Summary of the National review into child sexual abuse within the family environment

"I wanted them all to notice" – a summary of the Child Safeguarding Practice Review Panel's report investigating the experiences of children who were sexually abused by a family member

November 2024

Introduction

This report was commissioned by the Child Safeguarding Practice Review Panel (the Panel) to explore the challenges in identifying, assessing and responding to child sexual abuse within the family environment.

The Panel is responsible for commissioning national reviews of serious child safeguarding cases to improve learning, professional practice and outcomes for children in England.

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Between 2018 and 2023, the Panel received over 130 rapid reviews and related serious case reviews (SCRs) and local child safeguarding practice reviews (LCSPRs) featuring child sexual abuse in the family environment (also known as intrafamilial child sexual abuse).

Find out more about the case review process in each UK nation

In commissioning this national review, the Panel aims to highlight the contexts, experiences and needs of the children, parents and carers impacted by intrafamilial child sexual abuse.

Context

The introduction to the report includes a summary of existing research literature and practice guidance around identifying and responding to child sexual abuse in the family environment.

Methods

The Panel commissioned the Centre of expertise on child sexual abuse (the CSA centre) to undertake the work for the report. This work involved:

- a review of the relevant research and practice guidance
- an analysis of 136 rapid reviews, 40 related serious case reviews or local child safeguarding practice reviews, and one local thematic review received by the Panel between June 2018 and November 2023
- ten online reflective group discussions involving 107 practitioners and managers in nine local safeguarding partnerships who had been involved in ten of the reviews

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- one-to-one interviews with two children who had been sexually abused by someone in their family environment
- one-to-one interviews with five people who had sexually abused a child
- a series of roundtable discussions involving experts by experience (people with lived experience of being sexually abused as a child) and senior leaders from a range of agencies including policing, probation, universal health and specialist health services.

The children at the heart of the reviews

The introduction to the report includes information on the sex, ethnicity, age and additional vulnerabilities of the children involved in the reviews analysed. Although this information wasn't available in all the reviews the Panel received, the available information showed that:

- 75% of children were girls
- 73% of children were White British, while 27% were from Black or minoritised ethnic communities
- 29% of reviews featured a child under 6 years old, 46% featured a child aged between 6 and 12, and 25% featured a child aged between 13 and 17
- 29% of reviews featured the abuse of a child who had a disability or whose disability was in the process of being formally diagnosed
- in the majority of cases, the children were sexually abused by their father, stepfather or mother's partner.

Key findings

Four key findings arose from the analysis of the case reviews, one-to-one interviews, and group and roundtable discussions. These are set out below. For each key finding, the report also includes a series of reflections and considers implications for practice.

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Key finding 1: Hearing children's voices and understanding their needs

Not relying on children to tell

- Practitioners spoke about how their understanding from training and organisational messaging was that they needed to wait for children to approach them to talk about sexual abuse, rather than proactively speaking to children when they had concerns.
- A fear of interfering with potential criminal investigations meant practitioners felt they should not talk to children directly about possible abuse.
- Some children spoke about waiting for someone to ask them what was happening so they could tell them.
- A fear of asking children explicitly about child sexual abuse prevented practitioners from exploring concerns in more detail.

Talking to or listening to children

- When children did speak to practitioners about their abuse, they often felt unheard and weren't helped to understand what was happening.
- Practitioners didn't provide children with the information they needed or consult them about decisions affecting their safety and wellbeing.

Believing children when they do tell

- In many cases, children directly told practitioners they were being sexually abused by a family member and were not believed.
- When children retracted a disclosure, practitioners often accepted this without exploring the reasons for the retraction. Retractions were also often treated as evidence that the sexual abuse had not happened.

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

- The effects of racism, including bias and wider systemic experiences of discrimination, were not considered when practitioners responded to children and families from Black and other minoritised ethnic communities.
- The needs of children who had English as a second language were not sufficiently considered. This meant these children often didn't have a 'voice' in the assessment and investigative process.
- Adultification bias meant children from Black and minoritised ethnic communities were often treated as older than their actual age and blamed for their behaviour.
- Practitioners didn't recognise and explore family structures in different cultures.

Exploring and taking account of the needs of children who have disabilities

- Signs and indicators of sexual abuse were often attributed to the child's disability rather than explored in terms of potential sexual abuse.
- Signs of sexual abuse in children who were pre-verbal or non-verbal were often missed.
- In many cases, practitioners didn't seek out advice from those who knew the child well and who could have provided information about a child's abilities and preferred communication style.

Listening to children's wishes around visual recorded interviews (VRI) or achieving best evidence (ABE) interviews

- When children expressed concerns and uncertainties about taking part in VRI or ABE interviews, they were often seen as not co-operating and as impeding the investigative process, leaving them feeling blamed and responsible.

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- There was a lack of clarity about whether the transcripts or recordings of interviews could be shared. This left those who had an ongoing support role with the child uncertain about what the child had reported.

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

- When children were showing signs of distress and trauma following sexual abuse, practitioners often suggested they be assessed for autism or ADHD, rather than seeking to understand and respond to the distress.

Children having access to appropriate support following abuse

- Some children were deemed unsuitable or too 'unstable' to qualify for specialist support services. Others were provided with interventions that were inappropriate to their situation.
- When children could access therapeutic support, this was clearly beneficial.

Key finding 2: Understanding parents' and carers' needs and contexts

Understanding of parents' contexts and vulnerabilities

- Practitioners didn't always consider how vulnerabilities such as domestic abuse might prevent a parent from speaking out about sexual abuse within the family.
- Parents, particularly mothers, were often seen as displaying 'disguised compliance' rather than as potential victims of coercive control or grooming.

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

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- Practitioners didn't usually consider or respond to parents' needs in relation to their race, ethnicity and culture, including meeting communication needs and addressing bias.

Relying on parents to protect their children

- Working agreements and safety plans often placed sole responsibility on parents to keep their children safe, such as by placing the onus on one parent to protect their child from another family member who posed a risk to the child.
- There was often a lack of consideration for parents' own support needs and how they impacted their capacity to protect their children.

Sharing with and believing parents and carers

- Practitioners did not know they needed to advise parents about their rights to find out about a new partner's previous convictions for child sexual abuse.
- Some parents described how they felt practitioners were not listening to them or seeking their views. This led parents to disengage from services.

Support for parents and carers

- Parents were not offered appropriate support, particularly around parenting a child who had been sexually abused, coping with the information about the abuse and keeping their family together in a safe and appropriate way.

Key finding 3: Identifying signs, understanding risk and raising concerns

Identifying signs of intrafamilial child sexual abuse

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- Practitioners often sought other explanations for symptoms and behaviours that may have indicated a child was being sexually abused.
- Children's health needs that could have been signs of sexual abuse were often treated in isolation. This was often because practitioners were unaware of information held by other agencies that might have provided valuable context.
- In cases where the child became pregnant as a result of the abuse, it was the pregnancy or birth of the baby that led to the sexual abuse being identified.
- Practitioners didn't connect changes in children's behaviour, such as cowering when a family member collected them from school or pre-adolescent children seeking emergency contraception, with the possibility of child sexual abuse.
- Practitioner bias about who perpetrates child sexual abuse often prevented practitioners from recognising the signs of child sexual abuse.

Quality of risk assessment for sexual offending

- In some cases, convicted sex offenders and family members who had been previously prosecuted for intrafamilial sexual abuse moved into a home with children without a risk assessment or effective safeguards being put in place.
- In some cases, adults who had been investigated for or convicted of a sexual offence against another adult were not perceived as presenting any potential risk to children.
- When risk assessments did take place, there was often an insufficient focus on sexual abuse and practitioners' views were often disregarded if they differed from those of the assessing social worker.
- Assessments often didn't focus on the individual about whom there were concerns of sexual abuse, even when the child had reported the sexual abuse.
- Agencies were not always aware of a family's structure and makeup, including which family members were on different plans or interventions.
- In cases where other concerns were present, such as neglect, physical abuse or domestic abuse, practitioners tended to focus on these other forms of abuse, with concerns about sexual abuse becoming lost from sight.

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- Family court decisions around child contact and residence arrangements often took insufficient account of the sexual risk presented by family members.
- When concerns related to a child's sibling, practitioners lacked guidance, support and training in assessing and managing risk.

Key finding 4: Responding to concerns of intrafamilial sexual abuse

Exploration and recording of concerns

- There was on over-reliance on general health practitioners, including school nurses, GPs and non-specialist hospital clinicians, to assess concerns around child sexual abuse.
- Concerns of child sexual abuse weren't always fully explored or recorded. This meant practitioners weren't aware of previous concerns when subsequent concerns of child sexual abuse emerged.

Evidential thresholds

- Practitioners often thought that the threshold for action when responding to child sexual abuse was the criminal justice standard of proof (beyond reasonable doubt) rather than the safeguarding threshold for action (balance of probabilities).
- Even in cases where a child reported being sexually abused by a family member, practitioners often considered that more evidence was needed for the concern to be pursued.
- Practitioners reported feeling less reluctant to record concerns for other kinds of harm, such as neglect, than for child sexual abuse.
- When police recorded 'no further action,' children's social care often took this to mean that no child sexual abuse had occurred and therefore no safeguarding action was needed.

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The importance of information-sharing

- In many cases, information was not shared with the multi-agency group and practitioners often assumed that concerns they had raised had been resolved.
- Police investigations and child protection enquiries often happened in isolation, with practitioners having little knowledge of what information should be shared with the police and when.
- Practitioners sometimes appeared to assume that what children said in ordinary contexts, such as at home or in school, did not count as 'evidence' unless they had agreed to undertake VRI or ABE interviews.
- Where cases involved child sexual abuse by multiple perpetrators and where multiple children were suspected to have been harmed, complex safeguarding strategy discussions would have been beneficial in allowing practitioners to share information. However, these discussions were often not held.

Collaborative working

- In some cases, police acted on concerns before speaking with children's social care or holding a strategy discussion. This undermined the assessment of risk.
- Scheduling of strategy discussions often failed to take account of the clinical duties and work patterns of practitioners working in health and education. This often meant valuable perspectives were absent from discussions.

The impact of drift and delay

- In some cases, children were subject to multiple assessments for child sexual abuse over a number of years, with each assessment carried out in isolation from the previous one and failing to build a picture of cumulative concerns.
- Practitioners highlighted the significant length of criminal justice processes, and the impact this has on children and their families.

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Opportunities and interventions to address offending thoughts and behaviour

- Some of those who had sexually abused a child discussed their own experience of being sexually abused as a child. They highlighted how being able to speak to someone about their own abuse would have helped them to get help.
- Some spoke about the lack of support available to address sexual offending thoughts and behaviour.
- Services for substance or alcohol abuse, as well as the building up of relationship skills and problem solving, were identified as forms of support that would have been beneficial.
- It was highlighted that those at risk of re-offending should receive support upon release from prison and information on how and where to seek help.

Moving forward

In this section, the report sets out its conclusions and recommendations. It provides ten national recommendations, as laid out below. It also provides six key recommendations for local safeguarding partners in England. These mirror the first six national recommendations, with the emphasis on how they apply to local multi-agency practice.

National recommendations

Recommendation 1: National strategic plan. Government should develop and publish a strategic plan to deliver the necessary practice improvements identified in this report.

Recommendation 2: Professional knowledge, skills and confidence. Government should work with professional bodies to ensure that practitioners and

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managers have the necessary skills, knowledge and capabilities to identify, assess and respond to child sexual abuse, including access to relevant guidance.

Recommendation 3: Enquiries and investigations. Government should take the 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 people who present a risk of sexual harm and who have contact with children are robustly assessed, managed and supported.

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 ensure that local pathways and services are in place to identify and respond to the health needs of children who have experienced recent and non-recent sexual abuse.

Recommendation 7: Criminal investigations and charging advice. Government should work to implement 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.

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Recommendation 9: Cafcass. The Panel invites the Children and family court advisory and support service (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.

References

Child Safeguarding Practice Review Panel (2024) **"I wanted them all to notice": protecting children and responding to child sexual abuse within the family environment.** [Accessed 28/11/2024]

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

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