

## **“I wanted them all to notice”**

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

*November 2024*

This short briefing note aims to summarise the key learning points from the independent Child Safeguarding Practice Review Panel’s national review into the Child Sexual Abuse within the Family Environment. It outlines the main practice and systems issues that featured in the 136 incidents covered by the review, which professionals may find useful to reflect on. It sets out 10 national recommendations for improving child protection policy and practice across England, in response to this kind of abuse. Additionally, it sets out 6 specific recommendations for safeguarding partners. Read the full review report here:

<https://www.gov.uk/government/publications/national-review-into-child-sexual-abuse-within-the-family-environment>

### **About the national review**

The review fieldwork analysed 136 serious child safeguarding incidents, and 41 related serious case reviews (SCRs) and local child safeguarding practice reviews (LCSPRs). It included discussions with 107 practitioners across England, one-to-one interviews with 2 of the children at the heart of these reviews, discussions with experts by experience, and interviews with 5 people who had been convicted for sexually abusing children in these reviews.

### **What can we learn from what happened to the children in these serious incidents?**

We have set out in more detail the main practice issues that feature in this national review:

#### Professionals from across multi agency system struggle to identify and understand when there is risk of harm

- Our findings show that practitioners working with children and families are often not equipped with the knowledge, skills and practical guidance to identify and respond confidently when there are concerns of child sexual abuse in the family environment.
- This report highlights the need for a child-centred system that recognises the challenges children face in verbally reporting their abuse and that does not rely on them doing so in order to take action.
- Our recommendations include measures to ensure that practitioners understand that they can and should talk directly to children and families about concerns of sexual abuse. We are also recommending better training and support so that practitioners can respond more effectively and sensitively to children who may be being abused.

### There must be better join-up between the criminal justice and child safeguarding responses to child sexual abuse

- Our review has found that, when there are concerns about child sexual abuse within families, the response is too often led by the criminal justice system. We need the police, social workers and others to work better together, keeping children's best interests at the heart of all enquiries and investigations.
- Once concerns are raised there is too often drift and delay in criminal proceedings, leaving children feeling stranded as they wait to know what is happening. That's why our recommendations include keeping children and families appropriately informed of the progress and outcome of investigations and enquiries.
- One of our key findings is that when the criminal threshold is not met, action from all agencies to investigate abuse or help children often ceases. This leaves children feeling disbelieved and at further risk. When recording 'no further action' in a criminal case, it's crucial that social workers provide children and families with ongoing support, information about the rationale for decisions, the right to ask for review of these and about compensation schemes.

### Children and families are not receiving the support, help and protection they need throughout sexual abuse investigations

- Practitioners across the system need to be empowered to act quickly and confidently to safeguard and support children. Particular sensitivity is needed to support children who are very young or have communication needs. Children will also sometimes tell someone about abuse but, because of shame or coercion, then withdraw their statements. These situations require great sensitivity and care.
- We were concerned about how poorly children had been informed about video recorded police interviews. There was some evidence that, when children expressed uncertainty about whether they wished to take part, they were told that this would impede the police investigation, leaving them feeling blamed and responsible. We believe these interviews should be jointly executed with whoever is best placed to help the child talk about their experiences.

### We must improve assessment of people presenting risk of sexual harm to prevent further offending

- Over a third of reviews featured a family member with a known history of sexual offending or who was known to present some risk of sexual harm. This highlights concerns about the quality of risk-assessments and emphasises the imperative of professionals from different services, including probation and the police, working closely together to identify and address risks of harm.
- Whenever information comes to light which indicates that someone in the family has a previous allegation or conviction for any type of sexual offending, this should lead to a multi-agency discussion, which involves an up-to-date assessment of risk.

## Questions that you might want to reflect upon as a professional:

We have set out below some questions that you might want to reflect upon as a professional, either individually, as part of supervision, or as a group:

### Learning from the review

1. What are the key lessons in this national review for your organisation and your practice, including working with other agencies (including with probation services, education settings, police, health)?
2. Looking at the learning from this national review, do you have any reflections on whether you and your colleagues could have acted differently when responding to instances of child sexual abuse?
3. Looking at the key messages below for safeguarding partnerships, what are the immediate steps you and colleagues can practically put in place with respect to the identification and response to this form of abuse?

### Working with children and families

4. How does your practice need to change so that the needs, voices and experiences of children who are sexually abused or at risk of being sexually abused are better addressed?
5. How well are the specific needs of children from Black and minoritised communities understood and addressed with respect to child sexual abuse within the family environment?
6. How well do you seek the views of children and non-abusing parents and carers?

## Key messages for Safeguarding Partners:

The six recommendations for consideration by all Safeguarding Partners are:

### Recommendation 1: Strategic planning

Safeguarding partners should consider the findings of this national review and develop a local action plan to respond to its recommendations as it affects local multi-agency practice.

### Recommendation 2: Professional knowledge, skills and confidence

Safeguarding partners should undertake a multi-agency training needs assessment, to ensure that their practitioners are able to fulfil their roles and responsibilities in this area. This should include the achieving best evidence joint training.

The response to this assessment may require multi-agency and single-agency training initiatives, in a range of formats, supported by evidence informed resources.

They should additionally give specific attention to the role of schools, early years and other education settings and how they can identify and help children affected by child sexual abuse.

### Recommendation 3: Enquiries and investigations

Safeguarding partners should audit the quality of local multi-agency decision making when responding to concerns about child sexual abuse. This may include adoption of a pathway approach, use of guidance about signs and indicators of sexual abuse and reviewing threshold documents about assessment of need and risk.

Agencies should ensure that Working Together guidance is followed and that, at the conclusion of section 47 enquiries and police investigations, there is a multi-agency discussion to consider risk to the children and how they will be protected and supported.

The term 'no further action' should not be used in these circumstances as it is too often understood to mean the abuse did not happen. The term 'no further police action at this time' is more appropriate. There should be a clear record of why a criminal investigation has been closed and that this information has been shared with other relevant agencies.

Where the harm has been perpetrated by a sibling, plans must be made for all the children in the family, addressing the needs of the child who has harmed as well as the child who has been harmed, and any other siblings.

### Recommendation 4: Assessment of people presenting risk of sexual harm

Safeguarding partners should, with all relevant agencies such as the Probation Service, review how people who present a risk of sexual harm and who have contact with children are assessed and managed, with information about risk shared across agencies in a timely way. Partners should consider the use of civil orders and other measures to effectively manage the risk from the person of concern.

There is evidence of a need for safeguarding partners and probation to work together to create single points of contact, have robust information sharing arrangements and promote effective learning across agencies.

### Recommendation 5: Talking to children

Safeguarding partners should take necessary steps to ensure that all practitioners in their area (including foster carers) understand and are confident in talking directly to children, and families, about concerns of sexual abuse, taking due account of ethnicity, language and disability.

Safeguarding partners need to ensure that there are sensitive and effective plans to address the impact on children of any decision to end an investigation.

### Recommendation 6: Health

Safeguarding partners should ensure that there are local pathways for referring children for appropriate forensic medical and other health assessments, for both recent and non-recent sexual abuse, and that safeguarding practitioners understand them.

It is also important that strategy discussions about children, where there are concerns about possible sexual abuse, involve an appropriate health representative who either has clinical experience in assessment where recent or non-recent child sexual abuse is suspected or, as a minimum, has consulted with a professional who has this expertise.

## **How can we change nationally?**

The Panel is calling for Government to put in place a national action plan to combat the culture of secrecy around, and weak understanding of, child sexual abuse within families.

### Recommendation 1: National strategic plan

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

### Recommendation 2: Professional knowledge, skills and confidence

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

### Recommendation 3: Enquiries and investigations

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

### Recommendation 4: Assessment of people presenting risk of sexual harm

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

### Recommendation 5: Talking to children

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

### Recommendation 6: Health

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

### Recommendation 7: Criminal investigations and charging advice

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

### Recommendation 8: Family courts

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

### Recommendation 9: Cafcass

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

### Recommendation 10: Inspectorates

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