Child Sexual Abuse in the Family Environment

1. Definition

Working Together to Safeguard Children defines **sexual abuse** as behaviour which:

'Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening.

The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse.

Sexual abuse can take place online, and technology can be used to facilitate offline abuse.

Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.'

Sexual abuse often occurs in conjunction with the other categories of child abuse especially emotional abuse in order to maintain control and secrecy.

There is no single agreed definition of Child Sexual Abuse (CSA) within the family environment (also known as Intra-familial Child Sexual Abuse), but in addition to abuse by a relative (such as a parent, sibling or uncle), it may also include abuse by someone close to the child in other ways (such as a step-parent, a foster carer, pre-adoptive or adoptive parents a close family friend or a babysitter).

Children from the age of birth onwards may be subjected to sexual abuse. Sexual abuse can have a long-term impact on emotional, social, and educational development and is linked to the development of mental health issues in later life.

See also the procedures for: **Child Sexual Exploitation**, **E-Safety: Children Exposed to Abuse through the Digital Media**, **Harmful Sexual Behaviour** and **Under Age Sexual Activity**.

2. Risk and Indicators

Sexual abuse which takes place within family environments often remains hidden and is the most secretive and difficult type of abuse for children and young people to disclose. It may be particularly difficult to disclose abuse by a sibling. Care experienced children may have additional challenges to disclosure of abuse by foster carers, care workers or kinship carers due to their own histories of abuse and neglect. Care experienced children may present their distress in different ways to other children and young people. There could be an

increase in dysregulation in some children and young people and care must be taken not to assume this is due to past trauma alone.

Social workers and LAC Nurses should offer to see the child or young person alone and record or report if the child or young person declines the opportunity to be seen without the carer.

Many children and young people do not recognise themselves as victims of sexual abuse - a child may not understand what is happening and may not even understand that it is wrong especially as the perpetrator will seek to reduce the risk of disclosure by threatening them, telling them they will not be believed or holding them responsible for their own abuse.

Where sexual abuse is being perpetrated on one or more family members, it may be possible to identify by patterns of referrals or presentations to different agencies in their local community over time. There may be a range of signs, but any one sign doesn't necessarily mean that a child is being sexually abused; however, the presence of number of signs should indicate that you need to consider the potential for abuse and consult with others who know the child to see whether they also have concerns.

Signs include:

- Changes in behaviour, including becoming more fearful, aggressive, withdrawn, clingy.
- Problems in school, difficulty concentrating, appearing distracted and distant or dissociated, drop off in academic performance.
- Sleep problems, nightmares or regressed behaviours i.e., bed wetting.
- Frightened of or seeking to avoid spending time with a particular person.
- Knowledge of sexual behaviour/language that seems inappropriate for their age.
- Physical symptoms including pregnancy in adolescents where the identity of the father is vague or secret, STIs, discharge or unexplained bleeding.
- Poor hygiene, which often leads to social isolation in school.
- Injuries and bruises on parts of the body where other explanations are not available especially bruises, bite marks or other injuries to breasts, buttocks, lower abdomen or thighs.
- Injuries to the mouth, which may be noted by dental practitioners.
- Self-harm.
- Abdominal pain without an organic cause.
- Weight gain or weight loss without an organic cause.

Other Factors

- Frequent house moves.
- Isolation of children (and other members) within the family from practitioners, and the wider community.
- Failure to register with a GP.
- Frequent absences from school.

- Failure to cooperate with agencies or to let police, children's social care or other agencies into the home, or letting children be seen alone by professionals.
- Attempts to disguise injuries or attribute them to other causes.
- A child or young person who self-harms, misuses drugs, alcohol or solvents, and / or develops mental health problems.
- Domestic abuse within the family heightens the risk.
- Repeated pregnancies with no evidence of a father.
- Genetic abnormalities in pregnancy or in children who are born.

Finkelhor and Browne, (1986) describe four likely impacts of CSA:

1. Traumatic sexualisation (where sexuality, sexual feelings and attitudes may develop inappropriately).
2. A sense of betrayal (because of harm caused by someone the child vitally depended upon).
3. A sense of powerlessness (because the child's will is constantly contravened).
4. Stigmatisation (where shame or guilt may be reinforced and become part of the child's self-image).

The **Centre of Expertise on Child Sexual Abuse** highlights the impact that **secrecy** (including the fear and isolation this creates) and **confusion** (because the child is involved in behaviour that feels wrong but has been instigated by trusted adults) has on the child. While these impacts are not unique to Child Sexual Abuse in the Family Environment, their combination and intensity in the context that they take place makes the experience particularly damaging.

See Key Messages From Research on Identifying and Responding to Disclosures of Child Sexual Abuse (**Centre of Expertise on Child Sexual Abuse**)

In the long-term people who have been sexually abused are more likely to suffer with depression, anxiety, eating disorders and post-traumatic stress disorder (PTSD). They are also more likely to self-harm, become involved in criminal behaviour, misuse drugs and alcohol, and die by suicide as young adults.

3. Protection and Action to be Taken

Whenever a child reports that they are suffering or have suffered significant harm through sexual abuse the initial response from all practitioners should be to listen carefully to what the child says and to observe the child's behaviour and circumstances. Practitioners must:

- Clarify the concerns.
- Offer reassurance about how the child will be kept safe.
- Explain what action will be taken and within what timeframe.

The child must not be pressed for information, led, or cross-examined or given false assurances of absolute confidentiality, as this could prejudice police investigations, especially in

cases of sexual abuse. Once a practitioner is aware of these concerns, a referral must be made immediately.

The suspicion or allegation may relate to a parent, professional, volunteer or anyone caring for or working with the child - if so, see **also Allegations against Persons who Work with Children Procedure.** There are cases where it will not be appropriate to discuss concerns with parents/carers before referral. In such situations, the timing of contact with parents/carers will be agreed with Children's Social Care and/or the Police once the referral has been made. Situations where it would not be appropriate to inform family members prior to referral include where:

- Discussion would put a child at additional risk of Significant Harm;
- There is evidence to suggest that involving the parents/carers would impede the Police investigation and/or Section 47 Enquiry;
- Sexual abuse is suspected or it is suspected that a parent is involved in the sexual exploitation of a child – for more information **see Safeguarding Children and Young People from Sexual Exploitation Procedure;**
- Organised or multiple abuse is suspected – for more information **see Complex (Organised or Multiple) Abuse Procedure;**
- Fabricated or induced illness is suspected – for more information see **Fabricated or Induced Procedure;**
- To contact parents/carers would place them or others at risk;
- Discussion would place one parent at risk of harm e.g. in cases of domestic abuse;
- If it is not possible to contact parents/carers without causing undue delay in making the referral. **See Responding to Abuse and Neglect Procedure, Making a Referral and Child Protection Enquiries - Section 47 Children Act 1989 Procedure.**

Visually recorded interviews must be planned and conducted jointly by trained police officers and social workers in accordance with the **Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures (Ministry of Justice)**. All events up to the time of the video interview must be fully recorded. Consideration of the use of video recorded evidence should take into account situations where the child has been subject to abuse using recording equipment. Visually recorded interviews serve two primary purposes:

- Evidence gathering for criminal proceedings.
- Examination in chief of a child witness.

Relevant information from this process can also be used to inform Section 47 Enquiries, subsequent civil childcare proceedings, or disciplinary proceedings against adults, where allegations have been made.

Referral following suspicion and disclosure of Sexual Abuse

Where practitioners are uncertain about whether a disclosure meets the threshold for sexual abuse, they should always seek advice from the **East Midlands Children and Young People Sexual Assault Service Single Point of Access (SPA) 0800 183 0023**

A referral should be made to Children's Social Care where a child is suspected of having been subjected to or has disclosed sexual abuse, the abuse may involve physical contact including assault by penetration (for example, rape or oral sex) or non-penetrative acts, such as masturbation, kissing, rubbing, and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse.

Children's Social Care refer reports of sexual abuse to Leicestershire Police

The flow chart explains the ongoing process see **Referral to the East Midlands Children and Young People Sexual Assault Service Flowchart** or Appendix 1 at the end of this procedure.

4. Issues

The single and most important consideration is the safety and well-being of the child or children.

In reconciling the difference between the standard of evidence required for child protection purposes and the standard required for criminal proceedings, emphasis must be given to the protection of the children as the prime consideration.

The investigation and enquiries must also address the religious, cultural, language, sexual orientation and gender needs of the child, together with any special needs of the child arising from illness or disability.

A victim support strategy and service should be established at the outset. Support will be required in pre-trial, trial and post-trial periods if the case/s proceed to court. Minimum periods for contact should be established. It is clear from experience in research about sexual abuse investigations that many victims and families feel strongly that it is important that they remain in contact with the same practitioners throughout the investigative process.

Where an Initial Child Protection Conference takes place great care should be taken beforehand if the child / young person wishes to participate. The child should not be put in the position of meeting the alleged perpetrator or of attending the meeting at the same time.

Barriers to Disclosure

Children may disclose sexual abuse directly and verbally while others may attempt to disclose by non-verbal means including changes in their behaviours, requiring those around them not just to focus on the behaviour but why the behaviour may be happening. Rates of verbal disclosure are low at the time that abuse occurs in childhood. However, children say they are trying to disclose their abuse when they show signs or act in ways that they hope adults will notice and react to. This is particularly important for disabled children. Care experienced children should be afforded equal consideration as would any child or young person. Practitioners should use professional curiosity and be prepared to "think the unthinkable", children and young people are not always safe in care.

When there is a notable increase in dysregulation, practitioners should not assume that this is related only to past trauma but could be an indicator that something is wrong now. It is important to ask direct questions.

Children and young people often disclose abuse while it is still ongoing, there may be a significant delay between the onset of the abuse and any disclosure. The younger the age of the child when the sexual abuse starts, the longer it usually takes to disclose.

Many children are experiencing multiple forms of abuse and may live in households that are not safe and in which emotional support is not available to them.

Disclosures are more likely to come in adolescence as they learn about healthy relationships and how to recognise abusive behaviour. Adolescents often first 'reach out' to friends and peers after an experience of sexual abuse and these relationships can have significant influence on young people's emotional wellbeing after experiencing sexual abuse. Schools also have a very important role to play in aiding the disclosure process in providing developmentally appropriate education and a safe space within which to disclose. Professionals and children both highlight the importance of a trusted relationship between a child and a reliable professional as an important to aid disclosure.

See **Helping Education Settings Identify and Respond to Concerns**.

Children may disclose for a number of reasons possibly because they are not able to cope with the abuse any longer or because the abuse is getting worse. They may disclose in order to protect others from abuse or because they are seeking justice.

Barriers to disclosure include fear of not being believed, embarrassment and shame and fear of the consequences of telling. Some groups of young people will have additional challenges in disclosing due to communication, religious, language, cultural or sexuality issues. This includes Care experienced children who may experience a range of additional barriers to disclosure.

Disabled children are at increased risk of experiencing sexual abuse especially due to communication and developmental issues.

Whenever they choose to disclose, it is important that they are believed, that they are told what will happen next and kept informed and that they are provided with emotional support.

Research into young people's experience showed that they wanted someone to notice that something was wrong and to be asked direct questions.

Practitioners must be mindful of managing information to minimise the risks to the child when responding to any concerns or disclosures.

There will be situations where due to lack of forensic evidence or corroborating witnesses the threshold for criminal proceedings is not met. It is important in these cases that the lack of police action is not interpreted as disbelieving the child's disclosure.

5. The Centre of Expertise on Child Sexual Abuse

The Centre of Expertise on Child Sexual Abuse, is a multi-disciplinary team, funded by the Home Office, who have produced a range of resources to support professionals. These resources aim to give professionals the knowledge to identify concerns of child sexual abuse and the confidence to respond to it, not just with the child, but with the whole family.

These include:

- **Signs and Indicators**: A template for identifying and responding to concerns of child sexual abuse. It helps professionals to gather the wider signs and indicators of sexual abuse and build a picture of their concerns.
- **Communicating with children**: A guide for those working with children who have or may have been sexually abused. This guide aims to help you communicate with children in relation to child sexual abuse, including when you have concerns that such abuse is happening.
- **Supporting parents and carers**: A guide for those working with families affected by child sexual abuse. This guide helps professionals provide a confident, supportive response when concerns about the sexual abuse of a parent or carers child have been raised or identified.
- **Safety Planning in Education**: A guide to support education professionals' knowledge, skills and confidence to understand and respond to incidents of harmful sexual behaviour and ensure the safety of all children and young people is addressed.
- **Helpful 12 part short film series**: The CSA Centre have produced an accompanying 12-part short film series which distils key information from these resources quickly and accessibly for professionals. These films are designed for anyone whose role brings them into contact with children and young people under 18 years old or their parents or carers; including social workers, teachers, police officers, health professionals, voluntary-sector workers, or faith leaders/workers – whether they are new to the role, still in training or highly experienced.
- **Managing risk and trauma after online sexual offending**: A guide to help professionals safeguard the whole family when a parent has accessed child sexual abuse material.

- **Sibling sexual abuse and behaviour**: Supporting professionals to improve their understanding of the nature and consequences of sibling sexual behaviour and abuse, and how to navigate key decisions to best support the whole family.

Further Information

Useful Websites

Key messages from research on intra-familial child sexual abuse (Centre of Expertise on Child Sexual Abuse).

Centre for Expertise on Child Sexual Abuse - Measuring the Scale and Changing Nature of Child Sexual Abuse and Child Sexual Exploitation - Scoping Report June 2021, Professor Liz Kelly and Kairika Karsna (Centre of Expertise on Child Sexual Abuse)

Key Messages from Research on Child Sexual Abuse Perpetrated by Adults (Centre of Expertise on Child Sexual Abuse).

Protecting Children from Sexual Abuse (NSPCC)

Getting Support with Sexual Abuse (Childline) help for children in talking about sexual abuse

Protecting Children from Harm - A critical assessment of child sexual abuse in the family network in England and priorities for action.

Research in Practice - Child Neglect and its Relationship to Sexual Harm and Abuse: Responding Effectively to Children's Needs - open access resource considering the potential relationship between neglect and forms of sexual harm and abuse.

University of Bedfordshire 'Making Noise: Children's Voices for Positive Change after Sexual Abuse' - Children's experiences of help-seeking and support after sexual abuse in the family environment

Safeguarding Children as Victims and Witnesses (Crown Prosecution Service)

Pre-Trial Therapy (inc Annex A: Specific considerations for children) (Crown Prosecution Service)

Triennial Analysis of SCRs 2022 (2017-2019)

Leicester Safeguarding Children Partnership Board
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Appendix 1 - Referral to the East Midlands Children and Young People Sexual Assault Service (EMCYPSAS) (24 Hour Sexual Assault Service)

Referral Leicestershire Police refer to the 24 hour EMCYPSAS **Single Point of Access (SPA) 0800 183 0023**

Initial Discussion: A SARC clinician engages in a **threshold discussion** with Police and Children's Social Care to consider whether thresholds are met to proceed to a medical. A date and time for examination will be agreed. **In Acute cases**: The clinician will advise the Police of immediate actions to be taken to preserve evidence and initial samples that the Police need to collect. Key agencies may also be contacted to support the threshold discussion.

Multi-agency strategy discussion: Where cases meet the threshold a multiagency strategy discussion takes place to include EMCYPSAS. **A EMCYPSAS clinician to always be invited to the strategy discussion.**

At the strategy discussion the EMCYPSAS clinician can advise on correct CSA pathway for all sexual violence (including non -contact), support frontline practitioners working with CYP and ensure the correct medical advice is shared regarding what an examination involves, the significance of physical findings, managing the expectations of professionals and CYPs (Clinicians are happy to discuss the examination with CYP and families prior to attending) and ensures confirmation of who holds parental responsibility for consent

The clinician can also ensure the examination complies with forensic and safeguarding legislation, is offered clinically as well as evidentially and that the CYP are only examined when they have the capacity to be able to consent e.g. delaying an examination if tired (falling asleep or intoxicated due to alcohol or drug use). Prevents further trauma to CYP by clarifying chronology and events of the abuse at Strategy meeting rather than asking the CYP more questions. The strategy meeting gives background to case and informs examiner of home or contextual concerns/circumstances to inform examination and presentation of CYP Holistic care and robust follow up is offered to all CYP being mindful that some are very vulnerable and a Safe discharge plan is initiated, especially if child from out of area.

Examination: CYP attends with carers and Police at a pre- arranged time. Written consent obtained by Doctor from adult with parental responsibility and young person
Clinician takes history of offence from professionals attending examination, medical history etc from CYP and family
Examination explained to CYP and family. CYP given choice of who they wish to support them during the examination
Full general and genital examination with the use of video colposcope to document examination findings if CYP/parents consent, if no consent for the use of colposcope, injuries documented in records
NON-RECENT CASES (more than 3 weeks old) Urine pregnancy testing and STI screening (swab and blood test) for CYP
ACUTE CASES: Forensic samples taken by Doctor and handed to police officer attending. Base line bloods taken if (post-exposure prophylaxis for HIV) PEPSE prescribed

CYP showers and changes clothes. A SARC Doctor prescribes and dispenses emergency contraception/PEPSE/Hep B immunisation if required. A STI/sexual health screen referral will be made for follow up.

- **Results and follow up:** CYP and carers meet with Clinician to feedback re the examination findings and follow up arrangements including psychosocial therapy, Child Independent Sexual Violence Advisor (CHISVA) contact, follow-up and discharge details regarding next steps and the next contact from EMCYPSAS. Onward referrals and STI/sexual health screen referral will be made for follow up

Written Reports

- Handwritten summary given to Police/CSC regarding examination
- Doctor dictates the paediatric SARC report to be typed up by Admin team within 72 hours
- Full safeguarding report goes to Social Care, Police, patients GP, named paediatrician of the locality where the child lives