Sexual Abuse Audit:
Summary for Practitioners & Managers
April 2018

Background

The Local Safeguarding Children Board Quality Assurance (QA), sub-group is responsible for monitoring and evaluating the effectiveness of the work carried out by the Board partners to safeguard and promote the welfare of children and to make recommendations about ways this can be improved. It does this through an annual programme of case file audits and scrutiny of multi-agency performance data and inspection reports. The subgroup meets six times a year. Auditors include representatives from NHS organisations, Sussex Police and East Sussex County Council Children Services.

In November 2017 and January 2018 the QA Subgroup completed an audit of five sexual abuse cases. This summary provides a briefing on the findings of that audit.

What is sexual abuse?

Sexual abuse 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 (including via the internet).

The NSPCC indicate that nearly two-thirds of the contact sexual abuse reported by children and young people 0-17s was perpetrated by other children and young people under the age of 18yrs old (NSPCC, 2011).

Disclosure is difficult for children, often delayed and children do not always disclose. It is vital that there is effective multi-agency liaison and practice in cases of suspected child sexual abuse and the use of the Sexual Assault Referral Centres, (SARC), is an important element within this.

Method

Five cases with multi-agency involvement were selected using Children's Services data. Details of cases were gathered including family background, relationships, referral date, assessments and other key information

At the audit meeting auditors shared and discussed the information held on each child and agreed strengths, areas for improvement, recommendations, immediate actions required, and agreed an overall grade for each case.

Strengths in Multi-Agency Practice

In the cases audited, there was evidence of:

- ✓ Good initial response to referrals and disclosures immediately removing the risk to the child in four cases.
- ✓ Good consideration of the needs of, and risks to, other children, including whether the alleged abuser was also a victim.
- ✓ Careful and focussed work over a long period of time to support the child to make a disclosure.
- ✓ Good use of an intermediary and effective communication with CAFCASS where parents were in an acrimonious dispute.
- ✓ Good multi-agency information sharing and joint work to respond to the wider picture, disguised compliance and the therapeutic needs of children and adults and mostly good in another two cases.
- ✓ The needs and voice of the child, whether victim or perpetrator, were carefully considered in and reflected in child focussed work.

Improvements in individual cases

All cases demonstrated good safeguarding and child protection practice. Areas for improvement were identified in individual cases, for example:

- Auditors found gaps in otherwise good communication between agencies in three cases. For one of these three cases there should have been a strategy discussion after a second disclosure by a child and more consistent management oversight.

- For the fourth case the father, as the alleged perpetrator, should have been involved in the assessment process to include his views and the risks posed by him to other children.
- The auditors also found that the good focus and clarity found in the initial assessment stage was then less evident in the Plan and Family Assessment in two of the cases.
- Auditors were concerned in one case that Children's Services had not receive critical information from the National Probation Service which meant that an adult posing a risk to children and who caused harm, moved to east Sussex and into the life of a number of children without their knowledge, even though professionals were visiting the home

Learning Identified

- SARC paediatricians should be provided with information from any ABE interview or the child's first account, prior to conducting a medical.
- There is often a delay in securing appropriate intermediary support for young children to support them through the ABE process. This leads to a delay in securing disclosures and additional challenges for the professionals working to safeguard the child. It was recommended the Chair of LSCB raises this issue with National Crime Agency. This issue will also be included in the LSCB's Joint Investigation Training.

Recommendations for improvement

- Fathers views should be sought as part of assessments, even if they are the alleged perpetrator of the abuse.
- There should always be consideration as to whether the alleged abuser poses a wider risk to other children.
- Details of any and all disclosures of sexual abuse should be shared with Health and Sussex Police.
- The cross boundary MAPPA process should be used to communicate risks about an adult at the time of release from prison.
- The Health Visiting Service should use the agreed process for handing over information about vulnerable children to the School Health Service
- SARC should ensure that when they receive a referral by email that there is an immediate response to the referrer detailing that email referrals are not accepted and the correct referral procedure.

Learning for Practice

The LSCB invite you to discuss some of the issues raised in this case audit in your team meetings or during group supervision. We encourage your responses to be included in your team minutes and forwarded to the safeguarding lead within your organisation.

Points for discussion:

Applying learning

- ✓ What have you/your team learnt from this audit?
- ✓ How might you/your team apply that learning?

Engaging fathers, partners and other males

- ✓ How do you ensure fathers/ partners are engaged in the assessment process?
- ✓ What techniques do you/your team use in having difficult conversations with fathers/ partners?

Sexual Abuse Resources

If you think a child is being harmed or may be at risk of harm, please contact: SPoA (Mon-Friday 8.30am-5pm)

Phone: 01323 464222

Email: 0-19.SPOA@eastsussex.gov.uk or 0-19.SPOA@eastsussex.gcsx.gov.uk

LSCB Multi-Agency Training:

The LSCB offers training for professionals on child sexual abuse, MAPPA and Joint Investigation Training (for Police and Social Workers – this includes a visit to the SARC). Training on child sexual abuse covers a range of CSA related issues, including CSE and is linked into the CSA Learning Pathway. Training appropriate for an LSCB audience is highlighted in the Foundation and Professional Level sections of the Pathway. Details of future courses can be found on the East Sussex Learning Portal: www.eastsussexlearningportal.org.uk

Pan Sussex Safeguarding and Child Protection Procedures

Details of child protection and safeguarding procedures in relation to child sexual abuse can be found at:
http://sussexchildprotection.procedures.org.uk