



Department
for Education

Child Sexual Abuse and Exploitation: Recording Practices in Children's Social Care and Serious Incident Reporting - Qualitative Insights for Policy and Practice

March 2026

**Authors: Emma Ball, Michelle McManus,
Jessica McElwee, Paige Monaghan**



Government
Social Research

Contents

Contents	1
Glossary of terms	2
Executive Summary	3
Introduction	12
Chapter 1: Remit of Social Care Practice: Identification and Recording of CSAE	15
Chapter 2: Nature of CSAE harm	25
Chapter 3: Systems, tools and structures that shape visibility and variation in CSAE	31
Chapter 4: Serious Incident Notifications (SIN) and CSAE	38
Chapter 5: Practitioners' Reflective Learning Points	44
Conclusions	57
References	62
Appendix	66

Glossary of terms

Artificial intelligence: AI

Child criminal exploitation: CCE

Child exploitation: CE

Child exploitation vulnerability tracker: CEVT

Child Protection Authority: CPA

Child protection plans: CPP

Child sexual abuse and exploitation: CSAE

Child sexual abuse: CSA

Child sexual exploitation: CSE

Child in need: CIN

Child safeguarding review panel: CSPR

Child vulnerability tracker: CVT

Department for Education: DfE

General practitioner: GP

Multi-agency child exploitation: MACE

National Centre for Violence and Public Protection: NCVPP

No further action: NFA

Risk outside the home: ROTH

Sexual assault referral centre: SARC

Serious incident notifications: SINS

Executive Summary

Context

Recent national reviews and analyses¹ highlight a persistent gap between police-recorded child sexual abuse and exploitation (CSAE) and what is visible in children's social care datasets, particularly the Children in Need (CIN) census and Serious Incident Notifications (SINs).

Recommendation 9 of the Casey Audit called for further investigation into the potential explanations for these differences, including potential under-identification, variation in local authority recording practices and the adequacy of current statutory data systems. In direct response, the Department for Education (DfE) commissioned this qualitative study to explore how CSAE is identified, assessed, recorded and reported within children's social care practice.

This study involved 48 semi-structured interviews with practitioners across six local authorities. While not representative of practice across England, the research provides in-depth, practice-grounded insights that help explain national quantitative patterns and identify structural, cultural and system-level factors shaping CSAE visibility in statutory data.

Key Findings

Across all six local authorities, practitioners consistently described CSAE as a significant safeguarding concern. However, the study identified a set of structural, cultural and system-level factors that shape how CSAE becomes visible, or remains hidden, within statutory data. These findings help explain the national picture described by the Casey Audit (2025), National Centre for Violence and Public Protection (NCVPP) (2025), the Child Sexual Exploitation Taskforce et al. (2025), and recent GOV.UK (2025b) CSAE data release.

The report is structured across five chapters to address the three core research questions:

- How social workers identify and record CSAE within CIN processes.
- What drives variation in recording practices across local authorities.

¹Casey (2025); Child Sexual Exploitation Taskforce et al. (2025); National Centre for Violence and Public Protection (NCVPP, 2025); GOV.UK CSAE Data Insights (2025b): [Children in need: A focus on sexual abuse and exploitation, Reporting year 2025 - Explore education statistics - GOV.UK](#)

- How expectations and thresholds within the SIN system shape the reporting of serious CSAE-related harm.

Chapter 1 examines how CSAE is identified in practice and why it may not be explicitly recorded.

Chapter 2 explores distinctions and overlaps between CSA and CSE and how these shape thresholds and recording.

Chapter 3 considers how systems and local safeguarding structures influence visibility.

Chapter 4 reviews how SIN processes are applied in CSAE contexts and factors driving under reporting.

Chapter 5 summarises practitioners' learning points on improving identification and recording.

The conclusion draws together these insights to inform recommendations for improving CSAE data accuracy and SIN processes.

Chapter 1: Remit of social care practice: identification and recording of CSAE

Chapter 1 examines how CSAE is identified and recorded within children's social care practice. Practitioners described CSAE as a complex, pattern-based form of harm that frequently co-occurs with multiple vulnerabilities and unfolds over time. Risk was characterised as fluid and relational, with safeguarding responses often occurring during assessment or early help, before statutory thresholds are met or formal categories applied. As a result, significant CSAE-related work can remain poorly visible within national datasets.

The chapter highlighted how statutory recording frameworks, which require the identification of a single primary need at fixed points in the system, struggle to capture the complexity, timing and cumulative nature of CSAE. The findings demonstrated that CIN including child protection plan data are strongly influenced by recording design and system constraints, rather than providing a full reflection of the prevalence or seriousness of CSAE within safeguarding practice.

- Risk can be fluid and relational, often shifting day to day. Practitioners described building understanding gradually through relationships, interpreting fragmented information, changing narratives and subtle behavioural cues, rather than relying on clear or immediate disclosures.
- CSAE frequently co-occurs with multiple, overlapping risks, including neglect, missing episodes, mental health needs, domestic abuse, poverty, and peer or

online influences. This complexity can make single category recording challenging and can result in CSAE not being explicitly named in statutory records.

- Confidence to name CSAE is shaped by evidential uncertainty, grooming dynamics, cultural factors and delayed disclosure. Practitioners rely on patterns of behaviour and contextual indicators to identify harm, and some practitioners felt that without a clear disclosure or concrete incident, it can be challenging to meet statutory thresholds.
- Static recording systems, which require a single primary need to be recorded at a fixed point in time, do not reflect this fluidity. As a result, CSAE is often absorbed into broader child protection plan categories of significant harm such as neglect or emotional abuse.
- Effective early intervention can address elements of risk sometimes before the 45-day assessments are completed. For example, removing the alleged perpetrator of harm. Where risk has been mitigated, this particular harm may no longer be classified as a current concern at the end of assessment. In such cases, the child may not progress to a child protection plan, or if they do, there may be another category of harm which is listed on the plan. This means that early safeguarding activity is not consistently visible in CIN data, yet it may be documented locally.
- Although children's social care operates on the balance of probability, confidence to name CSAE was often described as tied to corroborating evidence or disclosure, with police NFA (no further action) decisions potentially influencing practitioner confidence to record sexual abuse explicitly.
- Differences in how risk is defined and recorded across systems contribute to data divergence. Police-recorded CSAE data includes both current and non-recent investigations, whereas children's social care data primarily reflects present safeguarding risk. This structural difference explains some variation between police and children's social care datasets.

Chapter 2: Nature of CSAE harms

Chapter 2 examined how practitioners understand the nature of CSAE, highlighting important distinctions between CSA and CSE in how harm presents and how safeguarding responses operate. While CSA—particularly intra-familial abuse—was described as more readily aligning with traditional child protection processes, CSE was understood as a dispersed, extra-familial and often digitally mediated harm that develops over time. These characteristics mean that CSE does not fit neatly within

intrafamilial-based child protection frameworks, prompting the use of additional safeguarding pathways² focused on contextual and extra-familial risk.

- CSA and CSE are closely related, can co-occur but can also present differently in practice. Practitioners described CSA, particularly intra-familial abuse, as more readily recognised within existing child protection frameworks, while CSE frequently involves extra-familial harm arising in peer, community and online contexts.
- CSE is typically identified as a gradual, pattern-based harm rather than a single incident. Unlike many cases of intra-familial CSA, which were described as more immediately legible within statutory frameworks, CSE risk was described as emerging over time through behaviour, relationships and online activity, often with fragmented information held across systems. This makes CSE harder to evidence, threshold and record within statutory safeguarding processes, despite ongoing professional concern.
- Extra-familial CSE presents challenges for traditional child protection pathways. Where parents are identified as protective partners and harm occurs outside the home, practitioners described child protection plans as not always well suited to addressing contextual risk. In these cases, Section 47 strategy discussions may be used for multi-agency information-sharing and risk management rather than progression to conference, which may help to explain lower conversion rates to ICPCs.
- Online environments and peer networks now shape much contemporary sexual harm. Practitioners described risk as dispersed across digital spaces, peer groups and geographic boundaries, creating safeguarding challenges that are not easily captured within household-based or static recording systems.

Chapter 3: Systems, tools and structures that shape visibility and variation in CSAE

Chapter 3 shows that CSAE visibility within CIN data is shaped by system design, with key information held in narrative records and practitioner judgement rather than structured fields, meaning national data can reflect recording logic more than lived experience. Practitioners described innovative tools to manage CSAE risk but that these sit largely outside CIN systems, contributing to variation and limiting a consistent national picture.

- CSAE indicators are dispersed across multiple systems, records and timeframes, making it difficult to reconstruct a child's journey through statutory

² [Embedding Risk Outside of the Home \(ROTH\) Pathways: Phase 3 Pilots | Contextual Safeguarding](#)

data. Chronologies provide rich contextual information, but this often sits within narrative text, limiting its visibility and extractability at a system level.

- CIN census returns are structured around incidents and single categories, rather than patterns, relationships or context. As a result, relational and extra-familial exploitation risks are frequently recorded outside statutory datasets.
- Key CSAE information is commonly held outside CIN systems, including within local case management tools, MACE documentation, police databases and bespoke local dashboards. While these sources often contain detailed and practice-relevant information, they are difficult to extract, link or standardise across agencies.
- Local authorities have developed innovative tools and processes, such as dashboards, screening mechanisms and contextual mapping, to ensure this information is recorded, in the absence of a consistent national statutory data set for this area. However, these locally developed systems vary in scope and design, influencing what is captured, recorded and reported.
- Variation exists in local areas regarding assessment of when strategy discussions should be held, system architecture, workforce capacity and multi-agency arrangements, all of which produce significant regional differences in CSAE visibility. As a result, CIN datasets can reflect local system design and infrastructure more than the underlying prevalence, complexity or nature of CSAE.

Chapter 4: Serious Incident Notifications (SIN) and CSAE

In Chapter 4, practitioners report that while SIN thresholds were generally well understood, applying them to CSAE cases is more complex due to delayed disclosure, cumulative forms of harm and the challenges of evidencing psychological or long-term impact. They also described local learning mechanisms and several system-level barriers affecting consistency.

- SIN thresholds in general were described as well understood across the local authorities interviewed, with practitioners recognising the “very high” bar for cases involving death or serious harm where abuse or neglect is known or suspected.
- CSAE cases were described as more complex to assess within the SIN framework, as harm may be disclosed late, emerge cumulatively, or involve primarily psychological or coercive harm rather than immediate physical injury, making application of thresholds more challenging and contributing to lower numbers of CSAE-related SINs.

- Local learning mechanisms, such as Cases of Concern reviews, Learning from Experience reviews and appreciative inquiry processes, were described as supporting proportionate multi-agency reflection and learning where CSAE cases do not meet national SIN criteria. These mechanisms were reported to follow comparable review processes while allowing greater flexibility in scope and timing.
- SIN decision-making processes in general were described as consistent and senior-led, with opportunities for multi-agency input. However, practitioners highlighted practical challenges with the national SIN system, including system fragility, the inability to save draft submissions and delays linked to coordinating multi-agency input.
- Lower levels of CSAE-related SINs were considered to partly reflect the nature of sexual harm and how it presents in practice, rather than misunderstanding or misapplication of thresholds. However, practitioners identified a need for clearer national guidance on how CSAE should be considered within SIN decision-making, particularly in relation to cumulative harm and the interpretation of “serious harm.”

Chapter 5: Practitioners’ Reflective Learning Points

Chapter 5 highlights three interconnected factors shaping the visibility of CSAE within statutory data: practitioner confidence, system design and national leadership.

Interviewees identified several enablers that strengthen identification and recording of CSAE, alongside system-level conditions needed to support accurate, consistent data.

- Practitioners’ knowledge and confidence in naming and recording CSAE are strengthened through ongoing training, specialist reflective spaces, clear tools and pathways, and supportive supervision that explicitly addresses the emotional and relational complexities of CSAE.
- Improving the quality and accuracy of CSAE data depends on systems that support relational thinking, track children’s journeys over time, surface patterns and alerts, and allow multiple, overlapping harms to be recorded.
- Consistency in recording requires both local structures that work with national standards, supported by clear guidance and resourcing to reduce structural variation between local authorities.
- Adequate resourcing across the safeguarding system is essential, including investment in data recording, collation, analysis and dissemination, to support effective and consistent safeguarding responses.

- Targeted investment in data and analytical expertise can significantly improve the consistency, visibility and usefulness of CSAE recording, strengthening oversight of risk patterns and alignment with safeguarding decision-making.

Implications and Key Learning

The findings highlight that addressing the under-recording of CSAE requires sustained attention to workforce confidence, system design and national consistency. Interviewees stated that under-recording can occur when there is a misalignment between practice and the way statutory data systems record and report CSAE, rather than necessarily reflecting the level of safeguarding activity taking place.

Workforce confidence and capability

Practitioner confidence in naming and recording CSAE is strengthened where practitioners have access to specialist reflective spaces, supportive supervision and training that explicitly engages with the emotional, evidential and relational complexities of sexual harm. All training should consider designing learning in formats that are realistic for a pressured workforce, especially in the context of high workloads. Where such structures exist (for example, CSA panels or dedicated reflective spaces), practitioners reported greater confidence in articulating concerns and greater consistency in recording practice. Nationally endorsed tools and pathways, such as those produced by the CSA Centre for Expertise, were seen to provide legitimacy and clarity, helping to reduce local variation in practitioner judgement.

Data system alignment and design

Current data systems are poorly aligned with the realities of CSAE safeguarding practice. Systems are designed to capture single incidents and endpoints, rather than safeguarding journeys, co-occurring harms and evolving patterns of risk. As a result, significant CSAE work remains invisible within national datasets. The findings indicate a need for systems capable of linking individuals, locations and incidents over time to surface relational and contextual³ intelligence relevant to CSAE. Local authorities have developed sophisticated dashboards and trackers to compensate for these limitations,

³ In this report, relational refers to understanding harm through a child's relationships over time, including interactions with family members, peers, professionals and others. Contextual refers to recognising that risk and harm can arise from environments beyond the family home, such as peer groups, schools, neighbourhoods and online spaces. Taken together, a relational and contextual approach recognises that child sexual abuse and exploitation often emerge through patterns of interaction, behaviour and environment over time, rather than through single incidents or disclosures.

but this information about exploitation concerns sits outside CIN and SIN reporting, reinforcing national under-representation.

Standardisation and national guidance

Variation in CSAE recording can reflect differences in local system design, CSAE-related thresholds, and safeguarding architecture. Clearer national standards for CSAE recording tools, alongside minimum recording expectations, would help to reduce inconsistency arising from locally designed systems. In addition, greater clarity is required in the application of national guidance, particularly in relation to the interpretation of complex forms of CSAE (including child-on-child abuse and online harm), and in defining what constitutes “serious harm” in CSAE contexts for the purposes of SINS.

System leadership and the role of the Child Protection Authority

The establishment of the Child Protection Authority (CPA) presents a critical opportunity to address the fragmentation identified in this study. On 11 December 2025, the DfE published a consultation on the proposed functions of the CPA. The consultation proposes that the CPA provide national leadership across child protection, support alignment between safeguarding practice and data systems, and strengthen learning from serious harm where CSAE is a feature. The CPA will play a central role in clarifying expectations around CSAE within SIN reporting, supporting consistent interpretation of cumulative and grooming-based harm, and ensuring that national datasets are informed by the relational and contextual intelligence already being developed locally. The proposals for the design of CPA are subject to change following the consultation.

Conclusions

The National Audit on Group-Based CSAE (Casey, 2025), alongside the Child Sexual Taskforce et al. (2025), NCVPP (2025) police-recorded CSAE analysis, and the GOV.UK CSAE report (2025b), all identify a persistent structural mismatch. CSAE is recognised in police recorded offence data yet remains under-represented in the CIN data. Drawing on qualitative evidence from six local authorities, the findings suggest that under-recording may be shaped by a range of system-level factors rather than indicating reduced prevalence or issues with frontline practice. Instead, the findings points to alternative explanations — including the complexity of how CSAE presents in practice, how practitioners assess and manage risk and how national data systems require harm to be categorised at fixed points in time, with little representation of the safeguarding journey — which can result in safeguarding activity not being fully reflected in national data.

Across the safeguarding pathway, increased focus on early intervention approaches, evidential uncertainty, delayed or non-recent disclosure, and the cumulative and

contextual nature of sexual harm all contribute to CSAE being displaced into broader categories such as neglect or emotional abuse, or risks being addressed before reaching statutory recording thresholds. Differences between police and children's social care remit and thresholds, particularly in relation to non-recent abuse and NFA decisions, further explain why CSAE may be visible in police recorded offence data but absent from CIN and SIN datasets. The findings also clarify why extra-familial harms can generate high safeguarding activity which can be recorded in social care systems, but which can also sit outside of traditional child protection pathways, therefore not being easily visible in CIN datasets. This is particularly the case where risk fluctuates or re-emerges rather than progressing linearly through statutory thresholds.

Crucially, the study demonstrates that improving CSAE visibility is a system-level challenge, requiring recording frameworks that capture journeys rather than endpoints, allowing co-occurring harms to remain visible, in addition to integrating extra-familial and intra-familial harm. Such frameworks can better support practitioner judgement in conditions of uncertainty. Chapter 5 further shows that practitioners already hold rich information about CSAE and are clear about what enables confident and consistent recording, including reflective spaces, supportive supervision, practice-focused training, nationally endorsed tools, integrated data systems and dedicated analytical capacity.

As the proposed CPA enters consultation and development, these findings provide timely and actionable evidence of where national leadership could have the greatest impact. In particular, the CPA presents a critical opportunity to address long-standing fragmentation across safeguarding data systems, strengthen national expectations for CSAE recording and serious incident reporting, and ensure that learning from exploitation, serious harm and local information is translated into system improvement. Embedding these insights within the CPA's remit would directly support the ambitions of Casey Recommendation 9 and help ensure that future national safeguarding policy is grounded in an accurate, practice-informed understanding of CSAE.

Introduction

Background, aims and objectives

The National Audit on Group-Based Child Sexual Abuse and Exploitation (CSAE) led by Baroness Casey examined the scale, nature, and drivers of group-based CSAE across England and Wales (Casey, 2025). Recommendation 9 from the audit tasked the Department for Education (DfE) with investigating the declining representation of CSAE within Child in Need (CIN) assessments; variation in recording practices across local authorities; and the effectiveness of Serious Incident Notifications (SINs) in capturing CSAE-related harm.

A central finding of the audit was a widening gap between police recorded offences and children identified within children's social care data as experiencing CSAE. In 2024, 102,878 child sexual abuse (CSA) offences were recorded in England, including 61,845 contact offences and 41,033 indecent image offences (Office for National Statistics Centre for Crime and Justice, 2024a, cited in Casey, 2025). The National Centre for Violence Against Women and Girls and Public Protection (NCVPP) (2025) reported 122,768 CSAE offences in 2024, a six per cent increase on the previous year; forty-two per cent involved an online element and over half of identified suspects were aged 10 to 17 years. The Complex and Organised Child Abuse Database (COCAD) recorded 4,450 group-based CSAE offences during the same period, with a growing proportion involving familial contexts (Child Sexual Exploitation Taskforce *et al.*, 2025).

In contrast, children's social care data presents a different picture. In the year ending March 2025, 648,830 assessments were completed, yet the number of children identified as in need fell to 402,400, the lowest level recorded in nearly a decade, alongside continued national reductions in child protection plans (CPPs) (GOV.UK, 2025a). No figures for CSA or child sexual exploitation (CSE) were reported as primary needs at the first assessment, as these categories are not available reporting outcomes within the dataset (GOV.UK, 2025a). However, CSA and CSE can be recorded as outcomes under additional factors at assessment completion. For the year ending March 2025, 18,900 cases of adult-on-child sexual abuse, 12,590 cases of child-on-child sexual abuse, and 12,400 cases of CSE were recorded as assessment factors (GOV.UK, 2025a). 29,560 children were assessed as affected by CSA, a figure that has remained broadly stable since 2016, while only 12,120 were assessed as affected by CSE, the lowest level recorded over this period (GOV.UK, 2025b). Despite this, statutory child protection responses continue to decline. Of 49,420 children subject to CPPs in the year ending March 2025, only 1,770 were initiated under the initial category of sexual abuse (GOV.UK, 2025a), with 2,190 CPPs overall recorded under that category which has been reported as the lowest number since records began (GOV.UK, 2025b). Variation between local authorities further complicates interpretation. CSA-related CIN assessment rates

range from 0.93 to 4.89 per 1,000 children, compared with police-recorded CSA contact rates of 2.77 to 8.19 per 1,000 (DfE, 2024; ONS Centre for Crime and Justice, 2024b, cited in Casey, 2025). Highlighting potential divergence between identification, assessment, and statutory protection thresholds.

Concerns were also raised regarding the SIN process, which requires notification when a child dies or is seriously harmed, and abuse or neglect is known or suspected. Only 26 CSA-related and 14 CSE-related SINs were submitted in the year ending March 2025 (GOV.UK, 2025b), following similarly low numbers in the previous year (The Child Safeguarding Practice Review Panel, 2024). Taken together the latest national evidence on CSAE highlights a consistent pattern forming. CSAE is being identified in police offence data but is becoming less visible in CIN data.

Evidence suggests this disparity may be influenced by recording structures and categorisation practices. Two-thirds of local authorities in England are placing no or very few children on CPPs for CSA (Kewley & Karsna, 2025), with children more commonly placed on plans under neglect, emotional or physical abuse (GOV.UK, 2025b). Structural features of recording systems including the requirement to select a single primary abuse category limit visibility of overlapping harms (Karsna, 2022; Office for National Statistics, 2025). Research found that only 20 per cent of children with a police-recorded CSA offence were categorised under sexual abuse by children's services with the majority recorded under other categories (Children's Commissioner, 2015).

Workforce capability also influences identification and recording. Reviews by HM Inspectorate of Probation [HMIP] *et al.* (2025) and the Child Safeguarding Practice Review Panel (2025) highlight gaps in practitioner confidence in identifying and responding to CSA. Reliance on disclosure, which is frequently delayed, partial or absent may further limit explicit recording (Tregidga & Lovett, 2021; Home Office, 2023; HMIP *et al.*, 2025; Child Sexual Exploitation Taskforce *et al.*, 2025). In such cases, behavioral presentations may be interpreted without recognition of underlying victimisation (HMIP *et al.*, 2025; Garstang *et al.*, 2023). These factors may result in CSAE being recorded under alternative categories thereby contributing to misleading representation of CSAE in the recorded data.

Taken together, the decline in CSAE representation within CIN data is unlikely to reflect reduced prevalence. Rather, it may indicate structural, organisational and practitioner factors which influence identification and recording of CSAE. In response to recommendation 9, the DfE commissioned Manchester Metropolitan University to undertake qualitative research to contextualise the quantitative analysis of national children's social care data. This research examines: (1) potential causes of under-recording and variation in CSAE recording practices; (2) discrepancies between police

and social care data; and (3) to understand the factors driving these differences and how CSAE is recorded within the CIN census at the local level.

The specific research questions for this project which were provided by the DfE include:

- What factors affect decisions made by social workers in identifying and recording CSA and CSE through the CIN data?
- What are the main barriers/challenges to recording CSAE concerns?
- What helps to facilitate consistent recording of CSAE concerns?
- Do social workers feel confident recording concerns about CSAE?
- What might be helpful to improve social worker knowledge and/or confidence in this area?
- Do current data systems impair accurate recording of CSAE concerns?
- What specifically might be helpful to improve the quality and accuracy of data in relation to the recording of CSAE concerns?
- Is there any data recorded locally that provides a more accurate picture of children at risk of/or experiencing CSAE?
- What are the drivers for variation in recording practices in relation to CSAE across local authorities?
- How well do local authorities understand expectations in relation to reporting via the Serious Incident Notifications (SIN) system, and what might be driving an underreporting of SINS in relation to CSAE?

Chapter 1: Remit of Social Care Practice: Identification and Recording of CSAE

- Risk can be fluid and relational, often shifting day to day. Practitioners described building understanding gradually through relationships, interpreting fragmented information, changing narratives and subtle behavioural cues, rather than relying on clear or immediate disclosures.
- CSAE frequently co-occurs with multiple, overlapping risks, including neglect, missing episodes, mental health needs, domestic abuse, poverty, and peer or online influences. This complexity can make single category recording challenging and can result in CSAE not being explicitly named in statutory records.
- Confidence to name CSAE is shaped by evidential uncertainty, grooming dynamics, cultural factors and delayed disclosure. Practitioners rely on patterns of behaviour and contextual indicators to identify harm, and some practitioners felt that without a clear disclosure or concrete incident, it can be challenging to meet statutory thresholds.
- Static recording systems, which require a single primary need to be recorded at a fixed point in time, do not reflect this fluidity. As a result, CSAE can be absorbed into broader child protection plan significant harm such as neglect or emotional abuse.
- Effective early intervention can address elements of risk sometimes before the 45-day assessments are completed. For example, removing the alleged perpetrator of harm. Where risk has been mitigated, this particular harm may no longer be classified as a current concern at the end of assessment. In such cases, the child may not progress to a child protection plan, or if they do, there may be another category of harm which is listed on the plan. This means that early safeguarding activity is not consistently visible in CIN data, yet it may be documented locally.
- Although children's social care operates on the balance of probability, confidence to name CSAE was often described as tied to corroborating evidence or disclosure, with police NFA (no further action) decisions potentially influencing practitioner confidence to record sexual abuse explicitly.
- Differences in how risk and harm are defined and recorded across systems contribute to data divergence. Police-recorded CSAE data includes both current and non-recent investigations, whereas children's social care data primarily reflects present safeguarding risk. This structural difference explains some of the variation between police and children's social care datasets.

Relational, gradual, and interpretive assessments

Practitioners across the local authorities interviewed emphasised that CSAE often presents alongside other issues and is intertwined with wider concerns about the child and their family over time. Clear disclosures of CSAE are not always present and, where they do occur, may emerge gradually or significantly later than initial safeguarding concerns. As a result, identifying CSAE frequently relies on relational and interpretive assessment processes, including the development of trust with children and families, and the careful integration of fragmented information, changing narratives and subtle behavioural indicators. As one professional described:

You're piecing it together from what you see, not just what the child says.
- *Local Authority 5 P1*

This information is typically gathered through sustained engagement as relationships are established over time. Practitioners described their work as relationship-based and interpretive, relying on holistic assessment to understand the lived experiences of children and families, rather than responding solely to discrete or incident-led events. Assessment was therefore described as depending heavily on practitioner curiosity, confidence and the capacity to tolerate uncertainty while continuing to support families over extended periods.

The parents were prosecuted, but then it was passed on to social care to manage and build this family up. - *Local Authority 2 P7*

Fluctuating, fluid and co-occurring risks and harms

Interviewees described CSAE as potentially being entangled with multiple, co-occurring risks and harms, including neglect and other forms of abuse, missing episodes, mental health needs, poverty-related stress, domestic abuse, trauma histories, peer and community influences, and online contact. Practitioners emphasised that exploitation rarely presents as a single issue, noting that “there’s never one issue now – exploitation sits in the middle of everything else” (Local Authority 6, P1). Unlike intra-familial child sexual abuse, which may involve a clearer precipitating incident and identified perpetrator, child sexual exploitation was described as emerging gradually through patterns of behaviour, relationships and wider social and digital contexts. As a result, CSAE is not always explicitly named within assessment documentation. As one practitioner explained:

You don't get that 'single event' that triggers your pathway - you get a cluster of worries over time; that's the bit that makes it harder to code. -
Local Authority 5 P4

Practitioners emphasised that this complexity, rather than a lack of practitioner concern, helps to explain why exploitation does not always appear as the primary need within statutory datasets. They highlighted that adolescents with caring responsibilities or those living in poverty may appear “parentified” or withdrawn, which can mask underlying exploitation risk. Practitioners also described children living in highly stressed or chaotic households, where exploitation can merge with other forms of vulnerability, making it harder to identify a single primary driver of harm. Multiple co-occurring risks and harms, alongside successful early interventions, can mean that exploitation becomes absorbed into broader categories of need that better reflect the full context of the child’s situation.

The complexity is what blinds us sometimes. Staff focus on the chaos... and they stop short of naming sexual abuse because it gets lost in everything else. - *Local Authority 3 P7*

The thing you’re most worried about isn’t always the thing that becomes the primary need. - *Local Authority 5 P4*

Practitioners stressed that this does not reflect minimisation but rather the constraints of evidential thresholds and data structures, where “we’re forced to pick something tidy, even when the situation is anything but tidy” (Local Authority 3 P5).

Early Intervention

It was highlighted in interviews that children can move between lower and higher levels of being at risk of CSAE, particularly regarding CSE, depending on peer dynamics, online contact and daily routines. This fluidity adds an additional layer of complexity to assessment. If a child is receiving help and support from Early Help and is considered potentially at risk of CSE, this may mean that this information is not easily visible within CIN data:

Children receiving early help don’t appear in the CIN census, but that doesn’t mean they’re not having an assessment and intervention” – *Local Authority 5 P1*

Practitioners noted that for children at risk of CSE particularly, early recognition followed by effective intervention can reduce risk, meaning cases may not progress onto formal exploitation pathways. This was described as illustrating how fluid risk levels affect categorisation within statutory systems. Where risk is mitigated before the 45-day assessment period closes, the factor at the end of assessment regarding CSE, may no longer be listed, even where exploitation was identified earlier in the process, as the risk of harm has been addressed.

Often, I find with sexual exploitation it can be disrupted a lot more effectively and a lot more quickly... if there's been effective intervention and the risk's reduced, it might not then go on to a sexual exploitation pathway. - *Local Authority 4 P3*

In Local Authorities 4 and 5, practitioners described how rapid safety planning, coordination with schools and context-focused intervention within peer and community settings could reduce CSE risk of harm within the assessment window.

Because this work is completed within assessment or early help - often resolving risk before the 45-day window ends - cases close without ever entering statutory categories. - *Local Authority 3 P3*

Some practitioners similarly noted that exploitation work often begins immediately, yet statutory categorisation reflects only the endpoint of the assessment rather than the work undertaken throughout:

National reporting captures the end point - nothing about what happened during the assessment. - *Local Authority 5 P4*

One practitioner described an example in which a child disclosed child on child abuse, triggering safeguarding activity supported by the school, alongside involvement from a youth worker during the assessment process. By the point of assessment completion, risks had been addressed meaning no CSE indicators were captured at the endpoint. As the CIN census records only cases that progress to statutory thresholds, early exploitation work for those at risk of CSAE is not easily nationally captured, despite involving intensive assessment, active risk reduction and multi-agency planning. This was described as explaining why some exploitation work which practitioners undertake "never touches CIN at all" (Local Authority 6 P3).

Lack of longitudinal tracking of risk

Within children's social care systems, there are multiple ways to record different forms of harm such as CSA and CSE. These can include selectable fields or drop-down options that are extractable for data analysis, as well as system 'flags' that highlight specific concerns and can be cross-referenced across datasets. Within formal statutory assessments, practitioners described the use of an 'end of assessment factors' list, which includes over 24 factors affecting a child's health and development and indicating potential risk of harm. Two of these factors are 'sexual abuse' (further broken down into child-on-child and adult-on-child abuse) and 'child sexual exploitation'. These were described as helpful, particularly for auditing and analysis purposes, as they allow data to be disaggregated. However, practitioners noted that there may be variability across local

authorities in how these and other factors are recorded. In addition, as noted earlier, factors are only recorded at the end of the assessment if the social worker has access to all relevant information, which may be held across different systems. This means that risks of harm identified earlier in the process may not be reflected within the final recorded data.

A key issue raised was how effectively systems capture both the identification of CSAE and the safeguarding activity undertaken in response, particularly within CIN datasets. Practitioners highlighted that there is no facility within CIN data to record specific factors at the point of referral or to update them during the assessment process. The reliance on end of assessment recording means there is no mechanism to continually input, review or carry forward identified risks as assessments progress. As a result, concerns identified earlier may not remain visible as cases move through different thresholds or pathways, even where they were present and actively addressed.

You're not allowed to put any assessment factors in because you're saying there is no factors now at the end of assessment, you know, but there has been factors you've been dealing with and we might have done a lot of work with our family in that 45 days. - *Local Authority 5 P4*

As one practitioner explained, each identified risk factor should be reviewed as part of ongoing reassessment, and "if that data was filled in properly, it would give a better idea of the risk level" (Local Authority 1 P7). While this information may be captured within case narratives, practitioners noted that it is more difficult to maintain oversight of how risks change over time. In practice, they reported that regular reviews of identified risks do not occur consistently, particularly where cases step down, close, or re-enter the system. This can result in CSAE-related risk becoming fragmented across records rather than tracked longitudinally. It was also highlighted that there is no option within the assessment factors to record change over time. Practitioners noted that different local authorities have developed their own approaches to managing this limitation through additional tools and processes.

Once the assessment has been completed... there's no additional way to track that after the assessment" (Local Authority 1 P10).

We also have a risk analysis framework which can be done as a standalone risk analysis where it would look at different things as well. So, there's lots of different places that things can be recorded. It wouldn't just not be recorded. - *Local Authority 6 P6*

Identifying and recording CSA as a category of significant harm on a child protection plan

Within child protection plans, there are currently four categories of significant harm: neglect, emotional abuse, physical abuse and sexual abuse. Some local authorities allow an additional 'multiple harms' category to be selected; however, in the local authorities interviewed, many practitioners reported that they could select only one of the four main categories. The option of 'multiple' as an abuse category may not necessarily identify specific types of harms. There was a mixed response in that recording one harm category can be limiting as "children's experiences often intertwine with other areas" (Local authority 1, P6), It was also noted by one practitioner that having multiple boxes to tick may not always be helpful:

"I'm not sure that would really make much difference, and I think you may be making it more complicated for people" -*Local Authority 2 P2*

Confidence, evidence and disclosures

Across the local authorities interviewed, professionals described challenges around confidence and a hesitancy to label concerns under the CSA category where clear or concrete evidence is absent: "There is a worry around putting it in that category if there's no clear evidence...it often gets put under the category of neglect" (Local Authority 4 P7). However, practitioners noted that this approach still allows safeguarding work to continue where needs are identified, regardless of the category recorded. Evidential uncertainty was described as being further compounded by the dynamics of grooming, whereby children may not recognise harm or may repeat the perpetrator's narrative. Practitioners spoke of cases whereby which a child could be perceived to be in an intimate or romantic relationship with an exploiter with children sometimes asserting they are making an informed choice, even when risk of exploitation is present. For example, one practitioner noted that young people do not always understand the impact of harm in sending nude pictures and that part of their role is getting them to understand the risks stating 'this is a real challenge for us' (Local Authority 1, P2). Adolescent teams were felt to be helpful in that they worked explicitly with teenagers and had specific experience to build these relationships with young people to undertake this work.

It was highlighted that while cases involving CSAE are often 'disclosure-led', this is not always the case for other forms of harm, such as neglect. In addition, disclosures of sexual abuse are frequently delayed and may only occur once trust has been established. Practitioners noted that children may struggle to articulate the abuse they are experiencing or have experienced and "don't always have the vocabulary" (Local Authority 1 P5).

In this context, practitioners rely heavily on behavioural and contextual indicators to identify risk of harm, even where evidence remains partial:

We don't want to label something as sexual abuse without a disclosure... but those disclosures often never come. - *Local Authority 3 P4*

Police decision-making was also described as sometimes exacerbating uncertainty, particularly for cases recorded as NFA by the police, despite ongoing safeguarding concerns. In such circumstances, social care continues to monitor risk, with practitioners noting that "We don't have to evidence it like the criminal courts" (Local Authority 6 P4). As a result, CSAE can become what practitioners described as a secondary narrative, central to practice but less visible within formal records. Current frameworks were described as offering no clear mechanism for documenting uncertainty without overstating or misrepresenting the available evidence. This was described as contributing to the use of broader categories, such as neglect, which one practitioner reflected on:

It feels like CSA needs to be so far down the evidential pathway before we can use the category. - *Local Authority 3 P3*

Practitioners emphasised that children's social care operates on the balance of probability, rather than the criminal standard of proof beyond reasonable doubt. Despite this, naming CSAE was still described as feeling dependent on definitive or corroborating evidence, with one practitioner noting: "If the police say they're not progressing it, that affects people's confidence to record it as sexual abuse" (Local Authority 3 P6). Confidence to name CSAE was described as closely tied to the presence of corroborating evidence, particularly from the child, police, or medical sources. However, practitioners reflected that while a robust evidence base is important, this should not prevent concerns from being explicitly named by practitioners.

This highlighted a wider concern among participants that evidential uncertainty, alongside practitioner discomfort, can sometimes inadvertently affect the explicit recording of CSAE. Practitioners described the ethical and relational dilemmas involved in naming CSAE, noting that "it's more comfortable, it's more acceptable for families and carers if you're naming something else" (Local Authority 3 P7). Practitioners suggested that confidence in naming CSAE can be strengthened through opportunities for reflection and professional dialogue. In one local authority, a CSA panel was developed and provided reflective space for practitioners to meet regularly to explore CSA concerns:

As a panel we would reflect on what we have heard, very different kind of perspectives, and thinking about unpicking some of the issues. What resonates for them and then doing some signposting, giving them tools, guidance, that kind of thing and next steps. - *Local Authority 1 P11*

Additionally, the CSA Centre for Expertise, was highlighted for its resources to support practice:

A universal response toolkit, interactive tool, if you're worried at all about child sexual abuse, and what we've done is we've really pushed this. - *Local Authority 2 P3*

Cultural factors and identification

Practitioners described cultural differences and taboos around discussing sex as influencing how CSAE is recognised and discussed in practice. Participants involved in the interviews described sexual abuse as difficult to imagine, articulate or confront. As a result, as mentioned already, practitioners emphasised the importance of having spaces and opportunities within the working environment to support reflection, discussion and confidence-building when working with this form of harm. Practitioners noted that vague or euphemistic language is sometimes used, creating additional challenges in explicitly naming CSA.

We often talk about sexual assault. We don't talk about the specifics, and the specifics can clarify the nature of something. - *Local Authority 1 P11*

Practitioners also highlighted how the absence of potential appropriate vocabulary in some languages can make conversations about safety and harm more challenging. One practitioner noted that when working with migrant families, there can be concerns about “getting it wrong” (Local Authority 6 P3) or causing offence. Some practitioners expressed uncertainty about whether addressing risk might be perceived as culturally insensitive. Taken together, these factors were described as creating additional layers of hidden risk, making it harder for practitioners to feel confident in identifying and naming CSAE. This uncertainty was described as contributing to a heavy reliance on ‘evidence’ before practitioners felt able to label concerns as CSA:

We are waiting far too long for evidence before we call something sexual abuse. - *Local Authority 3 P2*

There's something around cultural competency...addressing it in the same way as would for a white British family...that we're not fearful of addressing the risks. - *Local Authority 6 P3*

Other categories of harm encompass child sexual abuse

Practitioners described a pattern in which presenting concerns often reflect accumulated adversity, meaning that CSAE can become absorbed into broader categories of harm, particularly neglect or emotional harm. The statutory requirement to select a single

category of significant harm within a child protection plan, can result in practitioners choosing the label that best captures the wider safeguarding context, rather than explicitly recording all underlying harms. As one practitioner observed “exploitation gets lost because the home feels chaotic... so neglect becomes the category” (Local Authority 6 P2).

Practitioners noted that this pattern may distort national data, as cases entering services due to concerns about CSA may later be recorded under different categories:

It often gets put under the category of neglect because that covers so many areas, including inability to protect and ensure safety, which can include physical, emotional, [and] sexual. - *Local Authority 4 P7*

Practitioners also highlighted that selecting a broader category can sometimes support engagement with families, who may be more responsive to concerns framed in less sensitive terms. As one practitioner noted, “there’s always other risks that feed into that main risk” (Local Authority 1 P10). Despite these complexities, practitioners stressed the importance of explicitly naming CSAE when disclosures occur or when evidence is sufficiently clear, emphasising the need to “to name it for what it is” (Local Authority 1 P7). This reflects an ongoing tension between safeguarding practice, which is relational and pattern-based, and statutory recording systems, which rely on fixed thresholds and discrete categories.

While risks and concerns enter children’s social care through referrals and front door processes, which may relate to a specific harm, these are not captured in referral-level Children in Need (CIN) data (GOV.UK, 2025a). As assessments progress, additional concerns often come to light and a primary need is identified. In cases involving CSAE, this may be recorded under a single child protection plan category relating to abuse or neglect. However, this same category is also used to capture a wide range of other harms beyond CSAE. Where safeguarding action is taken early, for example, where immediate risk relating to CSA is addressed through protective measures such as the perpetrator moving out, this specific risk may be mitigated, while other concerns, such as neglect, remain and continue to require intervention.

Practitioners noted that CSAE frequently occurs alongside other risks, including poverty, parental substance misuse and domestic abuse, and that disclosures may occur a considerable time after the abuse has taken place. This can affect how concerns are reflected and categorised within plans:

If it wasn't a current issue, but it has been a historical one, you wouldn't necessarily have an action around it when you plan. - *Local Authority 2 P5*

This highlights a difference in remit between policing and children's social care. Where abuse is historical and there is no ongoing safeguarding risk, there may be limits on the actions children's social care can take within a child protection framework, while police action to investigate and prosecute the offence may still proceed. Some practitioners felt that introducing multiple child protection plan categories within a single plan could be confusing. However, concerns were also raised about the limitations of relying on a single category, with one practitioner observing that "you're trying to capture something fluid with a form that wants one primary category" (Local Authority 5 P4). Practitioners reflected on how this can lead to broader categorisation, arguing that:

To pick up all the things the child is experiencing, put it under the category of emotional harm, which causes an element of all forms of abuse. - *Local Authority 1 P7*

How language can shape the identification and recording of CSAE

Practitioners across the local authorities described how the wording used in assessments can shape how CSAE is interpreted, named and recorded. While practitioners acknowledged progress in recent years, they noted that minimising or victim-blaming language can still appear in assessment records. Examples included phrases such as describing children as "putting themselves at risk", a framing that "changes the tone of the whole assessment...it makes it about the behaviour, not the harm" (Local Authority 6 P2). Practitioners reported that such language was routinely challenged in practice to ensure that responsibility is placed appropriately with perpetrators.

If someone says, 'they keep putting themselves there', I stop them. That's not what's happening. Someone is putting her there. - *Local Authority 6 P1*

Language tensions were also identified in relation to harmful sexual behaviour between children. Practitioners described a reluctance to categorise these cases as sexual abuse within child protection processes, linked to concerns about "wanting to not blame the young person... recognising that it's very likely to be linked to their own experiences" (Local Authority 1 P7)

Chapter 2: Nature of CSAE harm

- CSA and CSE are closely related, can co-occur but can also present differently in practice. Practitioners described CSA, particularly intra-familial abuse, as more readily recognised within existing child protection frameworks, while CSE frequently involves extra-familial harm arising in peer, community and online contexts.
- CSE is typically identified as a gradual, pattern-based harm rather than a single incident. Unlike many cases of intra-familial CSA, which were described as more immediately legible within statutory frameworks, CSE risk was described as emerging over time through behaviour, relationships and online activity, often with fragmented information held across systems. This makes CSE harder to evidence, threshold and record within statutory safeguarding processes, despite ongoing professional concern.
- Extra-familial CSE presents challenges for traditional child protection pathways. Where parents are identified as protective partners and harm occurs outside the home, practitioners described child protection plans as not always well suited to addressing contextual risk. In these cases, Section 47 strategy discussions may be used for multi-agency information-sharing and risk management rather than progression to conference, which may help to explain lower conversion rates to ICPCs.
- Online environments and peer networks now shape much contemporary sexual harm. Practitioners described risk as dispersed across digital spaces, peer groups and geographic boundaries, creating safeguarding challenges that are

Relationship between CSA and CSE

While the two terms were generally understood as related, practitioners described CSE as a specific form of CSA. Some practitioners reflected that experiences of sexual abuse may increase vulnerability to further sexual harm, including exploitation. For example, one practitioner (Local Authority 1 P10) described cases where concerns about historical sexual abuse within the family were later followed by referrals involving different sexual harms, such as young people being pressured to send indecent images. Another practitioner noted that the boundaries between CSA and CSE can merge, explaining that “there will be children who’ve been sexually abused within their family that are more at risk” (Local Authority 1 P7). This risk was described as applying both in relation to victimisation and, in some cases, harmful behaviour towards others.

While distinct in definition, practitioners emphasised that these forms of harm are not always experienced as binary. Children may experience both CSA and CSE, both within

and outside of the home. One practitioner described a shift in practice towards naming CSE as part of CSA, rather than treating it as separate:

The separation between CSA and CSE isn't helpful anymore, the young people don't experience it as separate things" - *Local Authority 3 P7*.

I think people are getting less and less away from pigeonholing it, that it's just child sexual exploitation and calling it out more for being child sexual abuse. - *Local Authority 2 P3*

Language was described as playing a significant role in how harm is understood and recorded. Practitioners noted the use of the umbrella term 'harmful sexual behaviour' when discussing CSAE. However, they also highlighted that such broad terms can encompass a wide range of behaviours, including both contact and non-contact abuse, and may not fully reflect the complexity of children's experiences. As one practitioner observed, "there's a lot of nuance that goes on in it with each family" (Local Authority 1 P11).

Online harms

Practitioners across local authorities identified a significant shift towards online environments as one of the most profound changes in contemporary CSAE. They described a marked transition from place-based exploitation to digital contact occurring through messaging platforms, gaming sites, image-sharing applications and closed social media groups. This shift was described as reducing opportunities for early visibility and limiting the usefulness of traditional hotspot mapping, an analytical approach used to identify physical locations where crime prevention resources can be targeted.

The move to an online space is massive... I wouldn't be able to pick out a handful of parks anymore - perpetrators are finding these children online. - *Local Authority 5 P1*

Start online long before you ever see a real-world incident. By the time it lands in social care, the child has been in that network for months. - *Local Authority 3 P4*

Practitioners highlighted that much contemporary sexual harm, particularly CSE, now fluctuates rapidly and can become normalised within digital and social networks. Children were described as moving between different roles within these spaces:

...victim, influencer and associate, sometimes in the same week... today they're the victim, tomorrow they're influencing someone else - *Local Authority 5 P1*.

Image-sharing, coercive peer conversations and sexualised group chats were described as accounting for a growing proportion of exploitation cases. However, these relational dynamics were seen as difficult to capture within systems designed primarily for household-based or static forms of harm. As a result, sexual harm can become obscured within wider concerns about behaviour:

The cases don't come in as 'sexual abuse'. They come in as 'we can't manage her behaviour', or 'he's going missing'. The sexual harm is buried." - Local Authority 3 P4.

Educating children and young people about healthy relationships was viewed as crucial, but increasingly challenging. Practitioners noted that children may be adultified, by themselves, by others, or by wider societal attitudes, and may not recognise exploitation or understand what constitutes a healthy relationship. This was seen as increasing vulnerability to harm. Practitioners also reported that increased online activity has exposed children to inappropriate content at younger ages, with one noting that "we've created a world for them that they are not ready for at all" (Local Authority 1 P12). Risks associated with easy access to online pornography were highlighted, alongside concerns that parents may feel ill-equipped to support young people in navigating online spaces. One practitioner reflected:

Online harm, which is a whole category, and you've got children who live their lives online. They have an online presence and online social life, and online identity, which is important that we as a society haven't really got to grips with. We also haven't got to grips with how you control that, and you help children navigate. - *Local Authority 1 P11*

Ensuring that children and young people have access to education on healthy relationships was consistently viewed as imperative by the those interviewed.

CSE and Extra-familial harm

Although policy locates CSE within the broader category of CSA, practitioners described how frontline practice demonstrates that the two forms of harm often follow different trajectories. These differences were described as having implications for thresholds, categorisation, early intervention and national data visibility. Practitioners highlighted that CSA and CSE can involve distinct safeguarding risks and therefore require different safeguarding pathways to ensure an appropriate response.

Extra-familial harm refers to abuse and exploitation that takes place outside of the family home. Practitioners described safeguarding responses to these risks as often requiring a contextual approach, focusing on wider environments such as communities, digital

spaces and peer relationships. In some areas, Risk Outside the Home (ROTH)⁴ pathways are being piloted to respond to contextual risk, although these were described as still being at an early stage of development.

Practitioners emphasised that CSA typically presents as harm within the home and that traditional child protection pathways are generally well suited to accommodating this. One practitioner summarised this as “when it’s sexual abuse within the family, it is quite clearly safeguarding immediately ...” (Local Authority 5, P1). Local Authority 6 reinforced this view, noting that CSA often aligns clearly with Section 47 processes and existing statutory recording categories. By contrast, CSE was described as dispersed, relational and ambiguous, with practitioners emphasising that children affected by exploitation frequently do not recognise their experiences as abuse:

With exploitation, they don’t see it as abuse, they think it’s a relationship, or a friend... that’s why you don’t get that ‘moment’ where they tell you. You’re piecing it together. - *Local Authority 5 P7*

CSE was also described as involving harms that occur outside of the home and are “dispersed across peers, adults and online spaces” (Local Authority 5 P1). Practitioners noted that these risks of harm cannot easily be mitigated through a single protective action, particularly where parents are not viewed as the source of harm and the risk is extra-familial. This was especially evident in cases involving online exploitation, where practitioners described uncertainty about who the child is being protected from and where risk is located:

With online exploitation we often don’t know who we’re protecting the child from... it’s not one person anymore. It’s multiple risks, multiple places. - *Local Authority 3 P3*

Practitioners described this as reflecting a broader shift in the nature of CSE-related harm, which was viewed as more complex and less predictable than traditional safeguarding models anticipate. Digital spaces, fluid peer dynamics and cross-boundary exploitation were repeatedly identified as shaping a changed safeguarding landscape:

The cases coming through now are nothing like the ones I dealt with ten years ago: online harms, peer exploitation, image sharing... it’s a completely different landscape. - *Local Authority 3 P5*

Where CSA occurs within the home, removing the alleged perpetrator was described as a potential safeguarding intervention. However, practitioners emphasised that this

⁴ [Risk Outside of the Home Child Protection Pathways: Learning from Phase 2 Pilots](#)

approach does not necessarily reduce risk where harm is extra-familial, including where exploitation occurs online:

CSE is complex. There are so many factors at play... removing risk is very different compared to CSA where the risky person can often be removed quickly. - *Local Authority 3 P1*

A traditional child protection plan was therefore described as not always effective in reducing contextual risk, as plans cannot control what happens within wider community environments. In these situations, parents were often viewed as professional partners rather than sources of harm, with one practitioner noting that “you’re working with them, not protecting the child from them” (Local Authority 5 P1). However, practitioners cautioned that this framing can sometimes result in responses being “too tolerant” of ongoing risk, explaining that “parents look protective, so we wait... but the risk is still significant” (Local Authority 3 P3).

Responding to extra-familial harm was described as often requiring supplementary responses alongside statutory safeguarding pathways. One such response is a Multi-Agency Child Exploitation (MACE) panel. Children discussed at MACE may also be on statutory pathways, including being looked after by the local authority, being subject to a child protection plan, being supported as a child in need plan, or possibly receiving early help, depending on the assessment of experiencing harm or vulnerable to risk. The aim was described as recognising whether significant harm is occurring and ensuring that the safeguarding response is proportionate and appropriate, “making the right decisions that’s going to get the best outcomes” (Local Authority 2 P7). Practitioners described how these responses may involve additional plans and protocols operating alongside statutory processes, often with an emphasis on relationship-building, for example through work with youth workers. As one practitioner explained, “there are other ways of supporting or thinking differently rather than section 47” (Local Authority 2 P2).

I think there would be section 47s, like we would do strats and section 47 enquiries, but then it may not necessarily go on to a long-term section 47 plan in terms of a child protection plan. - *Local Authority 1 P10*

Sometimes they may think, I don’t know if conference is the right vehicle for this... there’s that alternative route via what ROTH [risk outside the home] does...this reinforces that low conversion rates can reflect good practice, not poor decision-making. - *Local Authority 4 P2*

While CSE often presents as extra-familial harm, practitioners noted that concerns within the home may still co-occur. Even where exploitation risks are external, assessments continue to consider the child’s lived experience and safety within the family home. Practitioners emphasised the importance of understanding all forms of harm. In one area,

it was considered helpful to specify harms beyond standard child protection plan categories, including whether CSA involved child-on-child or adult-on-child abuse, and whether risks of harm were extra-familial.

Practitioners noted that while CSA and CSE can require different safeguarding responses, CSAE is typically considered at the point of a strategy discussion. Strategy meetings were described as providing an important forum for information sharing and decision-making, including determining whether thresholds for harm are met and which safeguarding pathway is most appropriate. Some practitioners expressed concern that without strategy discussions, it can be difficult to bring together all relevant information for effective decision making:

You're having to navigate areas of consent, aren't you? And who can share information? So at least for the strategy discussion, you know you can share information. - *Local Authority 2 P2*

However, approaches to strategy discussions varied across local authorities, influenced by referral volumes, resource pressures and local practice cultures. Practitioners noted that in some areas, strategy discussions are used routinely for CSAE to support risk management, information-sharing and multi-agency collaboration, and to gather the information needed to determine whether there are concerns of potential significant harm. One practitioner reflected that this could increase the number of Section 47 enquiries without necessarily increasing conversion to Initial Child Protection Conferences (ICPCs). As a result, it can create the appearance of low conversion rates, not because concerns are minimised, but because strategy discussions are used to manage uncertainty and coordinate multi-agency decision-making:

Some areas are quite risk averse and prefer to hold that strat...we're doing a lot of work around making sure we're only holding strategy meetings where there is a real risk of significant harm. - *Local Authority 4 P7*

Finally, practitioners highlighted the need for earlier and more therapeutic support for children affected by CSAE. From a social work perspective, a lack of early intervention was described as increasing the risk of repeated referrals until children reach crisis point:

You can almost predict it... those three- or four-year-olds now will be in our hub at 15–16. We already know those children. - *Local Authority 3 P3*

Chapter 3: Systems, tools and structures that shape visibility and variation in CSAE

- CSAE indicators are dispersed across multiple systems, records and timeframes, making it difficult to reconstruct a child's journey through statutory data. Chronologies provide rich contextual information, but this often sits within narrative text, limiting its visibility and extractability at a system level.
- CIN census returns are structured around incidents and single categories, rather than patterns, relationships or context. As a result, relational and extra-familial exploitation risks are frequently recorded outside statutory datasets.
- Key CSAE information is commonly held outside CIN systems, including within local case management tools, MACE documentation, police databases and bespoke local dashboards. While these sources often contain detailed and practice-relevant information, they are difficult to extract, link or standardise across agencies.
- Local authorities have developed innovative tools and processes, such as dashboards, screening mechanisms and contextual mapping, to ensure this information is recorded, in the absence of a consistent national statutory data set for this area. However, these locally developed systems vary in scope and design, influencing what is captured, recorded and reported.
- Variation in local areas, application of thresholds and assessment of when strategy discussions should be held, system architecture, workforce capacity and multi-agency arrangements produces significant regional differences in CSAE visibility. As a result, CIN datasets can reflect local system design and infrastructure more than the underlying prevalence, complexity or nature of CSAE.

Narrative and capturing a child's journey

The overall design of children's social care case management systems was described as complicating access to key information about a child's experiences. Practitioners reported that systems are often time-consuming to navigate and fragmented across multiple pages, screens or notes. Narrative information, such as that recorded in case notes, is not always visible within primary categorisation fields and is therefore not easily extractable without conducting an individual, case-by-case review of records. A core structural issue identified by practitioners was that recording systems are relationship-based, reflecting the nature of social work practice, which centres on building relationships over time and supporting families through complex journeys. As a result,

rich and detailed information is often captured within narrative text to reflect complexity, rather than within structured fields.

The lived story doesn't fit the drop-down boxes. Workers end up writing long narratives that never translate into the national data. - *Local Authority 3 P5*

Current statutory systems were described as struggling to capture this fluidity of being at risk or vulnerable to risk, as they are structured around discrete incidents and fixed assessment points:

Practitioners explained that significant information and life events are often recorded within chronologies⁵. In social work practice, a chronology refers to a structured timeline that brings together key events, risk indicators and safeguarding activity to support understanding of a child's lived experience and patterns of concern over time. While practitioners described these chronologies as providing a detailed and rich source of information, they also highlighted challenges in piecing this together into a coherent account, particularly where multiple entries are dispersed across different systems. As children may have extensive histories and periods of involvement with children's social care over time, practitioners reported that there can be a vast volume of information that must be manually reviewed and synthesised, often under significant time pressure. Consequently, when new information is added, "unless the worker has remembered to put it in the case summary, it's not going to appear at the top" (Local Authority 1 P6). As a result, information contained within chronologies cannot be quickly retrieved to identify patterns over time, cumulative harm, or emerging risks and needs. Early indicators of CSAE were described as appearing as "tiny pieces of a jigsaw" (Local Authority 6 P2), limiting the ability of recording systems to surface a clear and coherent safeguarding journey.

Practitioners further noted that beyond case notes and chronologies, current recording structures offer no mechanism to track CSAE trajectories over time. As a result, manual dip-sampling exercises are often required to identify patterns, with one practitioner stating that "track trajectory – it is literally the only way to see" (Local Authority 2 P3). This reinforces a broader concern that while children's experiences are cumulative, relational and dispersed across time and services, recording systems remain linear, siloed and incident driven.

Threading that journey through is so difficult... children bounce between early help and social care, cases close and re-open and the data can't track that experience. - *Local Authority 3 P6*

⁵ See: [Completing social work chronologies: Practice Tool \(2022\) | Research in Practice](#)

As discussed in earlier chapters, practitioners also highlighted that children's circumstances are fluid and dynamic, with risks and needs fluctuating over time. These changes were described as difficult to capture comprehensively within fixed drop-down fields. Narrative notes were viewed as essential for conveying risk that sits within relationships, patterns and context, yet these are not easily integrated within structured system fields. One practitioner reflected that they are "trying to explain risk that sits in relationships, in patterns, in context, and the system wants a checkbox" (Local Authority 3 P4). Where multiple practitioners are involved with a child or family, this challenge is compounded, as each practitioner must have the time and capacity to read and interpret extensive narrative records:

Sometimes it'll take them a really long time before they actually do read my work notes...I spend hours and hours with these young people. -
Local Authority 2 P4

In relation to harms and risks outside the home, practitioners emphasised that systems are not designed to store or link key contextual information, such as repeat adult names, emerging hotspots, peer associations or online patterns, unless these are manually entered into narrative notes. This further limits the system's capacity to hold complexity or communicate nuance. Practitioners from Local Authority 6 described creating hand-drawn maps or working across "three spreadsheets" because "the system can't hold anything relational" (Local Authority 6 P1). As a result, meaningful safeguarding intelligence frequently sits within narrative text "not in the boxes we tick" (Local Authority 5 P2).

As discussed in earlier chapters, CSE was described as emerging over time through relationships, disclosures and contextual cues. Practitioners emphasised that narrative recording captures this process more effectively than rigid categories. However, frustration was expressed that analysts often struggle to extract exploitation-related information because it is not linked to structured fields. Consequently, important insight can become dispersed, overlooked or inconsistently recorded, meaning that frontline understanding does not always translate into accurate system-level visibility. Practitioners stressed that system design itself shapes what becomes visible, noting:

You're working with a system designed one specific way...families' lives are very complex" - *Local Authority 1 P6*

Information recorded outside of statutory systems

Practitioners described examples across local authorities where local forms, tools and protocols had been developed to assess exploitation risk of harm. These often combined structured drop-down fields with narrative sections, increasing local visibility of risk.

However, these tools were not always specific to CSAE. In some areas, assessment frameworks had been broadened to capture multiple forms of harm, which practitioners felt could dilute the visibility of CSAE. For example, a multi-participant group in Local Authority 4 explained that their risk assessment framework had “expanded... it was purely sexual exploitation, now it covers missing and criminal exploitation as well” (Local Authority 4 P8). While this reflected the reality of overlapping harms, practitioners noted that combining multiple risks within a single tool could make it harder to represent the nuances of CSAE as experienced locally.

We don't have a huge amount of indicators on the system to identify contextual exploitation... what's extractable is very different to what's held in the case record. - *Local Authority 3 P1*

This was described as placing additional burdens on practitioners, particularly when attempting to reconstruct a child's experience retrospectively for inspection, audit or review purposes, which often require clear and auditable evidence trails. One practitioner explained:

You have to be able to accurately capture it on a system and export it... we're always having to evidence missing, CME and exploitation for inspection” - *Local Authority 4 P5*

Practitioners consistently highlighted a mismatch between linear, incident-based statutory recording systems and the relational, cumulative nature of exploitation. Systems were described as being designed to record information about individual children, rather than relationships or contexts. As one practitioner noted, “systems aren't set up to show relationships or contexts - only the child” (Local Authority 5 P1). Another practitioner reflected more broadly that “children aren't cost codes... they don't care about our processes. They just want it to stop” (Local Authority 3 P2).

To address this limitation, local authorities described developing parallel mechanisms to understand networked and contextual harm. Local Authority 6 relied on manual “*relationship webs*”, while Local Authority 4 drew on police intelligence, MACE records and locality mapping meetings. Information relating to CSE was noted to be held across a range of non-statutory systems, including police databases, early help platforms, community safety tools, education and health records, and documentation developed specifically for MACE processes. These systems were not easily integrated, meaning practitioners must continually piece together information manually to form a coherent picture of risk. As a result, this information often exists within parallel structures that are not visible within CIN datasets.

The forms don't match the work anymore. - *Local Authority 6 P3*

As the safeguarding landscape has evolved, practitioners described the development of alternative safeguarding approaches, in addition to existing statutory approaches (see Chapter 2), including new protocols, panels and multi-agency processes, each of which generates its own datasets. While these developments were viewed as strengthening local responses to risk of harm, they were also described as contributing to variation across local authorities, shaped by the volume and nature of harms presenting locally, as well as the structures and resources available in each area.

Local authorities described the use of sophisticated local systems to capture exploitation-related information, often providing a more accurate and dynamic picture of risk than statutory datasets. These datasets are commonly fed into dashboards and used by specialist groups and panels, including MACE meetings, contextual safeguarding forums, missing-from-home databases, education-based monitoring, police mapping tools and specialist exploitation trackers. In addition, practitioners described the development of exploitation screening protocols at the safeguarding front door, enabling referrals to be assessed for indicators of exploitation at an early stage. These systems often generate dashboards tracking missing episodes, return home interviews, serious youth violence, CSE and child criminal exploitation (CCE), across varying levels of vulnerability.

Examples included Local Authority 5, which described developing dashboards focused on missing episodes, contextual patterns and daily exploitation triage; Local Authority 6, which used a combination of Child Vulnerability Tracker (CVT) analysis, MACE mapping and community hotspot tracking; and Local Authority 3, which operated a live exploitation dashboard integrating early help and education data. While practitioners viewed these systems as providing rich and actionable insight into local safeguarding activity, they also stressed that this information rarely feeds into national datasets. One practitioner stated *that* “national datasets will always understate exploitation” (Local Authority 6 P1), while another reflected that “we’re doing the work – it’s just invisible in CIN” (Local Authority 5 P1). Practitioners therefore suggested that the most accurate and practice-relevant information about exploitation often sits outside statutory CIN data. As a result, national datasets can present an incomplete, and at times misleading, picture of exploitation prevalence and local safeguarding activity.

ROTH pathways and the government’s Families First Partnership programme⁶ reforms were also discussed as emerging approaches for responding to CSAE. Practitioners referred specifically to the ROTH child protection pathway piloted by Durham University⁷. Adoption of this pathway varied across local authorities. Local Authority 3 highlighted concerns that overlapping safeguarding pathways could increase complexity, noting that:

⁶ [Families First Partnership programme - GOV.UK](#)

⁷ [Embedding Risk Outside of the Home \(ROTH\) Pathways: Phase 3 Pilots | Contextual Safeguarding](#)

You've got ROTH meetings, child protection meetings, early help meetings – families can end up in all of them at once" - *Local Authority 3 P4*

Practitioners in some areas were awaiting implementation of Families First and expressed cautious optimism that it represented “the right direction”, with the potential for “more tools and intervention much earlier on to reduce lots of those issues for those children” (Local Authority 3 P3). Local Authority 5 described piloting a Families First hub, with “social workers embedded at the front door, sitting alongside early help”. However, practitioners in areas yet to implement these reforms expressed uncertainty about how new arrangements would operate in practice and how emerging data collection would capture CSAE activity. One practitioner cautioned that:

Unless Families First changes how things are recorded nationally, we'll just be hiding the work in a different place" - *Local Authority 3 P6*

Variation in Local CSAE Systems and Structures

Practitioners highlighted that while local system architecture can support innovation, it can also produce significant variation in how CSAE is identified, recorded and responded to across local authorities. Practitioners described a range of different local models, including:

- Highly structured approaches, such as daily child exploitation triage processes, open child exploitation matrix submissions and specialist early help oversight, which were described as supporting more consistent interpretation and decision-making.
- More dispersed models, where exploitation concerns emerge across multiple services, including early help, community safety teams, youth provision and locality-based clusters.
- Strong specialist mapping arrangements in some areas, which practitioners felt enabled early disruption of exploitation and reduced the need for statutory escalation.
- Greater reliance on child protection conferences, which was described as creating the appearance of higher prevalence within statutory datasets.
- Variation in multi-agency groups and protocols used to identify and respond to exploitation, with differences in which partners are involved, for example:
 - One local authority described Sexual Assault Referral Centres (SARCs) being invited to strategy meetings to provide specialist input.

- Another highlighted the presence of a dedicated adolescent team, which was viewed as particularly effective in supporting work with CSE and understanding adolescent-specific risks of harm.

Together, these examples illustrate how localised areas are innovatively responding to demands to reflect the needs of their area which are underpinned by local systems and structures and could generate variation in recording practices.

Practitioners also emphasised that capacity and geography further compound this variation. Resource constraints were described as a significant factor shaping practice. One practitioner reflected that the responses could depend on “which locality picks it up... capacity shapes whether it gets recorded at all” (Local Authority 6 P3). Differences in police resourcing were also highlighted. For example, some areas were able to provide a dedicated exploitation-focused police officer for each child identified as at risk of harm, whereas this was not feasible in other forces.

Additional layers of complexity were described in relation to cross-boundary working and system interoperability. Local Authority 4 highlighted the challenges created by variation in data systems and local practice cultures across neighbouring districts, ranging from more risk-averse to more proportionate approaches. These differences were shaped by uneven staffing levels, variation in conference chairs and differing histories of joint working. Practitioners noted that children’s social care and police systems differ not only within individual local authorities but also across adjacent areas. Some authorities use Mosaic, others Liquidlogic; some operate child exploitation–specific dashboards (for example, Local Authority 3), while others rely on spreadsheets (Local Authority 5) or police databases. This creates significant challenges for regional and national comparison:

If each local authority builds a system in our own way, we’re each going to have different performance indicators... it makes it incredibly difficult to see anything more than the local picture. - *Local Authority 5 P1*

Collectively, these findings demonstrate that some of the variation in CSAE identification and recording is potentially produced by the organisational structures, governed by locally collected metrics, varying resources across departments. Interviewees described how differences can arise from local demand and need, thresholds, practice cultures, system design, pathway structures, geography and multi-agency alignment, which can impact quality of practice. As a result, national datasets may risk misrepresenting variation between areas, as what is captured within CIN data sometimes reflect system architecture more than the underlying prevalence of CSAE or the safeguarding activity undertaken locally.

Chapter 4: Serious Incident Notifications (SIN) and CSAE

- SIN thresholds in general were described as well understood across the local authorities interviewed, with practitioners recognising the “very high” bar for cases involving death or serious harm where abuse or neglect is known or suspected.
- CSAE cases were described as more complex to assess within the SIN framework, as harm may be disclosed late, emerge cumulatively, or involve primarily psychological or coercive harm rather than immediate physical injury, making application of thresholds more challenging and contributing to lower numbers of CSAE-related SINs.
- Local learning mechanisms, such as Cases of Concern reviews, Learning from Experience reviews and appreciative inquiry processes, were described as supporting proportionate multi-agency reflection and learning where CSAE cases do not meet national SIN criteria. These mechanisms were reported to follow comparable review processes while allowing greater flexibility in scope and timing.
- SIN decision-making processes in general were described as consistent and senior-led, with opportunities for multi-agency input. However, practitioners highlighted practical challenges with the national SIN system, including system fragility, the inability to save draft submissions and delays linked to coordinating multi-agency input.
- Lower levels of CSAE-related SINs were considered to partly reflect the nature of sexual harm and how it presents in practice, rather than misunderstanding or misapplication of thresholds. However, practitioners identified a need for clearer national guidance on how CSAE should be considered within SIN decision-making, particularly in relation to cumulative harm and the interpretation of “serious harm.”

Thresholds and Understandings

Practitioners stated that they felt confident in their general understanding of SIN thresholds, and view it as a “very high” bar for cases meeting the set criteria:

- Children who have died or been seriously harmed, and
- Abuse or neglect is known or suspected (DfE, 2025, p7)

This definition was well understood across the local authorities interviewed on SIN (note N=4, across 3 local authority areas). Practitioners also noted that national guidance has been strengthened in recent years, providing greater clarity and consistency in threshold expectations. Where differences between areas were discussed, these were attributed to local variation, frequency and pathways rather than differences in how thresholds were interpreted or applied. Importantly, practitioners did not describe serious harm as becoming normalised. Instead, practitioners emphasised that in CSAE contexts, harm is often recognised through delayed disclosure, cumulative understanding, or emerging evidence over time. While such disclosures can, and sometimes do, lead to SINS, practitioners described uncertainty about when the threshold for notification is met in cases where harm is psychological, coercive or long-term in nature; where safeguarding risk may no longer be current; or where learning has already been addressed through other review mechanisms. This makes decisions about whether and when to submit a SIN more complex than in cases involving immediate, clearly evidenced serious harm.

SINs relating to CSAE

Practitioners did not describe uncertainty about the definition of SINS or the core criteria for notification. However, they did describe greater complexity in applying both elements of the SIN criteria in cases where CSAE was a factor, namely, determining when a child has been seriously harmed and when abuse or neglect is known or suspected, particularly where these become apparent at different points over time.

This complexity was most often attributed to the way information about sexual harm emerges. Practitioners explained that disclosure and understanding of CSAE frequently develop incrementally, sometimes months or years after the period of harm, with the full extent and impact only becoming clear through cumulative information rather than a single event. As one professional noted, “more of it tends to come out sometimes decades later” (Local Authority 1 P7). While SINS can be submitted retrospectively, decisions about notification are often considered at an early point in professional awareness, before the cumulative nature or long-term impact of harm is fully understood. Practitioners highlighted that this could complicate judgements about proportionality and learning value, particularly where practice has already changed or safeguarding risk is no longer current.

Practitioners also reflected on the challenge of evidencing and articulating “serious harm” in CSAE cases where harm is primarily psychological, coercive or cumulative in nature. While statutory guidance clearly recognises that serious harm includes serious or long-term impairment to a child’s mental health, emotional, social or behavioural development, professionals described difficulty in consistently operationalising this within SIN decision-making where harm is not immediately observable or linked to a discrete incident. This was not described as a challenge to the definition itself, but to its application in CSAE

contexts characterised by delayed disclosure, grooming dynamics and evolving understanding of impact.

As a result, practitioners expressed that clearer expectations from the Child Safeguarding Practice Review Panel would be helpful, particularly in relation to how CSAE should be considered within SIN decision-making and how the criteria should be applied where harm is cumulative or recognised over time. As one practitioner suggested, the Panel could be:

Clearer about what their expectations are in terms of child sexual abuse and child sexual exploitation. - *Local Authority 2 P1*

Some practitioners also noted that lower SIN numbers relating to CSAE should be understood within the broader context of children's social care recording and reporting. As with CIN datasets, neglect and emotional abuse account for the majority of cases, while sexual abuse is often harder to identify and explicitly name, particularly in the absence of disclosure or criminal justice outcomes. Practitioners emphasised that this can affect the visibility and categorisation of CSAE within statutory processes, rather than reflecting lower levels of concern, seriousness or safeguarding activity

Local learning mechanisms

Practitioners described a range of established local learning mechanisms that are used to support reflection and improvement in cases involving serious concern, including CSAE, where the national SIN criteria are not met. These mechanisms were described as part of wider quality assurance and learning arrangements, rather than as CSAE-specific processes, and were applied where safeguarding concerns were significant but did not reach the statutory threshold for a SIN.

For example, one local authority described reviewing Cases of Concern alongside the use of Practice Improvement Consultants, who undertake case reviews using an appreciative inquiry approach. These roles were described as part of the authority's broader practice improvement and learning infrastructure, supporting reflective review across different areas of safeguarding practice, including sexual abuse and exploitation. Another local authority described a Learning from Experience review model, which operates as a 'two-tiered' system with parameters and timescales distinct from SINs, but using similar review processes, chairing arrangements and report formats.

These local mechanisms were considered particularly valuable in circumstances where sexual abuse was disclosed to an agency other than children's social care, or where concerns emerged over time, prompting multi-agency reflection even when the statutory threshold for a SIN was not met. While some partners, such as GPs, may not routinely

attend non-statutory reviews, practitioners described these processes as providing a meaningful forum for multi-agency discussion with the relevant professionals involved.

Learning from Experience Review process, apart from being not tied to the time scale is the same. We run it in the same way. We use the same process, the same people to chair, same report for report format. - *Local Authority 2 P1*

We do internal reviews even when it doesn't meet SIN criteria, otherwise we'd lose learning on most sexual abuse cases. - *Local Authority 3 P7*

Practitioners also highlighted the importance of having both operational and strategic representation within learning reviews. Operational staff were described as providing detailed, practice-level insight, while strategic practitioners were seen as essential for agreeing, embedding and overseeing changes to policy, procedures and practice. However, bringing together staff across different levels and agencies was acknowledged as logistically challenging.

One local authority described how recommendations arising from learning reviews are centrally coordinated and cross-referenced by strategic practitioners, ensuring alignment with findings from previous reviews and avoiding duplication. This approach was described as supporting organisational learning and strengthening the link between individual case reviews and wider system improvement.

Finally, one local authority reported considering a local thematic review of CSAE where sufficient cases arise within a defined period. This was seen to support area-level learning on exploitation, regardless of SIN volumes, while maintaining proportionality and alignment with statutory review processes.

SIN processes

Across the local authorities interviewed, responsibility for overseeing SINs sat with a senior role within safeguarding quality assurance or standards. These individuals were responsible for determining whether the statutory criteria were met, alongside senior leaders from the three statutory safeguarding partners⁸, with the local authority initiating the notification process. Authorisation to submit a SIN was typically restricted to a small number of senior practitioners, most often the same individual holding overall responsibility for SIN oversight.

⁸ Decisions to notify should be made collectively by senior leaders from the three statutory safeguarding partners, as set out in existing Working Together national guidance [Working together to safeguard children - GOV.UK](#)

While submission was tightly controlled, practitioners emphasised that concerns could be raised by a wide range of professionals across agencies. For example, one local authority described the use of a local Cause for Concern form, which any professional could complete to flag a serious safeguarding incident or significant practice concern for senior consideration. This was described as a way of ensuring that potential SINs were not missed, while maintaining clear senior oversight of decision-making.

There was general consistency in SIN processes across the local authorities interviewed, aligned with national guidance. Once a potential case was identified, relevant information was shared with safeguarding partners, typically through a review panel involving police and health representatives and the Director of Children's Services. Cases were discussed through a combination of written communication, face-to-face meetings and virtual discussions. Decisions were usually reached collaboratively⁹, with the local authority acting as the lead agency. One local authority noted the option of involving an independent scrutineer¹⁰ where consensus could not be reached, as an additional safeguard. The statutory five-day submission window was generally described as achievable, although delays in establishing an official cause of death sometimes required an initial submission followed by further information when available.

Once a SIN had been submitted, local authorities described a structured process of gathering relevant information from involved agencies to inform the development of a chronology. While there is no specific national guidance on chronologies at the rapid review stage, practitioners described this exercise as supporting a shared, multi-agency understanding of the child's journey, key practice decisions and critical moments. For later stages of the process, Child Safeguarding Practice Review Panel guidance specifies the use of "an integrated multi-agency chronology focused on key practice episodes" (Panel guidance), and local authorities described their approaches as aligning with this expectation.

Alongside this information-gathering stage, practitioners described how the review process was operationalised in practice. A chair was appointed from one of the safeguarding partners, a panel date was set, and relevant stakeholders were invited. This usually involved a core group of professionals, with additional specialist input included where appropriate. For example, one local authority described involving a member of an LGBTQ+ advisory group to support a rapid review where this expertise was relevant. Practitioners noted that police availability could be affected by operational demands and that court commitments occasionally impacted social worker attendance, but these

⁹ Decisions to notify should be made collectively by senior leaders from the three statutory safeguarding partners, as set out in existing Working Together national guidance. [Working together to safeguard children - GOV.UK](#)

¹⁰ Functions of independent scrutiny role, p37: [Working together to safeguard children 2023: statutory guidance](#)

challenges were typically managed through strong partnership working. Rapid review reports were generally completed within expected timescales, with the 15-day turnaround described as demanding but achievable.

SIN logistics

Practitioners noted that the SIN process has become more streamlined since the introduction of oversight by the National Child Safeguarding Practice Review Panel. Overall, the system was described as functioning effectively, although some practical and logistical challenges were identified in its day-to-day use. These included the requirement to complete the notification form in a single session, with practitioners suggesting that a 'save as you go' function would be helpful where work is interrupted by competing operational demands. The system was also described as occasionally fragile, with connectivity issues requiring forms to be restarted:

The form is clunky... once you start it you can't save it, and if you lose your connection, you start again. - Local Authority 3 *P4*

One local authority noted challenges associated with operating across different IT systems, including security firewalls that could prevent submission. Where Local Authorities had contacted the Child Safeguarding Practice Review Panel with queries, feedback was described as helpful, although practitioners suggested that additional capacity to support more timely responses would further strengthen the process.

Chapter 5: Practitioners' Reflective Learning Points

- Practitioners' knowledge and confidence in naming and recording CSAE are strengthened through ongoing training, specialist reflective spaces, clear tools and pathways and supportive supervision that explicitly addresses the emotional and relational complexities of CSAE.
- Improving the quality and accuracy of CSAE data depends on systems that support relational thinking, track children's journeys over time, surface patterns and alerts, and allow multiple, overlapping harms to be recorded.
- Consistency in recording requires both local structures that work with national standards, supported by clear guidance and resourcing to reduce structural variation between local authorities.
- Adequate resourcing across the safeguarding system is essential, including investment in data recording, collation, analysis and dissemination, to support effective and consistent safeguarding responses.
- Targeted investment in data and analytical expertise can significantly improve the consistency, visibility and usefulness of CSAE recording, strengthening oversight of risk patterns and alignment with safeguarding decision-making.

Chapter 5 brings together the interview responses to explore: (1) what might be helpful to improve practitioner knowledge and/or confidence in this area, (2) what specifically might be helpful to improve the quality and accuracy of data in relation to the recording of CSAE concerns and (3) what helps to facilitate consistent recording of CSAE concerns.

What might be helpful to improve social worker knowledge and/or confidence in this area?

Whilst local authorities reported practitioners with specialised expertise and experience in identifying and responding to CSAE, it was highlighted that this can vary across the workforce. To build skills and develop confidence in this area there were four areas of focus which can facilitate this: (1) specialist CSA spaces and reflective practice, (2) appropriate training, (3) supportive supervision and national guidance, and (4) specialist consistent toolkits and pathways.

Enabling supportive and reflective practice

Overview: In one local authority a 'CSA thinking/reflective space' was developed to enable CSA cases to be discussed weekly which is attended by social workers and their managers. Practitioners reported a lack of clarity in how to work in this area when there is limited 'evidence' or disclosure. Therefore, the 'CSA thinking/reflective space' is beneficial in addition to core supervision as it provides focused discussion, support and shared judgement. The 'CSA thinking/reflective space' is supported by either a senior principal social worker or a lead who has attended the leadership programme delivered by the Centre of expertise on child sexual abuse.

I think the CSA thinking space has helped us think about what we can do during a police investigation. - *Local Authority 1 P7*

People could come to these spaces and essentially present their family or whatever the dilemma was, get us to ask them some clarifying questions and then we as a panel would reflect on what we heard, very different kinds of perspectives, thinking about unpicking some of the issues given and then getting them to reflect what they'd heard, what resonates for them and then doing some signposting, giving them tools, guidance, that kind of thing and next steps. So that's gone really well. And what we found is that over time more people have wanted to use it. - *Local Authority 1 P11*

I'm sort of like a critical friend, you know, so to have those discussions and they were like, oh my gosh, oh yeah and actually, you know, they next time I know that that's what they'll do. - *Local Authority 4 P3*

Key Learning: Dedicated, specialist reflective spaces focused on CSA enable practitioners to build confidence, sit with uncertainty and make sense of complex concerns, some of which can sit below statutory thresholds. These spaces support the development of more assured safeguarding responses by prioritising reflective thinking and enabling shared judgement in an area that is often emotionally and evidentially challenging. These spaces can:

- Provide a protected forum for practitioners to reflect on distressing, ambiguous or uncomfortable CSA concerns that are difficult to hold alone.
- Strengthen practitioner confidence and curiosity through shared learning with experienced colleagues and senior principal social workers.
- Support earlier and more proportionate safeguarding action by enabling reflective discussion.

- Help practitioners think clearly about what action can be taken during police investigations or periods of evidential uncertainty.
- Be expanded to include wider CSAE harms.

Training: Content, formats and accessibility

Overview: Practitioners across local authorities saw training as essential for improving confidence and competence. They advocated for a need to design learning in formats that are realistic for a pressured workforce, especially in the context of high workloads and mandated attendance at court or strategy discussions, staff turnover and burnout. Practitioners repeatedly stressed that while some training is available, there remains a need for more training specifically focused on CSAE, its impacts and the practicalities of responding.

I would obviously say that the training is important because I think it, we need to continue to upskill practitioners like the needs and demands of young people are changing. They're getting more significant, they're increasing. - *Local Authority 1 P6*

I think maybe like more training around like how to talk about sexual abuse. What is the impact of sexual abuse? How do you safety plan around sexual abuse? - *Local Authority 2 P5*

Within our training delivery, we have a real focus on language. The feedback is that it is the most powerful bit in terms of the use of language, what's appropriate, what's not, how that impacts children, and how that leads to systemic failures...we do a lot to shape the narrative and how we're writing about our children. - *Local Authority 6 P3*

Key Learning: Targeted, practice-focused training on CSAE is essential to building confidence and consistency across the workforce, but it must be accessible, realistic and grounded in the complexities practitioners face. Training that reflects real-world practice challenges supports not only identification of CSAE, but also more confident recording and decision-making. Effective training approaches should:

- Go beyond theory to include realistic scenarios and case examples that mirror how CSAE presents in practice, including uncertainty, delayed disclosure and cumulative harm.
- Be delivered in flexible formats (multi-agency, face-to-face, online and bite-sized resources) to reflect workforce pressures and varying roles.

- Include a focus on how CSAE is recorded across the safeguarding system, helping practitioners understand how decisions translate into data.
- Support shared understanding across agencies, improving consistency in thresholds, language and recording practices.

Supportive Supervision

Overview: Supportive supervision was seen as vital to explore the anxieties in CSAE responses captured in Chapters 1-3, to ensure concerns are named even when the available evidence or disclosures are limited. Reflective group supervision was identified as a key mechanism in helping to build confidence. Practitioners described how shared discussion of complex cases and learning from colleagues can feel more powerful than isolated training sessions. These reflective mechanisms were understood as resources that not only deepen knowledge but support practitioners to capture the emotional and ethical complexities of CSAE work, which in turn strengthens their confidence to identify and record concerns.

I think you'd be having these conversations around in supervision. What's the impacts of sexual abuse upon this family? What are you seeing in terms of the behaviour of the young person, for example? - *Local Authority 2 P5*

We're looking to develop our group supervision model. And again, I think that is something because I think what's helpful is another social worker in your team says, Oh yes, I had a family like that and this is how I did it or how I wish I did it. You know, this is what I learned is really powerful. - *Local Authority 1 P7*

Key Learning: as reflected above, supportive, reflective supervision is a critical mechanism for developing practitioner confidence in CSAE work, particularly where evidence is limited or disclosure has not occurred. Regular opportunities to think collaboratively about complex cases help practitioners name concerns, manage emotional impact and sustain confident practitioner judgement. Supportive supervision can:

- Enable practitioners to explore the impact of CSAE on children and families and reflect on behavioural and contextual indicators of harm.
- Promote peer learning through shared discussion of complex cases, reducing isolation and reinforcing practitioner judgement.
- Support practitioners to confidently identify and record CSAE concerns despite evidential ambiguity.

- Improve consistency in practice and recording by embedding reflective discussion into routine supervision structures.

CSAE tools and pathways

Overview: Clear, research informed tools and pathways were described as highly valuable for building practice confidence and ensuring consistent responses across agencies. Practitioners emphasised that nationally endorsed resources provide not only practical guidance but also legitimacy, helping to normalise conversations about CSAE and reduce variation in practitioner judgement. Practitioners made suggestions on accessing specialist assessments and tools, such as The AIM (Assessment, Intervention, Moving On) Project¹¹ assessments for harmful sexual behaviour, which can enhance practitioners' capacity to understand and respond to risk.

Additionally, the adoption of the CSA Centre for Expertise, CSA Response Pathway¹² was viewed as a significant development and 'gold standard' because it sets out expected actions, offers step by step guidance. A participant noted that processes, structures, flow charts and tools can be helpful as a guide for practitioners to build up skills and confidence "to be able to respond consistently and adequately and to really sort of make sense of these children's behaviours" (Local Authority 3 P4). This shared framework was described as helping practitioners feel supported when concerns arise, including those who may have limited experience or feel anxious about responding to sexual abuse. In this sense, practitioners did not simply ask for more guidance, but for accessible, concrete and nationally endorsed tools that can be embedded in local practice.

As highlighted in Chapter 3, with ROTH Pathways and the Families First Partnership Programme¹³ reforms, local authorities are also at different stages of implementing CSAE specific approaches. A Local Authority area noted that as part of their implementation of the Families First Partnership Programme, they were piloting embedding social workers at the front door and sitting alongside early help. This was seen as enabling them to have a "social work lens early, before things escalate... you don't have to wait until it hits a threshold to get the right conversation" (Local Authority 5 P1).

The AIM Project is a specific assessment to assess the risk of sexually harmful behaviour of children, like to assess their risk of committing further sexually harmful behaviours. I've got that tool that I'm able to use.
- *Local Authority 1 P5*

¹¹ <https://aimproject.org.uk/>

¹² CSA Response Pathway: [pathway](#)

¹³ [The Families First Partnership \(FFP\) Programme Guide](#)

The CSA response pathway literally walks you through absolutely everything that you need to do and it also lets you know what will happen. [...] So you know how to talk to a child if they disclosed sexual abuse, how to support a child, you know, the do's and don'ts, of supporting a child. [...] So it's really, helpful [...] We had some feedback from a pharmacist who used it for the first time, and they said it was absolutely amazing. - *Local Authority 2 P3*

Key Learning: Clear, research-informed and nationally endorsed tools and pathways provide practitioners with confidence, clarity and legitimacy when responding to CSAE. Consistent frameworks reduce variation in practitioner judgement, normalise difficult conversations and support more assured identification, recording and intervention. Effective use of tools and pathways can:

- Provide step-by-step guidance for responding to CSA disclosures and concerns, supporting practitioners with limited experience or high anxiety.
- Enhance understanding of risk and protective factors through specialist assessments (e.g. The AIM Project), particularly in cases of harmful sexual behaviour.
- Support consistency across agencies by establishing shared expectations, language and processes.
- Enable earlier, more informed decision-making when embedded at the front door or within early help and the Families First Partnership programme.
- Reduce duplication and confusion by clarifying how CSAE tools align with ROTH pathways, MACE processes and traditional child protection routes.

What specifically might be helpful to improve the quality and accuracy of data in relation to the recording of CSAE concerns

Practitioners identified two interlinked areas as critical to improving the quality and accuracy of CSAE data: (1) systems that better support relational thinking, analysis and professional judgement, and (2) the ability to capture longitudinal, journey-based data that reflects fluctuating, co-occurring risks and harms over time. Practitioners emphasised that improving data quality was not simply a technical exercise but required systems that align with practice, drawing together information from early help, CIN and child protection, education, health, missing episodes, domestic abuse and information about exploitation concerns.

Systems which better support thinking, analysis and relational interpretation

Overview: Practitioners described how fragmented information and dispersed narrative notes can hinder both safeguarding practice and data quality. Information about exploitation concerns, such as recurring locations, repeated adult names, peer associations or early indicators, is often buried in case notes or spread across multiple systems, making it difficult to identify patterns or translate practice knowledge into accurate datasets.

In Local Authority 3, investment in dedicated analytical capacity was described as transformative. A specialist data role enabled the linking of information across children's social care, early help, schools, missing data and police intelligence, addressing longstanding fragmentation. This supported the development of a live Child Exploitation (CE) dashboard that could document all forms of CE (criminal, sexual, trafficking and missing episodes) patterns. Practitioners emphasised that this did not replace practitioner judgement but strengthened it, making contextual risk visible across services and enabling concerns to be identified "as it's happening, not months later" (Local Authority 3 P6). Another area discussed their current plans to develop a CE dashboard from scratch, as they were current working from multiple Microsoft Excel worksheets. They were not aware of other areas that had fully functioning CE dashboards that could help inform their dashboard, aside from the current project team linking the two areas up (with consent).

Give me the first, worst and last incident... and it goes ping...
we don't have systems that help us enough in our thinking... a closed off
algorithm... that brings what's relevant... boom. Stuff like that might
be really helpful. - *Local Authority 1 P11*

The way early help and social care systems interact varies so much —
some can't cross over at all. - *Local Authority 3 P1*

Key Learning: Data quality improves when systems are designed to support practitioner thinking, not just record decisions. Systems that make relationships, patterns and context visible strengthen both safeguarding practice and the accuracy of recorded CSAE data. This can be supported by:

- Developing systems capable of linking individuals, locations and incidents to surface relational and contextual patterns (e.g., locations) relevant to CSAE.
- Redesigning information systems to support analysis and interpretation, not just compliance. For example, through visual tools, relational mapping or intelligent search functions.

- Investing in analytical expertise that can translate dispersed information about exploitation concerns into usable, accurate and timely data.
- Creating national and regional learning forums to share effective system design, dashboards and analytical approaches already operating in some LAs, linked to the development of national bodies such as the CPA.¹⁴

Longitudinal visibility, fluid co-occurring risk and harm, alerts and the recording of change over time

Overview: Practitioners consistently reflected that current systems struggle to show how risk and harm change over time. Practitioners therefore had to go through the full narrative for each child to pick up this information. This can limit both oversight and the quality of extracted data. CSAE risk of harm was described as fluid and episodic, escalating and de-escalating across time rather than progressing linearly. Practitioners described the value of being able to see these fluctuations visually within a single child journey, something they believed existing data could support, but which is rarely realised due to system design and resource constraints. There was also strong interest in simple alert systems that could flag emerging patterns, prompt reflection or trigger supportive conversations across teams and specialist services.

It would be great to track a child's journey... you could do that from our data... we just haven't ever done it... all that data is there and could be correlated. - *Local Authority 2 P6*

The next dates it was medium risk and the next dates it went to 'vulnerable to', then it went up to high. And you're sort of, you don't, you'd be able to sort of see visually in one place that this is how it fluctuated over time. - *Local Authority 1 P2*

You could just click a thing that would just be another alert and then whoever's collating that, I would love it if someone would contact me from the CSE bit and say I noticed you're getting a lot of hits about child sexual exploitation... Do you have all the skills and knowledge? Is there anything I could do? That would be brilliant. - *Local Authority 2 P4*

We rely entirely on the police to be able to connect the networks of the adults because children's data systems are not designed to hold information about links between perpetrators. - *Local Authority 5 P1*

¹⁴ <https://consult.education.gov.uk/child-sexual-abuseexploitation-team/child-protection-authority/>

There's what's called the Child Exploitation Vulnerability Tracker, which is like a quick way to target a worker to make sure that they're thinking around exploitation. It's a spreadsheet with different categories. It scores it in different ways and every child over 10 years should have had one of those done, whether they're open to statutory social care or family help or youth justice. - *Local Authority 6 P3*

Key Learning: Accurate and meaningful CSAE data depends on systems that can capture overlapping harms and change over time. Improving the quality and accuracy of CSAE data requires systems that can capture harms as they manifest, including cumulative, psychological, relational and contextual (e.g., location) impacts that do not always align neatly with existing child protection plan categories or incident-based thresholds. Practitioners emphasised that visibility is currently lost not only because systems cannot easily track change over time, but because the categorisation of harm itself is too narrow and too rigid to reflect CSAE experiences across CIN datasets and SIN processes.

This learning reinforces that improving CSAE visibility is not simply a matter of better data entry, but of ensuring that definitions of significant harm, recording categories and system logic are fit for contemporary safeguarding realities. This can be supported by:

- Reviewing whether existing child protection plan categories are sufficient to capture CSAE, particularly where harm is cumulative, psychological, coercive or recognised retrospectively rather than incident based.
- Developing clearer recording mechanisms for overlapping harms, recognising that CSAE frequently co-exists with neglect, emotional abuse and extra-familial harm, and that single-category prioritisation can obscure sexual harm.
- Strengthening longitudinal tracking of children's journeys, so earlier indicators, prior child protection involvement and emerging exploitation risks can be connected and analysed over time.
- Introducing simple alerting and tagging mechanisms to log day-to-day incidents and information about exploitation concerns in real time, supporting pattern recognition and reducing reliance on narrative notes.
- Align recording systems with SIN decision-making, ensuring CSAE-related serious harm, particularly psychological harm, grooming, networked exploitation and delayed disclosure, is not rendered invisible by incident-led thresholds.

What helps to facilitate consistent recording of CSAE concerns?

When asking practitioners about what would help facilitate consistent recording of CSAE concerns, key themes identified were centred on the (1) development of clear national standards in tools and systems for recording CSAE, with this supplemented by (2) national guidance, with the last theme relating to (3) a well-resourced safeguarding system but specifically related to data and analytical expertise. There was a suggestion that a national approach could ensure more consistency.

Clear national standards in tools and systems for recording CSAE

Overview: Practitioners consistently reported that efforts to achieve consistent recording of CSAE are significantly hindered by the absence of clear national standards in tools and systems. In the absence of nationally defined expectations, local authorities have been required to develop their own recording mechanisms, categories, dashboards and definitions to identify and track CSAE. While this has enabled local innovation and responsiveness to extra-familial harm, it has also resulted in a fragmented national picture.

Practitioners described a ‘patchwork’ of locally developed matrices, trackers and screening tools, often designed to ensure all safeguarding activity and data is recorded, over and above the national statutory data. These tools varied considerably in their scope, terminology and thresholds, meaning that similar patterns of harm could be recorded very differently across areas. Practitioners highlighted that, without shared standards, national comparison becomes difficult and the reliability of national CSAE data is weakened, not because of poor practice, but because of divergent system design.

There was a strong sense that consistency does not require identical systems across all local authorities. Rather, practitioners argued for shared minimum expectations about what should be recorded, how contextual and relational risks are captured, and which elements of local data could meaningfully contribute to a national picture of CSAE.

If they want any sort of benchmarking public published data, then they would need guidance about what's what is available... because it's been left so long now, I think there's probably quite a lot of data out there. -
Local Authority 2 P6

If we all had some set standards... it makes it easier” - *Local Authority 5 P1*

Key Learning: Clear national standards for CSAE recording tools would support greater consistency while preserving local flexibility. Practitioners highlighted that this could:

- Reduce variation created by locally designed recording mechanisms.
- Improve comparability of CSAE data across local authorities.
- Enable national datasets to draw more effectively on existing local information on exploitation concerns.

Clear national guidance on identifying and responding to CSAE

Overview: Alongside system standards, practitioners emphasised the importance of clearer national guidance to support consistent interpretation and recording of CSAE concerns. Practitioners highlighted uncertainty around child-on-child abuse, peer relationships, online harm and healthy sexual development, where thresholds, terminology and appropriate responses were not always clear.

This lack of shared guidance was described as contributing to variation in how concerns are understood, discussed and ultimately recorded. Practitioners reported relying on local norms, supervision culture or individual confidence to navigate these areas, which in turn shaped recording practices. Several practitioners suggested that clearer national guidance would help create a shared language and framework, supporting both safeguarding decision-making and more consistent data recording. Practitioners stressed that guidance should support critical thinking rather than impose rigid rules, particularly in areas where harm is relational, contextual or developmentally complex.

I think the issue of child-on-child abuse...A lot of people think it would be good to have a debate about it and how to respond, and how to support young people. - *Local Authority 2 P2*

Staff are still thinking of CSA as something done by an adult at home. They don't automatically think of peer abuse or online abuse as 'CSA', even though it is. - *Local Authority 3 P6*

Key Learning: National guidance can support more consistent recording by providing shared frameworks for interpreting complex and emerging forms of CSAE. Practitioners identified that this could:

- Improve confidence in naming and recording CSAE-related concerns.
- Reduce variability in thresholds and terminology across areas.
- Support consistent understanding of peer, online and contextual harm.

Resources across the safeguarding system

Overview: Practitioners repeatedly emphasised that the ability to develop, sustain and consistently apply recording systems for CSAE is fundamentally shaped by resources and capacity. While many local authorities had invested in innovative tools, dashboards and processes to strengthen CSAE identification and recording, practitioners stressed that these developments rely on sufficient staffing, analytical expertise, training capacity and system investment. These resource pressures were described as affecting not only the development of recording tools, but also their consistent use. Time constraints, workforce pressures and limited analytical capacity were seen to undermine routine updating, review and quality assurance of CSAE data. As a result, consistency was not only a technical challenge, but also a structural one, shaped by wider funding and capacity constraints across the safeguarding system.

Practitioners highlighted that uneven resource distribution across local authority's risks embedding long-term variation in CSAE visibility, regardless of practitioner commitment or expertise.

What we're able to do is dependent upon and defined by the resource that we have to do it, and local authorities are under enormous financial strain. - *Local Authority 1 P3*

What's extractable is very different to what's actually held in the case record... having someone who can pull that together and make sense of it makes a massive difference. - *Local Authority 3 P1*

Once you can see it in a dashboard, you can ask better questions - about practice, thresholds, and where risk might be sitting. - *Local Authority 3 P6*

Key Learning: Targeted investment in data and analytical expertise can significantly improve the consistency, visibility and usefulness of CSAE recording. Where local authorities have the capacity to integrate information across systems, this supports both practice and governance by enabling clearer oversight of risk patterns and recording gaps. This highlights that consistency in CSAE recording is not achieved through frontline

compliance alone, but through system-level investment that translates complex practice information into accessible, actionable information. This approach can:

- Help practitioners and managers identify cumulative and contextual CSAE risk more easily.
- Support reflective supervision, audits and inspection activity through clearer evidence trails. Enable earlier identification of areas requiring additional scrutiny or intervention.
- Reduce reliance on fragmented spreadsheets and manual data extraction.

Conclusions

The National Audit on Group-Based CSAE (Casey, 2025), alongside reports from the Child Sexual Taskforce et al. (2025), the NCVPP (2025) police-recorded CSAE analysis, and the GOV.UK CSAE report (2025b), consistently identify a persistent structural mismatch. While CSAE is recognised across safeguarding systems, it remains under-represented in CSC datasets. This qualitative study was commissioned by the DfE in direct response to Casey (2025) Recommendation 9, with the aim of exploring why these discrepancies arise and what drives local variation in identification, recording and serious incident reporting. Drawing on interviews conducted across six local authorities, the findings provide a practice-grounded explanation for the national quantitative patterns observed.

Collectively, the qualitative evidence demonstrates that the decline in CSAE recorded in CIN data is shaped by a range of system-level factors rather than necessarily indicating reduced prevalence. These system-level factors include potential misalignment between how CSAE presents, how practitioners assess and respond to harm and limitations in how statutory data systems require harm to be categorised at set points. Practitioners highlighted a range of challenges in recording both the identification of, and response to, CSAE within CIN datasets. For example, the type of harm recorded at referral is not captured within CIN data, and the primary need at the point of initial assessment has a broad category for abuse, neglect and exploitation, without distinguishing CSAE. Practitioners also explained that the factors recorded at ‘the end of assessment’ do not include separate categories for CSE, child criminal exploitation and sexual abuse (child on child, and adult on child), which may have been present at the start of the assessment but mitigated through protective action and early intervention during the assessment. As a result, these categories may not be selected at the end of the assessment.

Whilst practitioners viewed the end of assessment factors as helpful in enabling the recording of CSA and CSE, they noted variation in how these categories are applied across local areas, with substantial information captured within narrative case records. Further challenges arise as cases progress through the safeguarding system to a child protection plan, where recording is limited to four categories (physical, emotional, sexual and neglect), with an additional ‘multiple’ option that does not specify which combinations of harm are present. In situations involving multiple concerns of harm, selecting a single category can be challenging, and CSAE related information is therefore more likely to be recorded elsewhere within social care case notes and narratives. Taken together, these findings demonstrate that CSAE can be absent from statutory CIN datasets, because the system is designed to capture outcomes rather than journeys.

Practitioners involved in the interviews provided insights into how the child protection plan significant harm categories are applied in practice, including the selection of neglect

or emotional abuse rather than sexual abuse, even where CSAE was central to safeguarding concerns. This pattern reflects national trends identified in the Casey Audit (2025) and the GOV.UK CSAE report (2025b), including the sustained decline in the use of 'sexual abuse' as a child protection plan primary significant harm category. Practitioners emphasised that this displacement can be driven by structural and evidential factors, rather than a failure to recognise sexual harm. These broader categories were often seen as better reflecting the child's lived experience, particularly where sexual harm was embedded within wider adversity.

Practitioners also described greater engagement with children and families when concerns were framed holistically, rather than explicitly labelled as sexual abuse at an early stage, particularly in the absence of police evidence or clear disclosures. In practice, naming CSA or CSE without a clear disclosure or evidential certainty was perceived as risking disengagement or resistance from parents and carers, especially where harm was suspected to occur outside the home or through peer or online contexts. Framing concerns through broader categories such as neglect or emotional abuse was therefore experienced as a pragmatic and proportionate safeguarding strategy, enabling practitioners to maintain relationships, keep children visible to services, and provide ongoing support while risks continue to emerge or be explored.

Across interviews, practitioners described that whilst CSE and CSA were related and could co-occur, they can also present differently, which can result in differences in recording. For CSA, practitioners highlighted that disclosures are frequently delayed, partial or non-recent reflecting national evidence from the Child Sexual Exploitation Taskforce et al. (2025), and the Home Office (2023). The Child Sexual Exploitation Taskforce et al. (2025) data indicates that 35% (1,558/ 4,450) of offences are non-recent, including 24% (1,071/ 4,450) reported the offence more than ten years after it had been committed. In these circumstances, children's social care involvement may be limited or not required at all where there is no current safeguarding risk to a child. This helps explain why CSA can be highly visible in police-recorded offence data but absent from CIN data returns, without necessarily indicating a failure of recognition or response within children's social care.

Where CSA is identified during childhood, practitioners described potential hesitancy in recording sexual harms in the absence of a clear disclosure or corroborative evidence, despite social care operating on a balance-of-probability threshold. This aligns with the GOV.UK (2025b) findings that CSA has one of the lowest re-referral rates nationally (19%), reflecting that once historical harm is recognised, addressed and stabilised, ongoing statutory intervention may not be required.

For CSE, a different mechanism of invisibility was evident. Practitioners consistently described exploitation as emerging gradually through information related to peer

networks, online contact, coercion, missing episodes, school concerns and wider contextual risk of harm. Much of the safeguarding work in these cases occurs during the 45-day assessment window, including safety planning, contextual disruption and multi-agency coordination. As extra-familial harms can occur outside of the home, it was noted that whilst significant harm can be evidenced, a traditional child protection plan may not address risk posed within the community. Therefore, additional or alternative contextual safeguarding responses may be required. Local authorities which participated in this research have identified varying practice responses to harm outside the home, with alternative pathways often used to respond to exploitation due to the limitations of traditional child protection processes, which often remain focused on harm within the child's home. This may explain why the GOV.UK (2025b) analysis found that CSE has one of the lowest conversion rates from Section 47 enquiry to Initial Child Protection Conference, alongside one of the highest re-referral rates (29%): contextual harm fluctuates and re-emerges, rather than progressing linearly through statutory thresholds and systems. Equally, high re-referral rates may reflect situations where exploitation risk is reduced but not fully eliminated, requiring renewed safeguarding responses as circumstances change, rather than indicating ineffective practice.

A central driver of the police and CIN data mismatch identified by Casey (2025) and the recent GOV.UK (2025b) findings lies in the different purposes and thresholds of the two systems. Police data records offences, including non-recent abuse, whereas children's social care data is generally oriented toward current and future safeguarding risk. In 2023/24, a total of 104,828 CSA offences were recorded, of which 13,098 (12%) resulted in a charge or summons; 63,315 cases (60%) were closed because of evidential difficulties (Kewley & Karsna, 2025). Combined with The Child Sexual Exploitation Taskforce et al. (2025) data above, this indicates how delayed disclosures and case complexity can limit evidential thresholds and contribute to NFA outcomes. This is significant given the police NFA decisions were interpreted by practitioners as signalling limited evidential strength, even when safeguarding concerns remained significant.

In addition, DfE data shows children assessed with CSE have a higher average number of co-occurring factors (five) compared with CSA (two). Practitioners consistently described CSE as multi-layered, relational and embedded within wider patterns of vulnerability, including missing episodes, peer dynamics, online contact, emotional distress and family instability. As a result, sexual harm in CSE cases is rarely experienced, assessed or recorded in isolation. In contrast, CSA, particularly where it relates to historical or intra-familial abuse, is often recorded as a singular presenting concern, with fewer concurrent assessment factors visible at the end of the assessment. This is likely due to harm occurring from one environment, whereas CSE was reported to be experienced across different environments (home and outside the home, including online). This does not imply that CSA is less complex or harmful in its impact but rather

reflects how different forms of sexual harm interact with recording systems that prioritise discrete categories and end-point summaries.

Casey (2025) Recommendation 9 also raised concerns about the low number of SINS relating to CSAE. This study shows that under-reporting can be driven by a mismatch between applying the SIN criteria and the nature of sexual harm. Practitioners consistently described serious harm in CSAE as cumulative, psychological, coercive and often recognised retrospectively, rather than as a single acute incident. Uncertainty about thresholds relating to CSAE, fear of over-reporting, and reliance on police outcomes further shaped SIN decision-making. As a result, SINS capture only a narrow subset of CSAE-related harm, reinforcing national under-visibility.

While chapters 1-4 explain why CSAE is under-recorded within CIN and SIN data, Chapter 5 is critical in demonstrating how practitioners believed this gap could be addressed in practice. Practitioners were clear that improving CSAE visibility is not primarily a technical problem of data entry, nor a deficit in practitioner commitment. Rather, it requires investment in people, structures and systems that support practitioner judgement in conditions of uncertainty. Across local authorities, practitioners described how confidence to identify and record CSAE develops through sustained reflective spaces, supportive supervision and access to specialist expertise, particularly in cases where disclosure is absent, evidence is partial, or harm is cumulative. Dedicated CSA thinking spaces, group supervision and specialist panels were repeatedly described as enabling practitioners to name concerns earlier, tolerate ambiguity and take proportionate safeguarding action without waiting for criminal thresholds to be met. National tools such as the CSA Centre for Expertise, toolkit were praised for supporting practitioners when working with children experiencing CSAE. Moreover, training was seen to be crucial in explicitly addressing the nature of CSAE and how concerns translate into recording decisions, helping staff understand how their professional judgement becomes visible, or invisible, in local and national data.

Systems design and analytical capacity play a critical role in shaping data quality. Challenges identified included extracting information about exploitation concerns, such as patterns of association, emerging locations and repeated concerns. Key data is often held in narrative notes or dispersed across systems, limiting both practice oversight and the accuracy of extracted data. Where local authorities had invested in dedicated analytical roles and integrated dashboards, this was described as transformative: not replacing practitioner judgement but strengthening it by surfacing risk patterns earlier and enabling more informed decision-making, auditing and supervision. Linked to this, practitioners cautioned against over-reliance on parallel contextual safeguarding systems that sit outside core social care records. While these systems are essential for responding to extra-familial harm, Chapter 5 emphasises the importance of integration,

ensuring that extra-familial and intra-familial risks are understood together to provide a holistic picture of the child's lived experience.

Practitioners argued that the absence of clear national standards and guidance for recording of CSAE was a key driver of inconsistency. In the absence of shared expectations about what should be recorded, how overlapping harms should be captured and how emerging forms of CSAE should be understood, local authorities have developed bespoke solutions. While innovative, this has entrenched variation and weakened national visibility. Practitioners are not calling for uniform systems, but for agreed minimum standards that allow local information about exploitation concerns to be used to inform a coherent national picture.

This study provides deep-dive insights in direct response to Casey Recommendation 9. It provides evidence to suggest that the under-recording of CSAE in children's social care data is influenced by a range of system-level and structural factors. The findings point to the role of system design, evidential expectations, time-limited processes and outdated recording architectures that are misaligned with contemporary forms of sexual harm. If national datasets are to reflect the true scale, nature and complexity of CSAE, reform must focus on aligning systems with practice realities, capturing journeys rather than endpoints, enabling overlapping categories of harm, integrating extra-familial and intra-familial harm and supporting practitioners through training, supervision and analytical capacity.

As the proposed CPA moves into consultation and development¹⁵, these findings provide timely evidence of where strengthened national oversight, data standards and system leadership could have the greatest impact. In particular, the CPA presents an opportunity to address long-standing fragmentation across safeguarding data systems, strengthen national expectations on CSAE recording and visibility, and ensure that learning from significant harm, exploitation and practice information is consistently translated into system improvement. Embedding these insights within the CPA's remit would directly support the ambitions of Casey Recommendation 9 and help ensure that national child protection policy is grounded in an accurate, practice-informed understanding of CSAE experiences.

¹⁵ [Child Protection Authority - Department for Education - Citizen Space](#)

References

Barnardos (no date) *Child sexual abuse and exploitation*. Available at:

<https://www.barnardos.org.uk/get-support/support-for-parents-and-carers/child-abuse-and-harm/child-sexual-abuse-and-exploitation> (Accessed: 11 December 2025).

Brooks, J., McCluskey, S., Turley, E. and King, N. (2015) 'The utility of template analysis in qualitative psychology research', *Qualitative Research in Psychology*, 12(2), pp. 202-222.

Bywaters, P., Brady, G., Bunting, L., Daniel, B., Davidson, G., Elliot, M., Featherstone, B., Hooper, J., Jones, C., McGhee, J., Mason, W., Morris, K., McCartan, C., Mirza, N., Scourfield, J., Shapira, M., Sparks, T., Webb, C. (no date) *Identifying and understanding inequalities in child welfare intervention rates: comparative studies in four UK countries. Briefing paper 2: UK four county quantitative comparison*. Available at:

<https://www.coventry.ac.uk/globalassets/media/global/08-new-research-section/16469-17-cwip---briefing-2-final.pdf> (Accessed: 28 November 2025).

Casey, L. (2025) *National Audit on Group-Based Child Sexual Exploitation and Abuse*. Available at:

https://assets.publishing.service.gov.uk/media/685559d05225e4ed0bf3ce54/National_Audit_on_Group-based_Child_Sexual_Exploitation_and_Abuse.pdf (Accessed: 28 November 2025).

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*. Available at:

<https://assets.childrenscommissioner.gov.uk/wpuploads/2017/06/Protecting-children-from-harm-full-report.pdf> (Accessed: 28 November 2025).

Child Sexual Exploitation Taskforce, National Police Chiefs' Council [NPCC], Hydrant Programme (2025) *Group Based Child Sexual Abuse and Exploitation Data*. Available at:

<https://www.hydrantprogramme.co.uk/assets/Documents/Group-Based-Child-Sexual-Abuse-and-Exploitation-Data-12-months-of-data-from-January-December-2024-December-2025.pdf> (Accessed: 12 December 2025).

Department for Education [DfE] (2024) Reporting year 2024. Children in need. Available at: <https://explore-education-statistics.service.gov.uk/find-statistics/children-in-need/2024> (Accessed: 28 November 2025).

DfE (2025) *Serious incident notification. Guide for local authorities – version 1.1*. Available at:

https://assets.publishing.service.gov.uk/media/68d6b455c487360cc70c9e35/Serious_incident_notification_guide.pdf (Accessed: 11 December 2025).

Garstang, J., Dickens, J., Menka, M. and Taylor, J. (2023) Improving professional practice in the investigation and management of intrafamilial child sexual abuse: Qualitative analysis of serious child protection reviews, *Child Abuse & Neglect*, 137, p.106053. Available at: <https://doi.org/10.1016/j.chiabu.2023.106053>

GOV.UK (2025a) *Reporting year 2025. Children in need*. Available at: <https://explore-education-statistics.service.gov.uk/find-statistics/children-in-need/2025> (Accessed: 12 December 2025).

GOV.UK (2025b) *Reporting year 2025. Children in need: A focus on sexual abuse and exploitation*. Available at: <https://explore-education-statistics.service.gov.uk/find-statistics/children-in-need-a-focus-on-sexual-abuse-and-exploitation/2025> (Accessed: 12 December 2025).

GOV.UK (2024) *Reporting year 2024. Children in need*. Available at: <https://explore-education-statistics.service.gov.uk/find-statistics/children-in-need/2024> (Accessed: 12 December 2025)

HM Government (2023) *Working together to safeguard children 2023*. Available at: https://assets.publishing.service.gov.uk/media/6849a7b67cba25f610c7db3f/Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf (Accessed: 11 December 2025).

HM Inspectorate of Probation (HMIP), Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Care Quality Commission (CQC) and Ofsted (2025) *Joint targeted area inspection (JTAI) of the multi-agency response to child sexual abuse in the family environment*. Available at: https://assets.publishing.service.gov.uk/media/69009b9fa6048928d3fc2aeb/Joint_targeted_area_inspection_of_the_multi-agency_response_to_child_sexual_abuse_in_the_family_environment.pdf (Accessed: 28 November 2025).

Home Office (2023) *The report of the Independent Inquiry into Child Sexual Abuse, Section 1 and Section 2 parts A to J*. Available at: <https://www.gov.uk/government/publications/iicsa-report-of-the-independent-inquiry-into-child-sexual-abuse/the-report-of-the-independent-inquiry-into-child-sexual-abuse-section-1-and-section-2-parts-a-to-j-accessible> (Accessed: 12 December 2025).

Karsna, K. (2022) *Child sexual abuse in 2020/21: Trends in official data*. Available at: https://csacentre.org.uk/app/uploads/2023/09/CSA-trends-in-official-data-2020-21.pdf?utm_source=chatgpt.com (Accessed: 28 November 2025).

Kewley, S. and Karsna, K. (2025) *Child sexual abuse in 2023/24: Trends in official data*. Available at: <https://www.csacentre.org.uk/app/uploads/2025/03/Child-sexual-abuse-in-2023-24-Trends-in-official-data.pdf> (Accessed: 28 November 2025).

King, N. (2012) *Doing template analysis*. Edited by G. Symon and C. Cassell (eds.). SAGE.

National Centre for Violence Against Women and Girls and Public Protection [NCVPP] (2025) *2024 National Analysis of Police-Recorded CSAE crimes report*. Available at: <https://www.vkpp.org.uk/assets/National-Analysis-of-Police-Recorded-Child-Sexual-Abuse-and-Exploitation-CSAE-crimes-report-2024-for-England-and-Wales-Totality-3-V2.pdf> (Accessed: 12 December 2025).

Office for National Statistics (2025) '*Abuse during childhood in England and Wales: March 2024*'. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/abuseduringchildhoodinenglandandwales/march2024#child-sexual-abuse> (Accessed: 28 November 2025).

Office for National Statistics Centre for Crime and Justice (2024a) '*Crime in England and Wales: other related tables. Year ending March 2024 edition of this dataset*'. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/crimeinenglandandwalesotherrelatedtables> (Accessed: 28 November 2025).

Office for National Statistics Centre for Crime and Justice (2024b) '*Crime in England and Wales: year ending March 2024*'. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingmarch2024#sexual-offences> (Accessed: 28 November 2025).

The Child Safeguarding Practice Review Panel (2025) '*I wanted them all to notice*'. *Protecting children and responding to child sexual abuse within the family environment*. Available at: https://assets.publishing.service.gov.uk/media/67446a8a81f809b32c8568d3/CSPRP_-_I_wanted_them_all_to_notice.pdf (Accessed: 28 November 2025).

The Child Safeguarding Practice Review Panel (2024) *Annual report 2023 to 2024*. Available at: [The Child Safeguarding Practice Review Panel - Annual Report 2023 to 2024](#) (Accessed: 28 November 2025).

Tregidga, J. and Lovett, J. (2021) *Identifying and responding to child sexual abuse within complex safeguarding approaches. An exploratory study*. Available at: <https://www.csacentre.org.uk/app/uploads/2023/10/Identifying-and-responding-to-child->

[sexual-abuse-within-complex-safeguarding-approaches-Sep](#) (Accessed: 28 November 2025).

Wachinger, J., Bärnighausen, K., Schäfer, L.N., Scott, K. and McMahon, S.A. (2025) 'Prompts, pearls, imperfections: Comparing ChatGPT and a human researcher in qualitative data analysis'. *Qualitative Health Research*, 35(9), pp.951-966.

Appendix

Appendix A - Methodology

A total of 48 practitioners were recruited to take part in semi structured interviews with three researchers. The interviews were conducted online via Microsoft Teams between 14th of October and the 28th of November 2025. The length of interviews ranged from between 22 and 58 minutes.

Sampling

Participants ranged from strategic to operational roles, in addition to analytical roles and were recruited from six local authority areas (please see Table 1). For example, those in strategic roles included senior leaders and service managers and those in operational roles included team managers and social workers. The DfE initially provided contacts for a principal social worker or head of safeguarding within each local authority, who then acted as a local gatekeeper. The gatekeeper in each local authority identified initial participants which included social workers, team and/or service manager, and where possible a senior leader. The research team then snowballed any additional participants needed to explain the local pathway. Contrasting local authorities were recruited to maximise understanding variation (under-visibility, higher-recognition, high-burden, and larger/metropolitan). The priority list and rationale are anchored to the Casey (2025) force-area table and the Child Sexual Abuse Centre trends.

Table 1: The role type of participants across each local authority

Local Authority	Strategic	Operational	Analyst	Total
1	5	7	1	13
2	4	2	1	7
3	4	1	2	7
4	4	0	4	8
5	6	0	1	7
6	5	0	1	6
Total	28	10	10	48

The interview schedule

A standard semi-structured interview schedule was initially developed using the project aims and research questions. This schedule was shared with DfE whereby feedback was provided. Final interview schedules can be found in Appendix B and C. Appendix C contains an additional set of questions on the SIN which only managers and/or senior leaders answered. It is important to note that only four participants from three Local Authorities were able to answer questions relating to SIN.

Interview analysis

To analyse the data, Template Analysis was used (Brooks et al., 2015; King, 2012, pp.118-134), whereby a hypotheticodeductive approach was conducted to draw tentative themes. Initial codes relevant to the research questions were used as a provisional framework to create a coding template (please see Appendix C for version 1). Within the template, the codes were ordered hierarchically with the highest-level codes representing broad themes in the data, and the lower-level codes demonstrating more narrowly focused constituent themes.

The data set was then coded by the research team using version 1 of the template. Subsequently, the research team met to discuss the findings in relation to the template and made further refinements. This included inserting, deleting or changing the scope/title of the themes. This stage of the analysis was supported by a ChatGPT Pro Artificial Intelligence (AI) software whereby the introduction to this report, the research questions, and version 1 of the template (which included anonymised quotes under each theme), and a previous DfE qualitative evaluation report were inputted into the AI software. The AI software was asked to detail the themes based on this information. The software also detailed why each theme was appropriate and suggested sub-themes for each of the broad themes. This provided the research team with additional oversight to ensure that the coding template answered the research questions and limited duplication across the sub-themes.

When AI software is used to complement human analysis, it has been suggested to be a useful tool to reduce duplication and is suited to a codebook approach to qualitative analysis (Wachinger et al., 2025). A further check was done on the AI generated template whereby a researcher assessed the applicability and usefulness of the template. The template was refined further until all sections of data were of clear relevance to the research questions, and the template was deemed well defined by the research team (see Appendix E for the final coding analysis framework version 2).

Interpreting the findings

It is worth noting that the findings presented here are not intended to be representative of all local authorities but reflect the most common experiences across the local authorities and practitioners interviewed within this study. This exploratory research is intended to help understand some of the data trends highlighted in various quantitative reports (such as Casey, 2025 and GOV.UK, 2025b) by providing the practice-based explanations for the recorded variances and under-reporting of CSAE. Importantly, where the findings do not reflect practice in all local authorities, this is still meaningful. Differences in local structures, thresholds and recording approaches are a known feature of the national picture and are central to the issues raised in the Casey (2025) audit. For this reason, areas that do not recognise themselves in these findings may in fact be illustrating the very variation and fragmentation that this research is seeking to explore.

Ethics

The research project received ethical approval from the Manchester Metropolitan University Health and Education Research Ethics and Governance Committee (Reference number: 82309). With consent the interviews were recorded and transcribed using the built-in transcription software on Microsoft Teams. The research team anonymised the transcripts through using a unique identifier. Any identifying information which was disclosed during the interview was depersonalised and replaced by pseudonyms by the research team. The research team continuously evaluated potential quasi-identifiability when analysing the data and developing the report. All research material including the transcripts are stored securely on the Manchester Metropolitan University Research Data Storage in line with data protection policy.

Appendix B -Semi structured interview guide (CSAE identification and recording)

Context and Purpose

“Nationally, identification of CSA/CSE within children’s services has fallen (CIN assessments at a nine-year low; Child protection plans for sexual abuse at a 30-year low; CSE declining since 2017/18), while police-recorded CSA offences are rising. The Casey Review (Rec 9) flagged inconsistent definitions and recording. DfE has commissioned this work to understand how CSA and CSE are identified and recorded locally, why practice varies, and what would improve accuracy and consistency.

Role and Remit

1) Tell me about your role and responsibilities re: safeguarding/recording CSA and CSE.

Identification in Practice

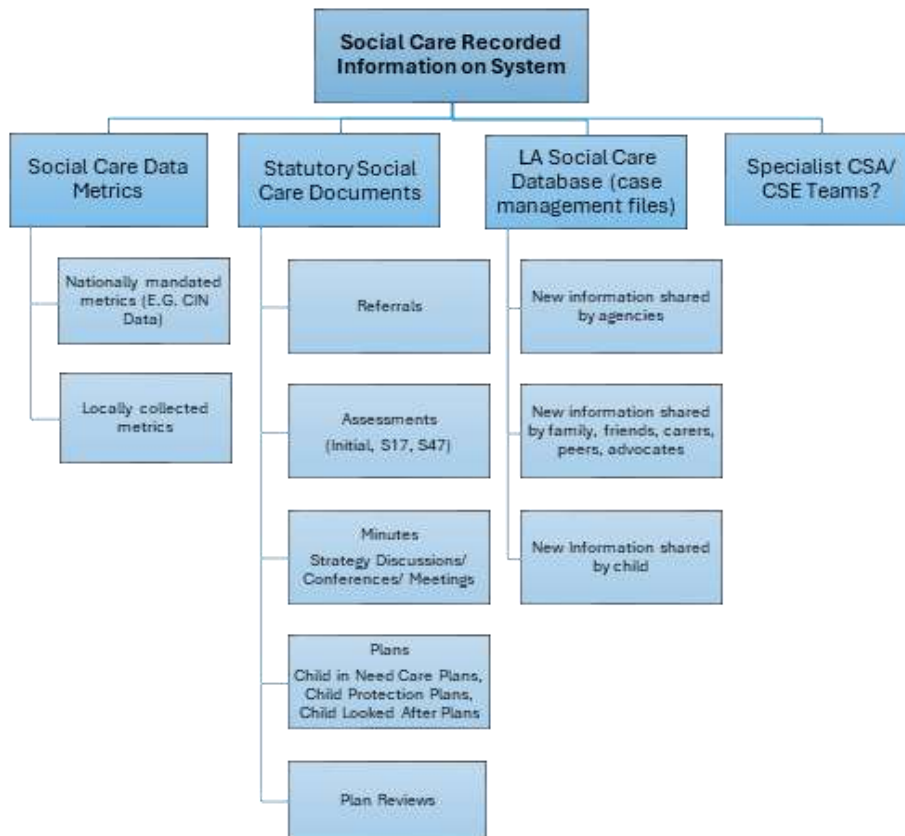
2) What are the different types of CSA/CSE which you encounter? How do you distinguish between CSA and CSE in day-to-day work?

(Relevance of thresholds, guidance documents etc)

3) How confident do you feel about identifying/ recording/ escalating CSA/CSE concerns?

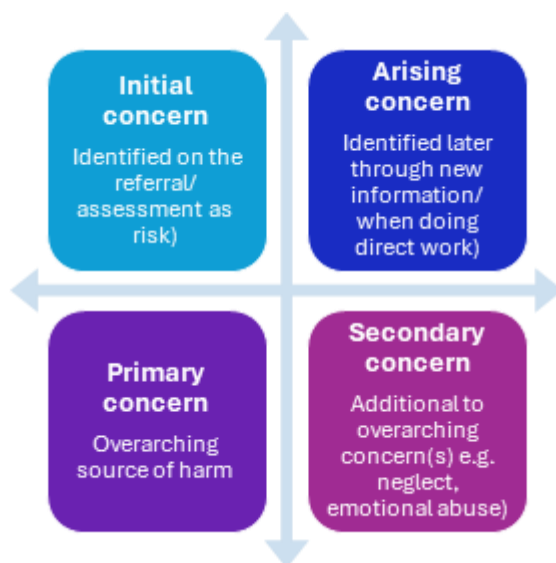
4) What does recording of CSA/ CSE on your system look like- from start to finish?

Note the image below is just for reference to outline potential relevant systems for participant.



5) How do we overlay multiple concerns/ risks/ harms with CSA/ CSE across safeguarding process? How do we make decisions regarding CSA/CSE- where is this recorded?

Note: the image below is again, just for reference to aid the researcher and interviewee on potential areas of concerns to cover.



Data Systems & Reporting

6) How do local case management systems help or hinder accurate CSA/CSE recording?

7) Is CSE/ CSA accurately represented within the system?

Training, Guidance & Consistency

8) What training/guidance do you receive CSA/ CSE?

Variation & Improvement

9) Can you see how there would be variation across LA? Why?

10) What can we do to better identify/ respond or improve recording CSA/ CSE?

Appendix C - Semi structured interview guide (SIN)

Interview schedule Q3 SIN prompts

Pathway narration (Senior Leaders):

Potential open question: "Talk through a typical process for reporting via the SIN system: Walk us through the steps from the first internal flag to submission (who does what, when; what must be recorded; typical timescales)".

Oversight & roles

- 1) Who is the senior LA manager overseeing SINs (e.g., PSW/Head of Safeguarding/QA)?
- 2) Who holds the submitter/approver roles for the online notification form (and out-of-hours cover)?
- 3) How does this work in practice?
- 4) Does the oversight change if the child is in the youth justice system including custody?
- 5) Including child perpetrators?

Local decision model

- 6) Who usually spots cases that might meet SIN criteria, and who decides whether to notify? Is this variable?
- 7) How do front line staff trigger the discussion/process of notification when they have serious concerns about CSAE?
- 8) How do the three safeguarding partners (LA, Police, ICB) agree whether to notify? Is it written down? How is disagreement resolved? Are other partners involved in making the decision to notify?
- 9) What happens if more than one local authority is involved who takes the decision to report. If a child is in custody how are custody involved?
- 10) Which model do you use for SIN decision making: standing CSPR subgroup, ad-hoc triage call, delegated sign-off, or emergency 'gold' or a combination?
- 11) Has the local process for notifying SINs, including thresholds of what should be notified, changed over time? If so, how?

12) If there is already deemed to be enough local learning for a particular type of harm in CSA/ CSE, would this alter the decision to notify the Panel of a serious incident? Is this part of the criteria?

13) Are there other reasons for not submitting an incident where a child has been suspected or known to be abused or neglected?

Timing / late awareness

14) How do you apply the 5-day duty from awareness if abuse/neglect wasn't suspected at first but becomes apparent later and there are serious concerns relating to CSAE (e.g., post-mortem findings)?

Coding when CSAE is present

15) When CSAE is present but there are other harms or concerns requiring a on the notification, what led to that choice and is CSA/CSE effectively represented? What, in practice, would have made CSAE the primary? And any examples where it is present, but may not be included as primary, where is then recorded?

Barriers / delays

16) What most often delays or prevents a SIN for CSAE here (e.g., threshold interpretation, workload, supervision, partner disagreement, form requirements)?

Learning points

17) Based on your experience, what would help decision-making and accuracy (e.g., clearer local guidance/examples, meeting cadence, fields/flags, simple checks)?

Appendix D Coding analysis framework version 1

Coding analysis framework version 1

Key Issue	Practice	Recording
Theme 1: Social work remit	Co-occurring risks, complexity, root causes	Incident categories of harm
-	Assessment based and relationship focused	Narrative recording: Child's journey
Theme 2: Distinction between CSA and CSE	Powers and focus of child protection legislation	CSE does not easily feature in traditional CIN data
-	Different pathways	Local exploitation datasets
Theme 3: Potential for variation	Time, resource, confidence and specific skillset. Threshold application, cohorts, volumes of referrals	Working culture and structures can inform metrics, varying datasets, varying analytical capacity and overlaying of data
Theme 4: SIN Process	-	-

Appendix E Final coding analysis framework (version 2)

Final coding analysis framework (version 2)

Theme	Sub-theme
Chapter 1: Remit of social care practice: Identification and recording	1.1 Co-occurring needs and risks: Holistic, complex and fluid
-	1.2 Issues impacting recording CSA as a category of significant harm
Chapter 2: Distinction between CSA and CSE	2.1 Relationship between CSA and CSE
-	2.2 Types of sexual abuse and changes over time
-	2.3 Thresholds, statutory pathways and evolving safeguarding response
Chapter 3: Systems, tools and structures that shape visibility and variation in CSAE	3.1 Chronologies and a child's journey: Current and historical risk
-	3.2 Local tools and databases to compensate for national gaps in recording contextual harm
Chapter 4. Serious notification identification (SIN) and CSAE	4.1 Thresholds and understandings
-	4.2 CSAE issues
-	4.3 Local learning mechanisms
-	4.4 SIN processes
-	4.5 SIN logistics
Chapter 5: Professionals' reflective learning points	5.1 What might be helpful to improve social worker knowledge and/or confidence in this area?
-	5.2 What specifically might be helpful to improve the quality and accuracy of data in relation to the recording of CSAE concerns?
-	5.3 What helps to facilitate consistent recording of CSAE



Department
for Education

© Department for Education copyright 2026

This publication is licensed under the terms of the Open Government Licence v3.0, except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3.

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

Reference: RR1611

ISBN: 978-1-83870-774-3

For any enquiries regarding this publication, contact www.gov.uk/contact-dfe.

This document is available for download at www.gov.uk/government/publications.