Working with the Risk of Intra-Familial Child Sexual Abuse

Practice Guidance

November 2021

Contents

1. Purpose

1.1 This guidance has been developed to support practitioners protect children at risk of intra-familial child sexual abuse (CSA). It should be read alongside the 6th Edition of the London Child Protection Procedures.

1.2 '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 step-parent, 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."[1]

2. Key Questions to Consider

2.1 When a concern is raised about a child or young person 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 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?

[1] www.csacentre.org.uk

Where a police investigation is ongoing, no contact should be agreed before a child is ABE interviewed. Following this, no unsupervised contact between a child and a potential perpetrator should be agreed and no contact should be arranged in the child's primary place of safety (usually their home). In some circumstances, contact between a child and a possible perpetrator of abuse could be appropriate (and in the best interests of the child), as long as it is arranged safely and 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.

- 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 are clear on 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 them on this? Are they at least willing to work toward this through Social Work and intervention/support from partners?

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.

- 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?
- For social workers in Hackney, have you consulted your link clinician?

3. The Impact of Intra-Familial CSA

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

3.2 It should be noted that it can be hard to isolate the impact of CSA. It often occurs alongside other forms of maltreatment and impacts may be linked to abuse, rather than caused by it. It is not inevitable that a victim/survivor experiences long-term harm because of CSA. It has been estimated that 40% of victim/survivors do not (NSPCC). Nevertheless, research suggests that CSA is associated with an increased risk of adverse outcomes in all areas of life (IICSA Research Team).

3.3 The recent Independent Inquiry into Child Sexual Abuse (IICSA) commissioned research into CSA and identified the following potential impacts to victims and survivors as follows:

- 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 long term. Long term health consequences include 20% more attendances at doctors and chronic illnesses and disabilities.
- Increased risk of emotional difficulties during pregnancy.

3.4 There are also a number of 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 of those close to them to the disclosure of abuse 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).

4. Investigating CSA

4.1 When there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm[2] because of concerns about CSA, a Strategy Discussion will be convened by Children's Social Care. Strategy Discussions will decide whether a child protection investigation[3] is required. These investigations can either be 'Single Agency' (led by Children's Social Care) or 'Joint Investigations' (undertaken by both Children's Social Care and the Police).

4.2 There are several different Police teams that are involved in criminal investigations of CSA, depending on the nature of the alleged abuse and the child's relationship to the perpetrator. For intra-familial CSA involving close family members, criminal investigations are ordinarily led by **The Child Abuse Investigation Team (CAIT)**.

[2] Section 47 Children Act 1989

[3] Child protection investigations can be referred to as Section 47 Investigations or Section 47 Enquiries.

4.3 CAIT 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:

a) **Intra-familial abuse** - within the family and extended family including aunts; uncles; cousins; siblings including step, fostered, half brother and sister, grandparents, step grandparents, step mothers or fathers and can include long term partners but must be an established relationship)

b) **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

c) **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,

d) Where the **victim is an adult** and the abuse occurred whilst he or she was a child under the circumstances as described in (a to c) - which are connected matters (offences against other children) coming to notice during enquiries by officers into (a) to (d) (e.g. where an abuser within a family has also committed similar offences against an unrelated child);

- Allegations categorised as parental abduction, outlined in the Child Abduction Act 1984 S1.
- Sudden Unexpected Death in Infants (SUDI)
- Female Genital Mutilation (FGM)
- Rape and serious sexual offences involving penetration where

i. the victim and suspect are both under the age of 13. [If the suspect is under 13 and a stranger to the victim Sapphire will lead the investigation]
ii. the victim and suspect(s) are both under 18 and co-reside in the same registered children's' care home
iii. the victim and suspect(s) are both under the age of ten - referred to as 'Oversexualised Behaviour'

4.4 Other Police teams involved with investigating CSA include:

- **Sapphire:** Investigates complex/linked series sexual assaults and all sexual offences involving penetration by strangers and partners. Non-complex sexual assaults will be dealt with by uniform officers unless there are aggravating features.
- **Online Child Sexual Abuse Exploitation (OCSAE) team**: Online Child Sexual Abuse Exploitation (OCSAE) team: Located within the local BCU team, OCSAE respond to Low and Medium KIRAT (Kent Internet Risk Assessment Tool) referrals taken directly from the National Crime Agency involving the distribution of indecent images of children by unknown persons. High and very high referrals involving immediate risk of contact offending are sent to the central specialist crime OCSAE team. Youth produced sexual imagery between child peers is progressed by uniformed officers with support from OCSAE team – unless there are aggravating features which requires escalation into OCSAE for primacy.
- OCSAE also lead on investigating suspects identified by Online Child Abuse Activist Groups, commonly referred to in the media as 'paedophile hunters'.

If you are unsure at any time about who in the police is investigating an offence, or you cannot get hold of a named investigating officer, please contact the Hackney MASH police team GD-PPD@met.police.uk for further advice and support about who to contact.

4.5 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:

- **Jigsaw**: Operation Jigsaw teams manage Multi-Agency Public Protection Arrangements (MAPPA) offenders living in the community, as well as those serving sentences for their relevant offences. MAPPA is the process through which the police, probation and prison services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public. MAPPA meets monthly. It reviews the pre-release of offenders from prison, to ensure appropriate multi-agency safety plans are in place. It can also consider thresholds for recall to prison if there are concerns about license conditions being broken. There are three categories of offenders managed via MAPPA:

    - Registered Sexual Offenders are required to notify the police of their name, address and personal details under the terms of the Sexual Offences Act 2003. The length of time an offender is required to register with police can be any

period between 12 months to life, depending on the age of the offender, the age of the victim and the nature of the offence and sentence they received.

- Violent Offenders who have been sentenced to 12 months or more in custody, or to detention in hospital, and are living in the community subject to probation supervision.
- Dangerous Offenders who have committed an offence in the past and are considered to pose a risk of serious harm to the public.

Working in Partnership with the Police

4.6 **Getting and Staying in Contact**: Wherever a joint investigation has been agreed with the Police, social workers should ensure that they ask for the names and contact details of the allocated investigating officers and their manager. Social workers and other involved professionals should similarly provide this information to the Police. As the investigation proceeds and as new information comes to light (or where there is a lack of clarity about the respective roles and responsibilities of partner agencies) remember to consider scheduling further face-to-face (or virtual) Strategy Discussions, to share updated information and agree the way forward.

4.7 **Achieving Best Evidence (ABE) Interviews:** 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 investigation, social workers should talk to the investigating officers about whether they plan to offer ABE interviews (video interviews) and if so, to which children in the family, and the timeframes for scheduling these.

4.8 If the investigating officers do not plan to proceed with ABE interviews, 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.

4.9 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, in order 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, if they have a learning or mental health need, 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. This is a process that can take a long time. Where the need has been identified for an intermediary, this service can take many weeks to set up.

4.10 **Other Police interviews:** 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.

4.11 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 have the ability to 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 that they are asked what, if any, impact this will have on the investigation strategy and the implications for partner agencies.

4.12 **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. However, in circumstances where there is insufficient evidence to charge, any bail conditions that the Police may wish to impose, during the duration of their ongoing investigation, may have very little enforcement power if broken. Therefore, it is far more likely, in these circumstances, that suspected perpetrators will be released under investigation.

4.13 **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.

4.13 **Escalation**: If professionals do not agree with the decision-making rationale of the Police at any point of a Joint Investigation, professionals should ask for this to be reviewed by them initially, and then (where required) by their supervisor, who is likely to be a Detective Sergeant (DS). Beyond DS level, the Sapphire, CAIT and Domestic Abuse teams within the local police BCU all have a Detective Inspector (DI)_ in a position of overall responsibility of the Unit. If any professional wishes to challenge the police response beyond a DS level, this should be escalated to the relevant management level consistent with the CHSCP Escalation Policy.. This interagency policy defines the process for resolving such professional differences and should be read alongside the London Child Protection Procedures and relevant internal policies on escalating matters of concern.

5. CSA Child Protection Medicals

5.1 There are a number of different services available for the medical management of suspected child sexual abuse:

- For acute cases, which involve concerns that a child has been sexually abused within the last 3 weeks, the child should be seen at *The Havens* as a matter of urgency. *The Havens* are specialist centres in London for people who have been raped or sexually assaulted and can be contacted on 020 3299 6900. More information can be found at www.thehavens.org.uk.
- If CSA occurred more than 3 weeks ago, the child should be referred to the *Hackney Ark* in order to be seen in the new CSA Hub Clinic, which is based at The Royal London Hospital. This Clinic runs once a week, which is why it cannot be used for acute medicals.
- If the CSA is non-recent (historical), they can still be seen at the *CSA Hub Clinic*.
- In most situations it is not appropriate to tell the child to attend an Emergency Department (ED), either at the Homerton or any other hospital. This is only appropriate when there is concern around acute bleeding, infection or an urgent medical need. The staff in ED are not qualified to do a CSA examination and therefore the child will have to have more than one examination. This is not best practice. The examination should be done when the images can be correctly recorded for future review if needed.

If unsure please contact the CP Medical team at Hackney Ark on 020 7683 4288 or at huh-tr.CHChildProtection@nhs.net. You can also contact the Named Doctor for Safeguarding for further advice.

CSA Medical Myth Busting

A 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 or young person 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 and young people 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.

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 or young person 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 with a young person is fully conscious during the assessment for CSA.

6. Types of Sexual Risk and the Balance of Probabilities

6.1 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.

6.2 In this respect, the partnership 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 also 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.

6.3 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. **Whilst we can infer something about risk to children based on the nature of an adult's behaviour, it does not follow that if they have not directly abused a child that they will not go on to do so. This assumption should not form a basis to any risk judgements.**

7. The Assessment of Risk

7.1 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.

7.2 **Risk judgement offered by the Jigsaw team engaged with convicted sexual offenders:** This judgement of risk is given based on a number of factors present or absent at a specific point in time. This risk judgement should always be reviewed in light of changing context (e.g. living circumstances for the alleged perpetrator), which could cause the assessed risk level to either increase or decrease. We should not base our decisions about child safety on this risk judgement alone.

7.3 **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 these types 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.

7.4 **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, etc.

7.5 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 '*Fact*

Finding' 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 partners 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.

Factors to consider in social work assessments of known / alleged perpetrators

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 and is there any possibility that their own children could be the subject of the images or that the images depict the family home?

Letters of Instruction for Specialist Risk Assessments

In Hackney, when writing letters of instruction for Specialist Risk Assessments, Clinical consultation should always be sought. This will support a conversation about what we are hoping to understand after the assessment that we do not feel we are already able to on the basis of the Social Work Assessment. This should include consideration of questions in respect of both the

perpetrator/alleged perpetrator and the protective parent. The specific nature of the assessment will depend on a number of factors, such as the age of the alleged perpetrator and the type of behaviour alleged. When choosing assessors to instruct, their level of expertise and professional background shoud be considered. For example, many practitioners offering this type of assessment have a Social Work background with extensive additional experience and training. However, if there are concerns about Parental Mental Health a mental health professional with expertise in sexual harm might need commissioning, so that they were able to answer all questions without necessitating two separate assessments.

8. Protective Capacity Assessments

Key factors to consider:

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?

Do they hold 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?

Are they willing to engage in safety planning work to the extent necessary to manage the assessed level of risk?

Are they willing to work to reduce the level of secrecy in the family in order to address the risk that this could pose to the children?

Do they work in an open and collaborative manner with agencies?

How do they plan for the safety of their children?

Do they understand the process of sexual offending, including grooming patterns and the context within which abuse occurs?

What are their wishes and views around contact and are they able 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 taken into account.

Do they support their children to understand the risk and safety work and any change in family circumstances as a result of the allegations?

Do they demonstrate assertiveness, capacity to effectively solve problems and appropriate help seeking behaviours?

9. Safety Planning

9.1 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).

9.2 It is important that the safety plan consists of only factors that the family are able to realistically commit to. 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.

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?
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 e.g. in relation to adults versus children, physical boundaries and family rules/practices?
Does the victim/alleged victim live in the family home and what are the attitudes toward the victim/alleged victim for each family member?
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?

9.3 To reiterate, where a Police investigation is ongoing, no contact should be agreed before a child is ABE interviewed. Whilst Children's Social Care assessments are ongoing, no unsupervised

contact between a child and a potential perpetrator should be agreed and no contact in the child's primary place of safety (usually their home). In some circumstances, contact between a child and a possible perpetrator of abuse could be appropriate (and in the best interests of the child), as long as it is arranged safely and 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.

Additional information / resources around Safety Planning:

- https://www.parentsprotect.co.uk/create-a-family-safety-plan.htm
- https://www.parentsprotect.co.uk/files/Family%20Safety%20Pack%20WEB%20JAN16.pdf
- Hackney Guidance on Safeguarding Agreements and Safety Plans
- Family Group Conferences (via Daybreak) - as space to explore the risk within the family network. Referral form

9.4 Safety plans should always be stored on children's files as stand-alone documents with clear indications of when they will be reviewed, how we will know if they are being complied with and what we would need to observe/assess before we were able to reduce any restrictions that are in place.

10. Interventions

Direct work with children

10.1 Direct work with children who have suffered or are at risk of suffering from CSA will invariably focus on aspects such as safe touching and boundaries. It is important to consider how children are told about why this work is being undertaken and who within the professional network might be best placed to lead on it. For example, it could be undertaken jointly with a protective parent or perhaps led by a teacher who the child trusts. It will ordinarily be necessary that all of the children in a family where CSA is either known or suspected to be told about the concerns. This is needed in order for robust safety planning to take place. If direct work is being blocked by a parent / carer and they are not willing to engage in interventions to support this process, this should be seen as an indicator of serious and increased risk.

10.2 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 and touching if they had any (including if they thought they couldn't tell someone in their family). Alongside touching this work should also cover picture taking or showing, particularly in cases where viewing sexual images of children has been a factor. This should also include specific reference to sharing harmful secrets, even if someone very important to them tells them not to.

10.3 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 need 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 / carer to be involved in this work, they will need to believe the child and hold the perpetrator/alleged perpetrator accountable.

10.4 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 the CAMHS professionals and the Clinical Service in Hackney. 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. However, the decision to initiate such work should neither be taken unilaterally nor in isolation from other agencies. 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.

Empowerment Work with Protective Caregivers

10.5 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 likely 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.

10.6 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/Alleged Perpetrators

10.7 Conversations with perpetrators in the context of multi-agency intervention with the family should focus on supporting them to understand the rationale for intervention, any 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.

11. Additional Resources

https://www.parentsprotect.co.uk/create-a-family-safety-plan.htm

Lesher, M. Sexual Abuse, Shonda and Concealment in Orthodox Jewish Communities

Smith, G. (2008). *The Protectors Handbook: Reducing the risk of child sexual abuse and helping children recover*. British Association for Adoption and Fostering: London, UK.

Still, J. (2016) *Assessment and Intervention with Mothers and Partners Following Child Sexual Abuse.* Jessica Kingsley Publishers: London, UK.

Turnell, A. & Essex, S. (2006). *Working with Denied Child Abuse: The Resolutions Approach.* Open University Press: Berkshire, UK.

Briefing: Intra-familial child sexual abuse: Risk Factors, indicators and protective factors (Research in Practice: 2018)