**Working with the**

**Risk of Intra-Familial Child Sexual Abuse**

**Practice Guidance**

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# Purpose

This guidance has been developed to support practitioners to identify and assess protection within the family, offer support to children where there is/are suspicions of child sexual abuse (CSA) and to clarify multi agency processes and pathways.

There is no single agreed definition of intra-familial CSA. However, it is generally recognised that, in addition to abuse by a relative (such as a parent, sibling or uncle), it may include abuse by someone close to the child in other ways (such as a stepparent, a close family friend or a babysitter). This understanding is in accordance with Crown Prosecution Service guidelines on the Sexual Offences Act 2003, which state: “These offences reflect the modern family unit and take account of situations where someone is living within the same household as a child and assuming a position of trust or authority over that child, as well as relationships defined by blood ties, adoption, fostering, marriage or living together as partners’’ [(CSA Centre)](http://www.csacentre.org.uk/).

Extra-familial harm is defined as risks to the welfare of children that arise within the

community or peer group, including sexual and criminal exploitation. A key element

of extrafamilial harm is that in general, harm does not arise from the home environment and parents may not be aware that their child is at risk or may be struggling to protect their child and the family from harm against exploiters.

Extra- familial harm has not been included within this guidance; the focus is on intra- familial harm.

Throughout the guidance the terms victim and survivor are both used interchangeably, both terms have their place and serve different purposes.

Within the criminal justice system, the term victim describes a person who has been subject to a crime, it serves also as a status that provides certain rights under the law. Investigators and prosecutors use this term to illustrate that a crime has been committed against a person.

A person that identifies themselves as a survivor may not see themselves as a victim because they have gained strength over time, this may be through the healing process which has enabled them to have a sense of peace in their life.

When working with victims/survivors of child sexual abuse the best way to be respectful is to ask for their preference in terms of language used.

# The Impact of Intra-Familial CSA

When working with children who have been (or who are suspected of being) sexually abused, it is important to hold in mind the potential impact of abuse and also the factors that can improve the probability of recovery. Such as

* Damage to relationships with others (42% of victims/survivors).
* Difficulty in forming intimate and trusting relationships in later life (28% of victims/survivors).
* Poor mental health and emotional well-being. Victim/survivors reported the following issues:
* Depression (57%)
* Suicidal ideation (28%)
* Anxiety (28%)
* Self-harming (49%)
* At least one suicide attempt (22%
* Engaging in risky behaviour or experiencing conduct disorders.
* Poorer educational outcomes and lack of earning in later life.
* Damage to familial relationships. This can be due to:
* the perpetrator being a family member.
* not being believed
* family members being aware of abuse occurring but not intervening.
* being blamed for changes to family dynamics in the wake of disclosures
* feeling responsible for the well-being of family members impacted by disclosures.
* Disruption to friendship groups: feeling lonely and isolated as a result of the abuse or being aware of being talked about following disclosures.
* Victims and survivors fear that the sexual abuse they suffered as a child will mean that they will not be safe parents, or that others will consider them to be a danger to their own children.
* Poor physical health, both short term due to the abuse and potentially in the longer term. Long term health consequences include 20% more attendances at doctors and chronic illnesses and disabilities.
* Increased risk of emotional difficulties during pregnancy.

[Interim Report of the Independent enquiry into child sexual abuse 2018](https://www.iicsa.org.uk/reports-recommendations/publications/inquiry/interim.html)

There are also several factors which increase a person’s resilience to the effects of CSA:

* Educational engagement, contentment, and attainment.
* Supportive relationship with at least one adult caregiver or positive adult role model.
* The response to the disclosure of abuse of those close to them being a positive experience.
* A supportive social and environmental context e.g., professionals who respond sensitively to disclosures, support from education and health services.
* Victim/survivors own emotions, beliefs, and attitude to the abuse, including having a sense of high self-esteem, locating the blame for the abuse in the perpetrator and having a sense of hope for the future.
* Factors relating to the circumstances of the abuse, e.g., age at onset, identity of the perpetrator, can have an impact on resilience although this area requires further research. [(Victim Support)](https://www.researchgate.net/publication/323662310_Responding_sensitively_to_adult_survivors_of_child_sexual_abuse_An_evidence_review)

## Signs and Symptoms

Identifying and understanding signs and symptoms of sexual abuse is a complex process. This section provides some broad information and links to further resources to explore particular issues around identifying signs and symptoms in more detail.

It is not known exactly how many children in the UK experience sexual abuse. However, the NSPCC write that research with 2,275 children aged 11-17 about their experiences of sexual abuse suggest that around 1 in 20 children in the UK have been sexually abused. [Statistics on child sexual abuse | NSPCC Learning](https://learning.nspcc.org.uk/research-resources/statistics-briefings/child-sexual-abuse). NPSCC state that ‘sexual abuse is usually hidden from view. Adults in the child’s life may not recognise the signs of sexual abuse and the child may be too young, too scared, or too ashamed to tell anyone what is happening to them’.

Knowing the signs of sexual abuse can help give a voice to children. Sometimes children won't understand that what's happening to them is wrong. Or they might be scared to speak out. According to NSPCC ([Preventing Child Sexual Abuse & Keeping Children Safe | NSPCC](https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/child-sexual-abuse/)), some of the signs practitioners might notice include:

## Emotional and Behavioural Signs

* Avoiding being alone with or frightened of people or a person they know
* Language or sexual behaviour you wouldn't expect them to know
* Having nightmares or bed-wetting
* Alcohol or drug misuse
* Self-harm
* Changes in eating habits or developing an eating problem
* Changes in their mood, feeling irritable and angry, or anything out of the ordinary

## Physical Signs

* Bruises
* Bleeding, discharge, pains or soreness in their genital or anal area
* Sexually transmitted infections
* Pregnancy

Physical indicators may require a referral to SARC (Sexual Assault Referral Centre) [Beech House - The Kent and Medway SARC - Home (beechhousesarc.org)](http://www.beechhousesarc.org/). When a referral is made to SARC (either from a professional or self-referral) they will ensure a referral has/is made to Children’s Social Care for a decision to be made about holding a strategy discussion.

## Technology Assisted Abuse (Online Child Sexual Abuse)

If a child is being or has been sexually abused online, they might:

* Spend a lot more or a lot less time than usual online, texting, gaming or using social media.
* Seem distant, upset or angry after using the internet or texting.
* Be secretive about who they’re talking to and what they’re doing online or on their mobile phone.
* Have lots of new phone numbers, texts or email addresses on their mobile phone, laptop or tablet.

# Key Questions to Consider

When a concern is raised about a child being at risk of intra-familial CSA, practitioners should consider the following key questions:

* Where a child has made a disclosure of CSA, have professionals demonstrated to them from the start that we believe what they have told us, even where there might need to be some further investigation into what happened in relation to the details of events?
* Have we done enough to reassure the child that we are working to increase their safety and are they clear about how we will try to do this?
* Do we have a detailed chronology/thematic chronology of sexual abuse to fully understand the history of concern about CSA?
* Have we been explicit with parents/carers about what we think the risk to their child(ren) is and why?
* Have we got a short-term safety plan in place which is adequate to manage the risk of harm whilst assessments are ongoing?

Consideration may need to be given to family time (previously referred to as contact) taking place between a child and a possible perpetrator of abuse. If in exceptional circumstances and where concerns are sufficiently serious the police may consider bail conditions that prohibit contact with any child, which provides a legal basis for no family time or supervised family time, at least for a specified period. The police may amend bail conditions should further information come to light which indicated risk had reduced/increased.

Although it is unlikely, in some circumstances contact between a child and a possible perpetrator of sexual abuse could be appropriate (and in the best interests of the child). Clearly, this would have to be considered carefully, be safe for the child, in line with any legal restrictions and be led by what the child wants. Where this is being considered, decisions in this regard should only be made following engagement and input from all involved professionals. Family Time would need to be supervised by a member of staff from Integrated Children’s Services.

Consideration could be given to convening a Family Group Conference to share information and consider the role of the family in safety planning.

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| **Safety planning: key questions to consider.** |
| Where we are relying on the capacity of ‘protective’ parents / carers / extended family members to keep children safe, are we reassured that they are willing to believe the child’s allegations of CSA may be true and are they clear about the actions they need to take to protect all children in the home?  Have we considered all children to which a potential perpetrator has (and may have had) access to in our safety planning?  Where a safety plan is in place, do we have a clear and transparent strategy for monitoring compliance with this plan, and is it clear to the parents/carers what will happen if they do not comply?  Are all partner agencies within the professional network clear about the risk assessment and safety plan?  Have we arranged one or more multi-agency face-to-face Strategy Discussions, particularly where there are joint investigations with the police, or where we are unclear about police actions and decision-making rationale?  Have we considered the need for a child protection medical?  Where we are unhappy with the response of partner agencies, have we escalated this?  Do we have a clear plan for progressing risk and protective capacity assessments?  Where parents/carers are reluctant for us to speak to children about the reason why we are worried for their safety, have we sufficiently challenged this? Are they willing to work toward this through intervention and support? Denial is the most normative response to allegations of sexual abuse and often there needs to be a few sessions with non-abusive parents/carers to get them to a point where they feel safe for the children to be informed about the concerns and prepared to contain any emotional consequences of this. Open communication reduces the risk of further sexual abuse as it helps to break the secrecy that often surrounds the abuse.  Have we been clear with the wider family network (extended families and any professionals involved with them) about our concerns and the recommendations arising from our assessment of risk and interventions, to support them to keep children safe in the long-term?  Have we alerted our managers to the disclosure / risk of CSA and sought advice from them?  Offer parents support on how to speak to their children, including how they keep the information age appropriate and honest; parents may find it useful to practice what they are going to say. |

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# Investigating CSA

When there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm [(Section 47 Children Act 1989)](https://www.legislation.gov.uk/ukpga/1989/41/section/47) because of concerns about CSA, a Strategy Discussion will be convened by Children’s Social Care. Strategy Discussions will decide whether a child protection enquiry is required [(Child Protection Investigations Section 47)](https://www.proceduresonline.com/halton/cs/p_sec_47_enq.html). These enquiries can either be ‘Single Agency (led by Children’s Social Care) or ‘Joint Enquiries’ (undertaken by both Children’s Social Care and the Police).

The Police team which is involved in criminal investigations of CSA in Kent is called the Vulnerability Investigation Team (VIT).

VIT will record and investigate all suspicions or allegations of crime that come within the scope of the term ‘child abuse’ in co-operation with Local Authorities and other appropriate agencies. This includes:

* Intra-familial abuse - within the family and extended family including aunts; uncles; cousins; siblings including step, fostered, half brother and sister, grandparents, step grandparents, stepmothers or fathers and can include long term partners but must be an established relationship).
* Professional abuse by persons working in a child focused environment who abuses their paid position e.g., teachers; sports coaches; youth workers; ministers; caretaker of a school; school cleaner; prison staff.
* Persons who act as a carer with some responsibility for the child at the time of the offence – e.g., babysitters; voluntary groups like scouting, unpaid sports coaches; close personal family friends or in any other position of trust in relation to children or young people.

Related to how the risk of CSA is mitigated, arrangements are also in place for the Police and other agencies to manage Registered Sex Offenders (RSOs) prior to their release from prison and once in the community:

* Multi Agency Public Protection Arrangements (MAPPA) are a set of arrangements to manage high risk sexual and violent offenders. They bring together the Police, Probation and Prison Services in Kent into what is known as the MAPPA Responsible Authority.
* Several other agencies are under a duty to co-operate with the Responsible Authority. These include - Children’s Services, Adult Social Services, Health Trusts and Authorities, Youth Offending Teams, local housing authorities and certain registered social landlords, Job Centre Plus, and electronic monitoring providers.
* The purposes of MAPPA are: - to ensure more comprehensive risk assessments are completed, taking advantage of co-ordinated information sharing across the agencies; and - to direct the available resources to best protect the public from serious harm.

## Who are the offenders subject to MAPPA?

There are 3 categories of offender eligible for MAPPA:

* + Registered sexual offenders (Category 1) - sexual offenders who are required to notify the police of their name, address and other personal details and notify any changes subsequently.
  + Violent offenders (Category 2) - offenders sentenced to imprisonment/detention for 12 months or more or detained under hospital orders. This category also includes a small number of sexual offenders who do not qualify for registration and offenders disqualified from working with children.
  + Other Dangerous Offenders (Category 3) - offenders who do not qualify under categories 1 or 2 but who currently pose a risk of serious harm, there is a link between the offending and the risk posed, and they require active multi-agency management.

The Violent and Sex Offender Register (ViSOR) is a database of records of those required to register with the police under the Sexual Offences Act 2003 (the 2003 Act), those jailed for more than 12 months for violent offences, and those thought to be at risk of offending. The use of ViSOR increases the ability to share intelligence across organisations and enable the safe transfer of key information when high risk offenders move, enhancing public protection measures. ViSOR allows staff from the Police, Probation and Prison Services to work on the same IT system for the first time, improving the quality and timeliness of risk assessments and interventions to prevent offending.

Sexual Harm Prevention Orders (SHPOs) (including any additional foreign travel restriction and interim SHPOs replaced Sexual Offence Prevention Orders. They are intended to protect the public from offenders convicted of a sexual or violent offence who pose a risk of sexual harm to the public by placing restrictions on their behaviour. They require the offender to notify their details to the police (as set out in Part 2 of the 2003 Act) for the duration of the Order. The court must be satisfied that an order is necessary to protect the public (or any particular members of the public) in the UK, or children or vulnerable adults (or any particular children or vulnerable adults) abroad, from sexual harm from the offender. In the case of an order made on a free-standing application by a chief officer or the National Crime Agency (NCA), the chief officer/NCA must be able to show that the offender has acted in such a way since their conviction as to make the Order necessary. The minimum duration for a full order is five years. The lower age limit is 10, which is the age of criminal responsibility, but where the defendant is under the age of 18 an application for an Order should only be considered exceptionally.

Detailed information regarding MAPPA can be found in the Kent MAPPA Annual Report. [Multi-agency public protection arrangements (MAPPA) annual reports 2021 to 2022 - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-annual-reports-2021-to-2022)

## Working In Partnership with the Police

Getting and Staying in Contact: There should be continuous contact between Police and Social Workers throughout a S47 Enquiry to update on significant events and outcomes of interviews, in order to inform risk assessments and safety planning.

Interviews and Achieving Best Evidence: The Police are committed to operating from a starting position that any child who discloses abuse should feel reassured through the actions of professionals that they are believed. At the beginning of a joint S47 enquiry, Social Workers should talk to the investigating officers about whether they plan to offer ABE interviews (Achieving Best Evidence) and if so, which children in the family and the timeframes for scheduling these. Social Workers should be present for ABE interviews to ensure they are fully abreast of the disclosure the child is making and to ensure the welfare of the child is paramount throughout the process. For further information see the KSCMP guidance [2.1.6 Child Protection (Section 47) Enquiries (proceduresonline.com)](https://www.proceduresonline.com/kentandmedway/chapters/p_ch_prot_enq.html)

In all cases where it is agreed to conduct a recorded interview of a child, the [Achieving Best Evidence](http://trixresources.proceduresonline.com/nat_key/keywords/achieving_best_evidence.html) guidance must be followed and staff conducting the interview must have had appropriate training, unless the need to depart from the guidance has been agreed by the investigating officers and their managers. Any such decisions must be recorded with reasons.

The aim of any such video interview is to gather evidence for criminal proceedings in cases which might result in prosecution.

Where a recorded interview is to take place, in order to avoid undermining any subsequent criminal case, any contact with a child prior to the interview must also be conducted under Achieving Best Evidence guidance and staff must:

* Listen to the child rather than directly questioning her/him.
* Never stop the child freely recounting significant events
* Fully record the discussion including timing, setting, presence of others as well as what was said.

If the investigating officers do not plan to proceed with ABE interviews, the Social Workers should ask them to explain their reasons for this, so they can be recorded. If there is a different professional opinion about the need to hold an ABE interview, it is important that Social Workers (and other involved professionals) articulate this and if necessary, escalate to management level in both agencies, with a request that the decision is reviewed.

Please bear in mind that investigating officers may be working to internal police guidance which stipulates that where there is an allegation of a very recent offence, delaying plans for an ABE interview may be appropriate, to avoid re-traumatising a child. Police often also need to consider the use of an intermediary to support an ABE, where, for example, there are questions about the child’s capacity, such as a learning or mental health need; if they have communication difficulties; or due to their young age. The investigating officers may be able to lead on an intermediary assessment themselves, however, they may need to enlist the services of a specialist to do this. The need for an intermediary may delay the interview but is essential if the need for one has been identified.

At the outset of the investigation and as it continues, investigating officers should keep the professional network up to date on who in the child’s family and network they plan to interview and when. This includes suspected perpetrators, protective adults, and other key individuals, including potential witnesses. This is likely to be via the Social Worker in the first instance, but it is important other involved professionals know this information too.

When investigating officers have no plans to speak with suspected perpetrators in particular, the rationale for this decision needs to be explained and recorded. Again, practitioners can escalate their concerns about this decision. It is important to remember that the decision-making of investigating officers may change over time, as new information comes to light. This is why it is vital that the professional network shares relevant and contemporary information to keep them up to date. For example, with further disclosures made by the subject child or their family; information from the professional network which appears to corroborate any concerns raised about CSA; or outcomes of any assessments undertaken. When sharing new information with investigating officers, ensure they are asked what, if any, impact this will have on the investigation strategy and the implications for partner agencies.

Bail conditions: Following an arrest, the Police are required to make a charging decision within 24 hours. If there is sufficient evidence to charge, an alleged perpetrator can potentially be remanded in custody awaiting trial or be released on police bail. Bail conditions cannot be indefinite though.

Sharing of Police Evidence: The key to effective joint working is two-way information sharing. Whilst the Police may be party to evidence that will inform safeguarding decisions, over time the professional network may also become aware of new evidence that may inform the progress of the criminal investigation. The Police are governed by complex guidelines with respect to various stages of evidential disclosure. They are particularly mindful about sharing any information that might compromise the integrity of investigations, and/or place anyone involved in the investigation at increased risk (for example, if suspected perpetrators may become privy to information about what has been shared). It may be that following a charging decision, the Police are able to share more detailed information, although decisions about what they can share when and with whom, will be made on a case-by-case basis. There should be no barriers to sharing general information with key partners or information essential to ensuring that a child’s is effectively safeguarded.

Escalation: If professionals do not agree with the decision-making rationale at any point of a S47 Enquiry, professionals should ask for this to be reviewed by the particular agency initially, and then (where required) by their supervisor. All agencies can use the Kent Safeguarding Children Multi-Agency Partnership (KSCMP) Escalation Policy. This interagency policy defines the process for resolving such professional differences and should be read alongside the [Kent Procedures Online](https://kentchildcare.proceduresonline.com/index.htm) and relevant internal policies on escalating matters of concern.

The Police will make a decision to charge an alleged offender based on the threshold of beyond reasonable doubt. Should a decision be made that this threshold is not met, and the prosecution of an alleged offender will not take place then Kent Integrated Children’s Social Care must decide what action they feel they need to take based on the balance of probability to protect and safeguard a child or young person from sexual abuse.

See flowcharts in [appendices.](#_Appendices)

# CSA Child Protection Medicals

Considering when a medical examination is needed and the timing for this is important in ensuring the wellbeing of a child and gathering important forensic evidence.

A CSA medical examination may be considered whenever there is an allegation of sexual abuse, sexual abuse has been witnessed, or when there is a suspicion by the referring agency that sexual abuse, including exploitation, has occurred (RCPH/FFLM 2015), whether this be recent or non-recent.

The role of the medical examination is not only to identify any physical findings which may support a disclosure and may be considered evidential but, just as importantly, to consider the overall physical and emotional health and wellbeing of the child and the wider family.

Although specialist doctors with training around sexual abuse undertake and approach these in as sensitive and non-invasive as they can possibly be, consideration must be given to the balance between the benefits of undertaking a medical examination against the challenges of undergoing this for the child.

The doctor undertaking the examination could provide additional advice about the benefits of undertaking medicals for individual children if needed and should be invited to strategy discussions to explore the information, ask appropriate questions about the information, and to consider the need for an examination.

Some aspects of a medical examination are greatly influenced by timing. After a recent sexual assault, forensic findings like DNA or physical injuries are much more likely to be found in the first 24 to 72 hours following last contact. However, it should be noted that many children who have experience sexual abuse show no physical signs of injury so examination should not be used purely to ‘prove’ abuse. The general health, welfare and impact would be considered.

There are also important health considerations early on and especially in the first 72 hours including, but not limited to, emergency contraception in older girls and considering whether medication could be provided to minimise the risk of HIV transmission, following abuse that carries this risk.

Where there has been historical abuse there is still a benefit to a timely assessment. This may vary according to clinical need and the child’s or carers’ wishes but it is usually expected that such children would be seen within two weeks of a decision being made that such an examination is required (RCPH/FFLM, 2015). This is usually following achieving best evidence (ABE) interviews but should not be delayed significantly if an ABE is not done or takes time to arrange.

Even if the last abusive contact was several months or years earlier there is still a benefit to a health check.

**CSA Medical Myth Busting**

**CSA examination includes an internal examination**: False.

A CSA examination uses a piece of equipment called a colposcope which is a magnifying glass with a bright light and recording equipment to look at the external genitalia. In order to obtain the appropriate view, the doctor will have to position the child on an examination couch and use their hands to apply traction to the skin of the legs. This would be similar to positioning for a nappy change and traction as for cleaning after a nappy change.

**Any doctor can perform a CSA examination**: False.

CSA examination is a specialised examination. It is performed by a senior paediatric registrar or consultant who are experienced in this field. In order to perform single person examinations, the doctor must perform at least 20 per year. The majority of examinations that take place have 2 practitioners for this reason.

**Children are traumatised by CSA examinations:** False.

These examinations are done in a child sensitive child focused manner. The event that has led to the need for a CSA examination is usually traumatic, however, these can begin to start the healing journey as they are therapeutic examinations that can reassure that appearances are normal. Although there must not be an automatic default that a child needs to undergo a medical examination. These can be intimate and invasive and the impact of undergoing such a personal examination must be weighed against the likelihood of the examination providing conclusive evidence.

**If you refer a child for a CSA examination, the child is fully committed to having all aspects of the examination completed**: False.

Consent is taken at each step of the process of a CSA examination, a child can stop the procedure at any point if they decide they are not happy.

**CSA examinations are often done under general anaesthetic**: False.

A child is fully conscious during the assessment for CSA.

See Kent Safeguarding Children Multi-Agency Partnership (KSCMP) Pathway for child sexual abuse (CSA) medicals (under 18-year-olds)for further information and guidance.

[Kent-and-Medway-Pathway-for-child-sexual-abuse-medicals-June-2022-Final (1)](https://kentcountycouncil-my.sharepoint.com/personal/jane_caldwell_kent_gov_uk/Documents/CSA%20project/Kent-and-Medway-Pathway-for-child-sexual-abuse-medicals-June-2022-Final%20(1).docx?web=1)

# Types of Sexual Risk and the Balance of Probabilities

The assessment of risk in respect of sexual abuse is complex. Risk judgements, regardless of the type of assessment, are only ever valid at the point in time and within the specific context they are given. Most often, professionals will be initially working in the context of unsubstantiated allegations or in the absence of a conviction, due to insufficient evidence proving an allegation ‘beyond reasonable doubt’ (as required by the criminal courts). This threshold does not have to be met for safeguarding professionals. Multi-agency decision-making, actions and interventions should be based on the ‘balance of probabilities’ and what is considered to be in the best interests of the child or young person.

In this respect, multi-agency partners will typically be working from a position of uncertainty and with a level of denial and/or limited understanding from the parents or carers. Understanding that a risk is high, medium, or low might help us to understand how robust a safety plan needs to be, but even ‘low risk’ in the context of CSA means that risk is present. Our focus should be on both the likelihood of harm being caused to a child and the potential impact should that harm occur. A good quality risk assessment, instead of aiming to categorise a risk level, will focus on situations/scenarios in which risk is more likely to occur, factors that may make risk incidents more likely to happen and factors that can mitigate or eliminate risk.

CSA can take many different forms including showing children inappropriate adult material; taking inappropriate images of children; viewing inappropriate images of children; making children watch adult sexual activity; sexual assault or sexual touching of children; and encouraging children to sexually abuse one another for adult gratification. There is no hierarchy in respect of which type of abuse is likely to have the greatest impact on children.

# The Assessment of Risk

Methods of risk assessment are varied depending on the nature and purpose of the assessment. It is useful for practitioners to be aware of the different types of assessment both to support families in understanding risk judgements and the basis upon which they are made and also to support them in making judgements about the relevance of a particular risk judgement to the child protection context. Information and tools to support risk assessments are within the toolkit.

Risk judgement offered by the Police in response to allegations: This risk judgement is unlikely on its own to be sufficient and Social Workers and other safeguarding professionals should always err on the side of caution in the context of unproven risk that cannot be fully assessed owing to ongoing police investigation. For example, the removal of Bail Conditions is often procedural and related to the length of time this type of allegations can take to investigate or the high threshold required to progress to criminal conviction, rather than based on an assessment of ongoing risk. It may require the implementation of interim safety measures whilst we await the outcome of the Police investigation so that we can actively explore the risks based on our lower threshold for proof. We should not be over-reliant on the view of the police or unduly influenced by police actions but identify actions needed from our own assessment based on our thresholds of significant harm and the balance of probability.

Risk judgement reached as a result of social work assessment: This should be informed by the other risk judgements that have been offered, but will also take into account wider contextual factors such as the assessed protective capacity of other adults in the children’s life, age of the children and capacity to understand the context of Social Work involvement, willingness of the family for open and honest discussions about the allegations/offending.

Specialist comprehensive risk assessment: This is a risk assessment completed by an individual who has expertise in the risk of sexual harm. These types of assessments can be completed in relation to alleged abuse, abuse that individuals have been found guilty of in Criminal Courts or where abuse has been found likely to have happened on the basis of a finding of fact’ in the Family Courts. These assessments will typically combine static risk factors (things that will not change), dynamic risk factors (things that can change through intervention) and protective factors to draw a conclusion about specific risk to children being worked with and children more generally and will offer guidance on the required level of intervention to ensure safety. When reviewing these assessments Social Workers and partner agencies should always consider the context within which they were completed. For example, a lower risk might be given in the context of a protective adult in the lives of the children or in the context of the perpetrator not residing in the family home. If these circumstances have changed the risk assessment will need to be reviewed. Specialist assessments can be commissioned by ICS, for example, from Lucy Faithful/Stop It Now. All assessments, in Kent that require funding would need to go to Access to Resource Panel for approval, including those ordered by the Court.

## Factors to consider in social work assessments of known or alleged perpetrators.

The following are factors that should be taken into consideration when undertaking assessments of children where it is known that they have suffered sexual abuse, or it is alleged.

* What does the adult, who potentially poses a risk, currently say about the allegations and are they willing to engage appropriately with services until conclusive plans can be made, if they are still under investigation?
* Are they willing to work with a safeguarding plan that assumes there is some risk to children or a plan that is responsive to risk to children where this has been proven?
* Is there consistent compliance with any external conditions (Bail, Probation, Jigsaw, etc.)? Are they willing to prioritise the needs of the child, e.g., by allowing assessment of and intervention with them, encouraging them to engage openly, living separately where this is required?
* Is there any evidence of grooming, controlling behaviours or otherwise, concerning issues that won’t necessarily directly relate to sexual harm, e.g., emotionally abusive behaviour? Sometimes cases of CSA can lead us to miss evidence of other types of abuse.
* If convicted, have they engaged in intervention to support them in understanding why the behaviour occurred, to address any distorted thinking in respect of this and to develop an adequate and realistic safety and relapse prevention plan? Do they take full responsibility for their actions or are they denying, minimising and victim blaming? Are they now meeting their sexual needs in appropriate and healthy ways?
* If accused of accessing sexual images of children, what are the image categories given following police analysis? Is there any possibility that their own children could be the subject of the images or that the images depict the family home? For example, if a mother/father has been arrested for having indecent images of children on their phone.

# Assessing Protective Capacity

When considering what needs to be put in place to safeguard children from sexual abuse it is important to understand the capacity of family members to protect children or young people.

An understanding of the protective factors in a family may need to be included in a variety of assessments including Early Help assessments, Child and Family Assessments, assessments for court or stand-alone parenting assessments that may have a focus on a parent’s capacity to safeguard and protect a child or young person from a perpetrator or alleged perpetrator.

A risk assessment of a person of concern and protective parenting work are separate but complimentary pieces of work that may need to be undertaken to gain assurance around the safety needs of a child.

This will involve careful planning including who should undertake the work (consideration of an additional worker), the number of sessions required, venue for the sessions, consideration to the safety and wellbeing of the worker and what debrief, or supervision will be required to support the work. In addition, there would need to be consideration to the stage of any police investigation and the implications of our work, whilst balancing the need to safeguard.

Consideration, throughout an intervention should be given to the tools that will be used including genogram, timeline (including relationships, sexual experience and sexual identity) and exploring the person of concerns version of allegations.

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| **Key Factors to consider when assessing capacity to protect.** |
| Are the non-abusing caregivers willing to at least accept that there is a possibility that something harmful could have happened in the case of alleged but not proven behaviour? If there is a conviction, do they accept the conviction?  Is the perpetrator accountable for their offending (in the case of a conviction) or are they willing to prioritise the needs of their children over the alleged perpetrator and themselves in the case of unsubstantiated allegations? What do they make of the allegations that have been made and the person who made the allegations?  Is there a willingness to engage in safety planning work to the extent necessary to manage the assessed level of risk?  Is there a willingness to work to reduce the level of secrecy in the family in order to address the risk that this could pose to the children?  What is the ability to work in an open and collaborative manner with agencies?  How is plan for the safety of their children considered and undertaken?  Is there an understanding of the process of sexual offending, including grooming patterns and the context within which abuse occurs?  What are the wishes and views around contact and what is the ability to freely express these, or are there concerns that they are experiencing pressure from external sources? Observations as well as statements from the child should be considered.  What is the ability to support their children to understand the risk and safety work and any change in family circumstances as a result of the allegations?  How is assertiveness, capacity to effectively solve problems and appropriate help seeking behaviours demonstrated? |

# Safety Planning

It is important to ensure that all safety planning where possible is incorporated into the plan for the child whether this is Early Help plans, Child in Need, Child Protection or Child in Care Plans.

It is acknowledged that some safety planning cannot wait for the outcome of an assessment or review of the current plan and will need to stand alone until the appropriate time at conclusion of assessment or review to be incorporated. But until that time, clear signposting to the recording and sharing with children, young people and families must be in place to ensure that these remain clear, understood and effective.

There should always be a collaboratively developed safety plan in cases where there are concerns about risk of sexual abuse in a family. It is difficult to do this collaboratively if all family members do not have an age-appropriate understanding of the concerns. The extent of safety planning and the framework within which this is held should depend on an assessment, based on the factors below rather than external factors such as bail conditions (although these may be relevant).

Given safety plans are about the children and setting up family living arrangements so everyone knows the children will be safe and cared for, it is important to involve the children in safety planning and make the process understandable to them.

A Safety Plan is a journey not a product, the most important aspect of safety planning is that it is co-created with the family and an informed safety network. The plan will be operationalised, monitored and refined carefully over time and the commitments of the plan are to be made and owned by the parents in front of their own children, family and friends.

This is not something that can be done in one or two meetings, and a safety plan that will last, cannot be created by professionals deciding on the rules and then trying to impose them on the family.

Above all, meaningful safety plans are created out of a sustained and often challenging journey undertaken by the family together with the professionals. That journey is focused on the most challenging question that can be asked in child protection: ‘What specifically do we need to see to be satisfied this child is safe?’

It is important that the safety plan consists of only factors that the family can commit to realistically. For example, it would not be appropriate for the plan to be ‘no unsupervised contact’ if the perpetrator was living in the family home with only one other adult, because it is not practically possible for that adult to supervise the children with the perpetrator at all times. In this circumstance there would be a need to consider the perpetrator/alleged perpetrator living outside of the family home at least in the first instance, whilst more comprehensive assessment is undertaken, and interventions considered necessary.

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| **Factors to consider when safety planning** |
| Do the children know about and understand the context of our involvement?  Are the children allowed and able to engage openly with professionals in sharing their experiences?  What are the feelings of all family members, including siblings?  Are there other concerns in relation to the care and protection of the children that could be overshadowed by concerns about sexual harm?  What are the boundaries like in the family home (physical boundaries, family rules, practices around bathing/nudity)?  Does the victim/alleged victim live in the family home and what are the attitudes toward the victim/alleged victim for each family member?  What are the practical arrangements needed, are they reasonable and achievable?  Is there an adequate family safety plan and if not, would the family be willing to work on this? What do the family want/think should happen and how well does this fit with the assessed level of risk?  What does the professional network understand about the risk and safety plan for the family and what will their role be in monitoring this/what are the expected actions if they are concerned? |

## Sibling sexual abuse

Parents can be significantly impacted when finding out that one of their children has sexually harmed their sibling. Parents may present as in denial and find it easier to believe the sexual abuse has not taken place. They may experience a number of different emotions such as fear, guilt, anger and shame.

In some circumstances parents may not see the concerns as serious and may shift between supporting each child to blaming them.

Parents can feel they are in an impossible situation and feel torn between the needs of both their children, they may also feel isolated and worry about being judged by family, friends, and professionals. Therefore, it is important parents are offered support and short- and long-term safety planning.

This helpful guidance can be used to support families where there are worries around sibling sexual abuse. [Sibling sexual abuse](https://www.ccinform.co.uk/).

# Interventions

## Trauma and sexual abuse

It is important to work in a trauma informed way with children who have experienced sexual abuse as they will have been impacted by their experiences of trauma through the abuse. An understanding of trauma and its impact and effects will inform understanding of what a child’s behaviour may mean and what they are trying to communicate.

Children can struggle to tell someone about their experiences, and this can be compounded by the impact of trauma. Understanding the impact of trauma can support conversations with children about sexual abuse in a sensitive way.

## Language

When working with someone who has been through trauma, we need to think carefully before speaking, be aware of the words we choose, the tone we use and how we phrase our questions. Because language matters and words have power.

When working with someone who has been through trauma, care needs to be taken with the language used. Before speaking there needs to be an awareness of the words chosen, the tone used and how questions are phrased. Language matters and words have power.

We need to start to shift our language and our thinking from **“What’s wrong with you?” to *“*What’s happened to you?*”.*** Asking “What’s happened to you?” helps us to understand and acknowledge the impact of trauma rather than focussing on the behaviour arising from the trauma. However, it is also important not to sanitise language but say things clearly and unambiguously in order that a shared understanding is reached and agreed.

The Centre of Expertise in CSA reminds us that a child rarely tells everything about their abuse in one go. The may move from unintentional and indirect methods of telling, such as behavioural manifestations, through to more direct means, such as purposefully or accidentally telling someone what is happening ([communicating with children guide](https://www.csacentre.org.uk/documents/communicating-with-children-guide/)- page 18) is more easily understood in the context of an understanding of the impact of trauma.

## Direct work with children

Typically, direct work should cover a number of areas: body parts and names for them; differences between private and public; thinking about where on your body you can show/touch and exceptions to this; secrets and the difference between harmful and non-harmful secrets; and consideration of who the child might tell if something happened they weren’t comfortable with and who they would ask questions about bodies/touching if they had any (including if they thought they couldn’t tell someone in their family). This work should also cover picture taking or showing, particularly in cases where viewing sexual images of children has been a factor and also reference to sharing harmful secrets, even if someone very important to them tells them not to.

Following a conviction or in light of significant change in circumstances for a child (as a result of allegations), direct work will be needed to help the child understand what is happening in their life. Ideally this work can be done through the protective parent. It will involve an accurate but age-appropriate narrative around what has happened, so that the child is able to have a coherent sense of why decisions have been made or actions taken. Direct conversations or social stories can be used to support this process. Where a protective caregiver is involved in delivering this work, there may need to be a period of preparatory work. For a protective parent or carer to be involved in this work, they will need to believe the child and hold the perpetrator/alleged perpetrator accountable.

It will be important to consider who may be the best person to undertake this work taking into account, who is best placed to build trust, experience and expertise and what the child or young person’s views are.

Direct work can focus on areas such as building self-esteem, explore understanding and feelings, locating blame with perpetrators or self-regulation. Children and their protective parent/carer may need specialist therapeutic support, particularly if the child has been a direct victim of the abuse. The timing and nature of this can be considered in consultation with NELFT to enable appropriate support to be sourced. For further information on support NELFT can offer see their [website.](https://www.nelft.nhs.uk/services-kent-children-young-peoples-mental-health)

This intervention does not need to wait until the outcome of any Police investigation and there should always be a focus on the mental health needs of a child being paramount. All involved professionals should be engaged in decisions about the nature and timing of such intervention, particularly the Police where there is an active criminal investigation.

See below for helpful tips when completing direct work with children of all ages.

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|  | **Helpful tips when completing direct work with children of all ages.** |
| 0-5 Years | Verbal communication alongside non-verbal communication such as drawing and game -playing.  Use of toy telephones, puppets, dolls, and doll houses. This can support your understanding of the child’s lived experience including life at home and their key relationships.  Use of play dough, this can help set the scene for your discussions. |
| 6-9 Years | Use of play to initiate discussions.  Use of toys such as playdough and puppets, this can help the child identify a person they can talk to about their worries.  Use open questions and take care to show the child you are listening. |
| 10-15 Years | As children develop into and through adolescence, their understanding of language naturally develops.  It is important to remember, however, that teenagers may often appear more knowledgeable or aware than they are.  It is important not to assume knowledge or to forget about the techniques you would use when engaging with a younger child.  Teenagers often respond well to the opportunity to play a game or do a drawing at the same time as talking to an adult – but, again, don’t assume this. Talk to them and find out what they want and how they want to talk to you.  Start with more open questions, but there are occasions when you might want to ask more direct questions.  When talking to older children and teenagers about child sexual abuse, it is important to consider that the abuse may have been going on for a long time, and they may have been led to believe that they were in a relationship with the person who abused them.  Some teenagers may assume that you know everything that has happened, and that you will make judgements about this. You should remind them that you will listen to them and that you want to help.  Be honest and offer reassurance. |
| 16-18 Years | The same communication principles should apply with these children as with younger teenagers (see above) – but as they approach adulthood, their sense of independence is developing and honesty from professionals may feel even more important to them.  If you are concerned about their behaviour, you may choose to use questions such as:  I have noticed you seem upset at the moment, tell me about that.  Has anything been happening to you which you did not like and is hard to talk about?  I have noticed you doing X, I am worried about that and wonder what it is about?  I have noticed you drinking more recently. I wonder how that feels for you.  Is there anyone you can talk to about how you are feeling? |

## Empowerment Work with Protective Caregivers

It is possible that the protective caregiver may be experiencing some level of internal conflict, confusion or ambivalence following concerns being raised about CSA. Where this does not lead to circumstances that constitute a risk of immediate or significant harm, it should be expected by the multi-agency partnership and worked with. It is possible that the protective caregiver has also been a victim of a grooming process and conditioned by the perpetrator. They may require support to understand and come to terms with this before they are able to effectively support their children to remain safe and make sense of what has happened. This is a response that should be normalised, and a level of risk minimisation should be expected.

Work could be completed with the protective caregiver to empower them to understand and manage any risk and to aid their family in recovering from what has happened. This work should include thinking about imagined consequences for themselves, their partner, their children, and their relationship. This is likely to give a sense of the source of any denial and allow professionals to identify practical solutions. This should be followed by educational work around the process of grooming generally and then more specifically about the patterns of behaviours experienced in their own family. This work should also include support to understand how children can be impacted by CSA and strategies for supporting the child who has been abused or made the allegation.

## Accountability Work with Perpetrators or Alleged Perpetrators

Working with sexual abuse perpetrators in terms of the abuse is a specialist area. However, conversations with perpetrators in the context of multi-agency intervention with the family should focus on supporting them to understand the rationale for intervention, safety requirements and what solutions might be available to address any practical difficulties that have arisen. This is important because if robust plans can be made and cooperation established (for example, about where the perpetrator/alleged perpetrator will live or how contact might be safely maintained, if appropriate), they are less likely to return to the family home against guidance. Work in this context should remain firmly focused on making sure children are made safer.

# Additional Resources

For further information on content within this guidance see the Kent Multi agency CSA Toolkit [Child Sexual Abuse Toolkit\_.docx](file:///C:\Users\caldwj01\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\6KH91PEE\Child%20Sexual%20Abuse%20Toolkit_.docx)

For further information related to safety plans see the Kent [Safety Planning Guidance](https://eur01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.proceduresonline.com%2Ftrixcms2%2Fmedia%2F18261%2Fsafety-planning-guidance.docx&data=05%7C01%7CJane.Caldwell%40kent.gov.uk%7C77dd6796853d437eeade08db15b6a643%7C3253a20dc7354bfea8b73e6ab37f5f90%7C0%7C0%7C638127646433078382%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=8NN8cdqYV7Guk%2BBiPbnh0kTiPrSojuMntDyFF1JSblk%3D&reserved=0)

## Direct Work with Children Who Have Experienced Sexual Abuse Resources

**Self esteem:**

[Self-esteem Archives - Free Social Work Tools and Resources: SocialWorkersToolbox.com](https://www.socialworkerstoolbox.com/category/mental-health/self-esteem/)

**Feelings:**

Triangle and NSPCC (2002) How is it: an image vocabulary for children about feelings, rights and safety, personal care, and sexuality (Socialworkertoolbox)

Feelings Bear Cards

Virginia Ironside (2011) The huge bag of worries= helps children understand how they can deal with worries

Khadj Rouf (2015) Mousie = read to children who have a secret they are afraid to tell

Spinal-Robinson and Easton Wickham (1993) and Goodyear-Brown (2010, p172) Colour your body/mapping feelings. Draw body and 4 boxes at the bottom of the outline. Child to choose 4 colours for *happy, sad, angry, and scared.*  Ask child for another feeling they know or name a feeling they have a lot. Ask child to colour in their outline body showing how much they have that feeling and where in the body they have it. A rule is every colour must be used once. Talk about when they have the feeling. Ask how doing the activity made them feel.

Sutherland, M. (2018) Draw on your emotions.

Feelings word search [Printable Feelings and Emotions Word Search - Cool2bKids](https://www.cool2bkids.com/feelings-and-emotions-word-search/)

**Self-Regulation:**

Using bubbles – take turns blowing big and small bubbles with different size breaths.

Relaxation exercises e.g., box breathing [NHS in Mind](https://www.nhsinmind.co.uk/)

**General:**

McMahon, L. (2009) The handbook of play therapy and therapeutic play

Spinal-Robinson, P. and Easton-Wickham, R. (1992) Cartwheels: A Workbook for Children Who Have Been Sexually Abused, Ages 11-13

# Appendices



