse in the family environment and gather information about the wider prevalence. The audit also looked at how confident staff felt in response to cases of sexual abuse. The audit led to an action plan that identified a number of multi-agency tasks. The LA is monitoring

progress against this.

Senior leaders in Cornwall had also taken the initiative to progress, prioritise and aim to improve practice for children who are at risk of sexual abuse in the family environment. As a result of learning from multi-agency audits, they identified areas for development in practice. Recently, Cornwall has developed a comprehensive child sexual abuse strategy.

Identification of child sexual abuse

It is extremely difficult for both parents and professionals to establish whether sexual abuse of a child has occurred. Often, no physical or medical evidence of the abuse will be apparent, or the evidence may be inconclusive.²⁹ Only an estimated one in eight children who suffer abuse will come to the attention of statutory services.³⁰

Identification of child sexual abuse is also limited by the fact that victims often do not disclose abuse until much later, sometimes into adulthood.³¹ Information about the incidence of child sexual abuse generally comes from agency-published data, for example from the DfE (children subject to child protection and other social care intervention) or from the Home Office (recorded offences), which relies on abuse having been identified or disclosed.

In general, in preparing for these inspections, the LAs we visited identified more sexual abuse cases than they had previously been aware of. In most cases, the main area of risk identified for the children was recorded as neglect or emotional abuse, rather than sexual abuse. This supports the finding from the Children's Commissioner report, that for the majority of child sexual abuse cases reported to the police concerning children who were also the subject of a child protection plan, these plans were not categorised under sexual abuse. Only 20% of child sexual abuse victims known to the police had been subject to a child protection plan under the category of sexual abuse: 32% were under the category of neglect, 29% emotional abuse, 5% physical abuse and 14% under multiple categories.

Recognising the signs of sexual abuse remains a challenge. There are clearly a large number of children for whom risk has not been identified, which adds to the challenge of local areas having a comprehensive understanding of the prevalence of sexual abuse in the family environment. This means that a large proportion of children who were subject to sexual abuse were potentially not receiving support or services relating to their needs. If children do not get the help they need to understand what has happened to them, interventions are likely to be only partially successful.

In our inspections, we found four areas of practice that could be improved to aid the identification of sexual abuse of a child earlier. These areas are:

- ensuring that professionals in all agencies recognise the signs of abuse in the

- family and that they feel comfortable talking about it with children and families
- strong multi-agency information-sharing protocols in place across the local area
- consideration of all potential victims of the perpetrator
- equipping adults to see what is happening – we cannot rely on children to disclose

Verbal disclosure by children is rare, so professionals and other responsible adults need to be able to spot the signs of possible abuse and take appropriate action. The nature of disclosure as a process means that some disclosures are partial, and more detail may emerge over time. The details of the abuse will largely be missing when disclosure is communicated through behaviours or other signals.³²

Disclosures, when they do occur, are often not recognised or are misunderstood, dismissed or ignored. Some groups of children, such as boys, disabled children and children from some ethnic minority groups face greater barriers to disclosure.³³ Girls in some communities, for instance South Asian, find it very difficult to raise the subject of sexual abuse because of religious and cultural beliefs and attitudes towards women, so they do not disclose for fear of reprisal or rejection from the family or wider community. When they do disclose, they can feel responsible for the sexual violence and for the potential perceived loss of theirs and their family's honour.³⁴

Research has shown that disabled children may be less likely to disclose at all, and more likely to delay disclosure, compared with other children. There are also barriers for disabled children in child protection processes, including:

- failure to recognise abuse or apply appropriate thresholds
- lack of holistic assessment
- lack of communication with the child and maintaining a focus on their needs
- despite improvements, a continuing lack of effective multi-agency working³⁵

Children abused by a female family member can face higher levels of disbelief from professionals, who may also view the abuse as less serious and less harmful than male-perpetrated abuse.³⁶ To enable children to disclose, they need access to safe adults with the skills to listen and the opportunity to obtain information and confidentially explore the consequences of disclosure.³⁷

Just because children have not verbally disclosed the abuse does not mean they have not disclosed. Many children do not 'tell' in a straightforward way; rather, their behaviour and demeanour or the characteristics or behaviour of caregivers indicates that something is wrong.³⁸ In the same way in which a child might not disclose any other form of abuse, such as neglect or emotional abuse, professionals can still work to uncover or protect the child from sexual abuse without a verbal disclosure from the child themselves.

This JTAI identified a lack of school nursing, which meant that there was less involvement and knowledge about children who might be at risk of, or subject to,

child sexual abuse in the family environment.

Islington, through strong strategic commitment, has improved practice by creating a working environment in which children can build trusting relationships, across both universal and specialist provision, to increase the likelihood of disclosure when they are at risk of sexual abuse. The LA has also invested in an early help strategy, encompassing prevention work, early help support services and the rollout of trauma-informed approaches across schools. So far, 11 schools across the borough have benefited from this training. It has made a significant difference to the culture in schools, for example by providing a safe space for children to disclose abuse and helping teachers to be professionally curious.

However, in general across our inspections, we found that a significant number of professionals lack confidence in talking about sexual abuse within the family environment and do not have the skills and knowledge they need for this. One of the consequences of this is that sexual abuse is not identified as the main risk for the child. Instead, the focus is steered towards other abuse, such as emotional harm or neglect. This can then be recorded in child protection and children in need plans and multi-agency planning therefore does not always focus enough on reducing the risk of sexual abuse and planning for the future.

Charlotte

Charlotte disclosed to a teacher that she had been sexually abused by her adult brother. Another child in the family had previously disclosed sexual abuse by the same family member, but this was not shared with children's social care immediately. Professionals did not fully recognise the risk indicators of child sexual abuse.

Full information about the known offending behaviour of Charlotte's adult brother had not been taken into account. This meant that not all relevant agencies were invited to contribute to the strategy discussion. The level of risk could not, therefore, be appropriately assessed. Decision-making focused on issues of neglect rather than the risk of sexual abuse. The plan for Charlotte was ineffective and did not appropriately address the degree of risk or the core issue of concern. Only staff from children's social care and school attended the child in need meetings.

In Derby, we saw work that helped children to disclose in a safe way that did not hinder the ongoing investigation.

Hannah

Hannah disclosed to school that she had been the victim of sexual abuse

by her older adult brother. The school immediately referred the matter to children's social care, and a strategy meeting was held on the same day. This resulted in a joint child protection investigation. Hannah was visited at school by a police officer and social worker on the same day, where she was given the opportunity, with the support of her teacher, to confirm the disclosure. Other family members were visited the same day too and the alleged perpetrator was immediately removed from the home environment. Hannah received very good emotional support from her teachers, school nurse and social worker. Hannah was well supported in her Achieving Best Evidence interview by an intermediary.

[39 Achieving Best Evidence](#)

Supporting professionals to identify abuse

Identifying cases as child sexual abuse is tricky for professionals. Many of the signs and symptoms of sexual abuse can be indications of many other problems faced by children. For example, physical symptoms such as abdominal pain, trouble swallowing or recurring infections can be symptoms of underlying medical conditions. Behavioural and emotional symptoms such as bed wetting, anxiety or changes in eating habits can also be normal at different stages of development.

Focusing on the child's signs and symptoms without considering the actions and behaviours of suspected perpetrators might mean that professionals miss important information that would help them to identify risks of sexual abuse earlier. It might only be when a number of signs or symptoms are considered together that there is a strong indication that a child may be suffering sexual abuse.

Practitioners may fear incorrectly accusing adults of sexually abusing a child, splitting up families and getting it wrong. That is why it is so important that professionals in health, policing, social care, probation services, schools receive training in identifying and responding to the signs of abuse and have clear pathways for investigating child sexual abuse and ongoing support and supervision. Although we did see individual examples of social workers being well trained, overall we found that professionals lacked confidence in these areas. This lack of confidence had a serious impact on their ability to respond.

Clear pathways and thorough training should also mean that professionals are clear about the balance between intervention and intrusion into family life. Practitioners need help to understand what they can do in the absence of police action to make the situation safer and to meet the therapeutic needs of the child and family. Local areas need to provide clearer guidance on how to do this.

Some areas we visited were focusing increasingly on child sexual abuse in the family. However, evidence from the cases we reviewed showed that this had not

yet significantly improved the quality of practice. They had failed to adequately give attention to elements of practice such as having a timely multi-agency response and access to support.

There is some evidence that not all LAs have access to decent Achieving Best Evidence (ABE) training. The risk with fewer social workers receiving this training is that they are less aware of how special measures can be implemented, and what they can advocate for under that guidance for children in their care. This often leaves the police, who are ABE-trained, as the sole decision-makers about how an investigation can best be carried out in a child's best interests.

Some of the professionals we spoke to, particularly in LAs and the police, believe that there has been a shift in emphasis, particularly in training, to sexual exploitation that has overshadowed risks from familial sexual abuse.

The importance of sharing information in local partnerships

In each of our JTAI reports to date, we have emphasized the importance of good information-sharing between agencies as a major factor in the protection of children. In the inspections for this JTAI deep dive, we saw, arguably, the least effective practice in information-sharing and inter-agency challenge to date. The consequences of this for children were stark.

We saw inconsistent attendance by agencies at multi-agency decision-making forums. Sometimes partners, such as probation, were not invited when this was relevant, so not all relevant information could be shared. The absence of safeguarding partners meant that assessments did not always take account of the continuing risk of harm, and therefore incorrectly assessed the risk to a significant number of children. We saw examples of decisions made to conclude child protection plans when other agencies held important information that would have had a critical impact on those decisions.

Another important finding from the deep dive was the lack of effective challenge between agencies and professionals. This was most apparent in relation to the police's decision-making, which was not challenged by other agencies. Strategy discussions in most cases we saw did not involve health agencies or the appropriate health professional and did not involve the sexual assault referral centre (SARC). This led to inadequate decision-making and agencies working in silos. It also led to health professionals not being able to challenge decisions by the police, exacerbated by the lack of challenge by children's social care professionals. For example, in several cases, police stated that a medical examination was not required for a child because it was outside the forensic window – the period during which evidence from an examination would be of value. However, these assessments are necessary to identify and treat children for sexually transmitted diseases or other harm they may have come to, as well as for assessing the child's emotional well-being. Although the evidence may not be

permissible in a criminal court, local partnerships were missing opportunities to protect the children in question and to meet their emotional and physical health needs.

The lack of effective challenge between agencies and professionals resulted in decisions to carry out single-agency child protection enquiries when a joint agency enquiry by police and children's social care was required. This means that investigations have not routinely had the benefit of the expertise and knowledge of all partners from an early stage, and in some cases, this meant that valuable evidence for prosecutions was not collected at the outset.

Peter

For Peter, concerns had been raised on multiple occasions with children's social care about neglect. Latterly, there were concerns that he was having contact with adults who were family friends, who were known to have harmful sexual behaviours. Despite a history of concerns in Peter's background, it was only on the fourth occasion of concerns about sexual abuse being raised that they were then progressed to an assessment.

Despite several professionals expressing concern about the safety of Peter and his brothers and sisters, there was an absence of professional challenge or any formal escalation of concerns. There was a delay in fully assessing and understanding the complex risks to Peter and other children. A multi-agency strategy meeting was held and the outcome was no further action.

When a child's case is already open to children's social care, new information about risk of significant harm relating to child sexual abuse is often referred direct to the allocated social worker. This does not always result in a strategy meeting taking place as soon as it should, which in turn leads to delay in information-sharing, decisions and timely action to ensure that children are protected.

As we highlighted in our report 'Children living with domestic abuse: prevent, protect, repair', there are clear guidelines for professionals about information-sharing that all local partnerships need to ensure are working well.⁴⁰

Protection of children when abuse has occurred

This section sets out our findings about the protection of children when abuse is strongly suspected, or known, to have occurred. Although we saw pockets of

good practice, in general we found that children who are known to have been abused are not well protected from further harm.

Even when abuse has been identified, children can be left at risk.

The response to suspicions of child sexual abuse is too often police-led and dependent on determining whether a crime has been committed. The strong focus on the criminal investigation and the decision-making of the police and Crown Prosecution Service (CPS) too often leads to an insufficient focus on the child. Often, due to the lack of hard evidence in relation to child sexual abuse, professionals do not always feel confident to address it head on with the family, despite significant indicators that a child has suffered, or is suffering, child sexual abuse in the family. This leads to a focus on other areas of abuse or neglect on which evidence can be clearly demonstrated. Once the child is safe, this can mean that the focus on the suspected perpetrator disappears. This does not protect children from the perpetrator.

In addition, professionals can face significant challenges in working with families in which there is a continued risk of sexual abuse that the family is reluctant to accept. In some cases, police investigations have ended with no further action. It is important that children's social care professionals understand their role and are confident in challenging the police: just because there is not enough evidence to secure a conviction does not mean that agencies should retreat. In a significant number of children's cases evaluated by inspectors, there was a lack of effective multi-agency working, which meant that the perspectives, skills and insights that different agencies can bring were not evident.

Professionals often focus on the child identified as being at risk and keeping that child safe. In a number of the cases we looked at in which offences have been reported, inspectors did not find wider consideration given to brothers and sisters, other children who were potential victims, or children who have displayed harmful sexual behaviour, in risk plans. We found missed opportunities to assess and intervene earlier for brothers and sisters, other connected children, suspects and the wider public. This means that risks to some children are overlooked or not responded to in a timely way.

Alex

A referral was made to social care because Alex had been sexually abused by an older child from the family's circle of friends. However, there was delay in acting to fully assess the risks posed by the older child committing offences against him. Risks to the suspect's brothers and sisters, and another child, were not considered swiftly enough. This led to delays in appropriate safeguarding action being taken in order to protect

these children.

Actions by the police have left children at further risk of harm

A significant theme from our visits was delay in criminal investigations. Delays in arresting or questioning suspects of sexual abuse, the use of the voluntary attendance of a potential perpetrator at a police station, or delays in the forensic examination of digital equipment, which can take up to a year to do, can mean that investigations take too long and impact on children's well-being.

In addition, in some cases, this also led to a delay in children receiving the therapeutic support they needed, which was further exacerbated by the misunderstanding by some professionals about children not being able to access support during investigations. There was a lack of communication between the police and children's social care services and consequently a lack of challenge by the latter about the police's delays and decision-making. Children and their families were not always updated on the progress of investigations.

We also saw some examples of delays in carrying out essential enquiries and missing opportunities to provide enhanced safeguards. In one case, the family member who the child disclosed had sexually abused her was not interviewed until four weeks after the disclosure. He was not arrested, which meant that no further protection was afforded by bail conditions. In other cases, inspectors observed good initial responses to disclosures that then lost impetus. For example, in one case there was then a delay of five weeks to hold a victim's Achieving Best Evidence (ABE) interview and four months to 'interview' the child's cousin, who the child had disclosed had sexually abused her.

In some cases, voluntary attendance was used, which is when a potential perpetrator is asked to attend a police interview but not arrested. This means that children do not benefit from the protection afforded by bail. It also gives potential perpetrators the opportunity to destroy evidence. In some cases, we saw an inappropriate use of bail conditions that meant that abusers were free to contact, and in some cases return to live with, the children they were charged with abusing.

The legislation related to the use of bail has changed in recent years, in order to reduce the length of time people who are suspected of an offence spend under investigation. Once the initial bail period has ended (and if the investigation has not been concluded), the police can apply for a further period of bail if certain conditions apply. In a number of cases, officers have applied strict bail conditions on suspects, because they have understood the risk to the children in the household and in the wider community, and bail has been a protective factor.

However, in many cases we saw, extending the bail period was not considered

despite the investigation not having reached a conclusion. The consequence of this is that the suspects in these cases were in the community, with no legal conditions limiting their behaviour or the potential risk they posed. In the cases we saw, the decision not to extend bail conditions by the police was made without involvement of other agencies. Therefore, no consideration was given to alternative arrangements to manage risk despite the likely or potential risks remaining the same. This meant that children were exposed to unmanaged risk and potential further harm.

Over-optimism that women can police their own homes

We saw too often that women were expected to manage contact between the perpetrator and the children at potential risk. We saw inappropriate use of written agreements that included unrealistic expectations by professionals about the parent's ability to keep the child safe from the perpetrator. For example, a written agreement was used in a case where a registered sex offender was released from prison despite the mother not believing that the perpetrator had committed an offence. Other examples include mothers who have been subjected to coercive control and domestic abuse being expected to manage supervised contact.

Samantha

Samantha was aged seven and lived with her mother. Her mother had a new partner. He was a registered sex offender who had convictions for offending against children. He had just been released from prison.

Before the offender's release from prison, no pre-release risk assessment was carried out. On the offender's release, there was no specialist sexual offending assessment carried out, and a delay in the probation service's assessment of risk of harm. When this was finally completed, the assessment did not take full account of the offender's risk to children.

Probation services did not make a referral to children's social care. Despite the challenge from the police officer, no referral for assessment was made and Samantha was left at risk of significant harm.

Professionals need to better understand the relationship between abusers and non-abusing parents or guardians. In most cases, it will be unrealistic to expect non-abusing parents or mothers to protect their children from harm without significant support from agencies and partnerships.

Support for children and families

The impact of child sexual abuse on children, non-perpetrating parents and wider family members can result in an increased risk of adverse outcomes in a variety of areas of personal and family life, such as:

- physical health
- emotional well-being, mental health and behaviours
- interpersonal relationships
- socio-economic outcomes
- religious and spiritual beliefs
- vulnerability and re-victimisation

An increased risk of adverse outcomes does not mean that all victims will experience all of them, and they can vary in terms of severity and duration. Some victims may experience severe, lifelong impacts and others may experience very few adverse effects.⁴¹ Although not all children and families will experience all of these adverse outcomes, it is important that their needs are assessed and therapeutic support offered as early as possible. We saw many examples of cases where children's therapeutic support was delayed because of a lack of knowledge about when it can be introduced and confusion about it interfering with criminal evidence and prosecutions. There was a lack of accessible support for parents and other children in the family in most areas we visited.

Parents may find it difficult to care for and support a child who has been abused. An important element in minimising these effects is to provide therapeutic and support services as early as possible, both for the child and other family members affected.

Support for children and young people who display harmful sexual behaviour

Our findings from these JTAI visits identified issues relating to children and young people displaying harmful sexual behaviour that cut across each of the four themes of prevention, identification, protection and support.

There are no accurate figures on the extent of harmful sexual behaviour by children and young people, largely because it covers a broad spectrum of behaviours, most of which do not come to the attention of the authorities. In one UK study, two thirds of the contact sexual abuse experienced by children and young people was perpetrated by other young people, though this is usually outside of the home environment.⁴²

Research into effective interventions among children and young people who display harmful sexual behaviour, though limited, has identified that structured,

holistic and family-oriented approaches may be the most effective, but must take account of the young person's own history of abuse. In addition, research highlights the damaging effects of stigmatising young people as 'mini adult sex offenders', which may even increase the likelihood of reoffending.^{43 44}

In some cases on inspection, we found that professionals lacked sufficient understanding of the vulnerabilities of children who have displayed harmful sexual behaviour. Therefore, professionals did not focus on these children being potential victims of sexual abuse. In a number of cases, we saw delays in their assessment and in putting appropriate risk management in place. Specialist support was not offered to a number of these children.

We also saw examples of these children being considered safe once they had been removed from the family home. In one example, a young person who had displayed harmful sexual behaviour within his family was placed into the care of the LA and accommodated in a local hotel without appropriate safeguards or support. This raises an important issue about the need to ensure that appropriate placements are commissioned for children who have displayed harmful sexual behaviour and that foster carers are properly prepared and know how to manage the behaviour.

Kyle

For 17-year-old Kyle, a lack of well-coordinated multi-agency work has meant that the potential risks of his harmful sexual behaviour to his brothers and sisters and the wider public were not fully recognised or adequately managed. This is despite a range of professionals being involved. Work to identify the underlying causes of Kyle's behaviour and an ongoing youth offending team intervention have not been well coordinated.

A multi-agency safety plan is in place, but it relies primarily on Kyle's parents keeping him and other children safe.

We saw some good practice in Shropshire, where professionals did not rely solely on a disclosure of abuse. They had a good range of interventions for young people with known, or emerging, harmful sexual behaviour. This included the routine use by some professionals, including in schools, of assessment tools to identify emerging sexualised behaviour in children and the commissioning of specialist risk assessments when children are known to potentially pose a risk. Youth offending services understood how the behaviours of the children and young people who they work with may be signs of distress. They increasingly recognised the benefits of using a trauma-informed approach to their work.

In Bracknell Forest, youth offending service staff are suitably trained to assess and support children who have experienced sexual abuse or who display harmful

sexual behaviours. There are specialist interventions that allow children to explore their experiences around consent and healthy relationships. Likewise, Islington offers clear pathways for young people who display harmful sexual behaviour to ensure that they receive appropriate interventions.

Ben

For Ben, a young person with a learning disability, sensitive and cohesive work from a range of professionals is addressing complex behaviour that may place other children at risk of sexual abuse. Ben received a range of specialist assessments to help both himself and professionals working with him to better understand his behaviours. These have then informed his care planning and ensured that his behaviour management programme is tailored to address his very specific needs.

Ben's social worker, youth justice worker and educational professionals worked well jointly to consider his need to access education in a safe and supported way.

Medical treatment

As stated previously, one consequence of police-led responses is that, in some cases, health practitioners with a good knowledge of the case had been unable to attend strategy meetings. This meant that important medical information was not shared and children were not always offered medical assessments when they should have been.

The absence of relevant health professionals, such as paediatricians and the SARC, impeded the robustness of multi-agency decision-making and planning for children who experienced child sexual abuse in the family environment. In one case, a paediatrician who had a disabled child under their care was unaware of the fact that the child had experienced child sexual abuse in the family environment until our inspection. This meant that partners were not able to have a thorough understanding of the child's medical needs and respond effectively.

Where child sexual abuse in the family environment and SARC pathways were unclear between partners, effectiveness of meeting children's needs and securing improved outcomes was hindered. One case showed initially good liaison between police and the paediatrician, but this was not maintained, which weakened the effectiveness of joint working and decision-making.

We found, in one area, pathways for older children were not well established. This meant that health leaders had limited assurance that the ongoing medical needs of 16- and 17-year-olds who had accessed the SARC were met effectively.

Quality of therapeutic support

There is a lottery of therapeutic support based on funding available in local areas and/or a lack of clarity about pathways. Support for children can be too fragmented, and not always identified early enough. When children do get support, it is generally of a good quality. However, sometimes children only receive the support for a limited period of time and it was clear that, once support ends, children and families are not given a point of contact for if further impact of trauma might emerge later. It needs to be clear to parents and children where they can go if they need support some time after the event.

In Cornwall, we saw some effective direct work and practice with children. Inspectors saw strong and sensitive work from many professionals, who are committed to improving support and help for children and their families. They use a wide range of appropriate commissioned services. They also involve schools and specialist psychological and therapeutic services, such as Jigsaw, which provides individual psychological support to children and their carers. All of these contribute to improved life chances and outcomes for children. This is making a positive difference to children, families and carers in reducing trauma, understanding healthy relationships and reducing risk.

The creation of the Lighthouse for five London boroughs to support a holistic and effective response to children who have been sexually abused is an excellent development. Cross-border and multi-agency partnerships have supported the development of the first Child House model. Children and adults can access medical and therapeutic support. This can be provided over time and at a pace that recognises children's vulnerabilities, rights and choices effectively. Although it is too early to assess the full impact, the service model is firmly rooted in the child's voice and experience. At the time of the inspection, the Lighthouse had already secured positive interventions for three children.

Due to the criminal-led approach, many children who have not been able to disclose have received no help. Exceptionally, in York, one charity runs therapeutic courses for children and young people who have been victims of sexual abuse, including an innovative course for children who have not made a disclosure but about whom there are well-grounded concerns that they may have suffered abuse.

York also has a child sexual assault assessment centre (CSAAC) that provides a timely, child-centred service to the children and young people who have suffered, or are at risk of, child sexual abuse. The use of play therapists alongside experienced paediatricians helps to make the process feel more comfortable for children.

Islington and its partner agencies are embedding a model of trauma-informed practice. This is driving a cultural shift across the partnership. Their model promotes developing a skilful and confident workforce that builds good relationships with children and their families and keeps children at the centre of interventions. This has had a positive impact for children subject to or at risk of

child sexual abuse in the family environment by building positive relationships with children and listening to their views.

Matthew

Matthew and his brother and sisters were at risk of being sexually abused by their father. There was a timely referral, leading to a strategy meeting at which all relevant agencies were given the opportunity to inform an assessment of risk of sexual abuse within his family. This meant that the ongoing multi-agency activity to locate the children and make them safe was successfully achieved following assessment of risks of sustained significant harm. There was evidence of appropriate professional challenge, both at the strategy meeting and subsequently by senior managers. This excellent multi-agency approach has continued since the abuse came to the attention of services, making the children involved safer.

Conclusion

Child sexual abuse in the family environment needs to be a priority across government departments and local areas. Too often, responses leave children repeatedly victimised, perpetrators unidentified, who therefore remain a risk to children, and known victims not supported well enough. We are calling for greater priority to be given to child sexual abuse both locally and nationally. Evidence-based strategies need to be in place to support agencies and professionals in improving the prevention, identification and response in this challenging area of practice. Strategies need to include:

- a focus on prevalence
- the reasons why perpetrators sexually abuse children in the family
- impact on children
- evidence-based responses
- long-term holistic therapeutic response

Communities, organisations and the media have important roles to play. We need to create an environment in which children and adults are able to talk about sexual abuse more easily.

Health agencies are important partners. Their involvement should be seen by all as essential in enabling effective assessment and decision-making.

There needs to be a greater emphasis on better training, support, supervision and resources for all professionals and a culture of greater professional challenge in

the best interests of the child.

We saw some good examples of children being effectively supported through good-quality police investigations when these were carried out by experienced and well-trained police officers. However, in too many cases we saw delays and insufficient focus on the child. Police need to have a greater focus on:

- ensuring that investigations are timely
- all children who are potential victims or at risk
- effective action being taken to put the necessary safeguards in place, working together with other agencies

The variation in practice in relation to children and young people who have displayed harmful sexual behaviour towards others was striking. In the poor cases, we saw delays in assessment and a sole focus on the harmful sexual behaviour. We saw good practice when there was a holistic assessment to identify the child's needs and risks and take action to help and support that child. We need to ensure much greater consistency in our response to these children, who in the majority of cases are themselves victims of abuse and neglect.

Too often, risks to all children from perpetrators were not considered. Better training, supervision and support for professionals is needed to address this, as well as implementing the learning from other forms of child exploitation.

Programmes for sex offenders are not always effectively evaluated in terms of their impact in preventing further offending. There needs to be better use of evidenced-based approaches to working with offenders. We found that practice was too inconsistent when managing known sex offenders in the community, and the risks they pose to children on their release.

In conclusion, we can no longer stay silent on this issue. We have to talk about it and act. Everyone needs to play their part in identifying, preventing and tackling child sexual abuse in the family environment.

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