Multi-Agency Case Audit Learnings

Child Sexual Abuse

Professional confidence in risk assessment

Professionals demonstrated confidence and clarity in their assessment of risk through naming and maintaining focus on Intra-Familial Child Sexual Abuse explicitly, throughout the intervention. Relationship building and direct work was completed with the children to understand their lived experience.

Threshold decisions were over-reliant on verbal disclosures of child sexual abuse

Threshold decisions were over-reliant on a child telling them about the sexual abuse they had suffered, rather than recognising the full range of CSA indicators as sufficient evidence to escalate. Retraction appeared to undermine the credibility of the original disclosure(s), rather than being understood as a trauma response.

Missed opportunities to map historical risk

There were missed opportunities to map historical risk, and flag adults who pose a sexual risk to children. The importance of genograms and completing them as early as possible was highlighted. All three men had concerning histories, including children reporting sexual offences, as well as patterns of domestic abuse and controlling behaviours. Several agencies were unaware of the sexual abuse histories or active sexual risk these adults posed.

Decisions did not reflect the escalating evidence of sexual abuse

Decisions were sometimes based upon the perception that the family were engaging in assessments, and the 16-year-olds presentation had stabilised. However, in retrospect, this decision did not reflect the escalating evidence of sexual abuse.

Lack of understanding of the complexity of adult behaviours

There was a lack of understanding of the complexity of adult behaviours, including deliberate tactics such as multiple name changes, avoidance of meetings with professionals by perpetrators, and moving across geographical boundaries. This made it difficult for agencies across all local authorities to track and understand the risks posed by individuals.

Safety Planning was not fully understood

Safety Planning was not fully understood or enforced effectively, which undermined its protective function. See multi-agency safety planning practice tool.

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Learning points

- Development of Child Sexual Abuse practice guidance or Thinking Tool
- Review of existing approaches to adding Hazard markers or key information on adult records where they are a sexual risk to children ensuring easy visibility
- The Child Protection Service & Child in Need Reviewing Services use their Independent Role to promote and model best practices when working with ICSA
- Family Centres to consider how they can strengthen their role in how Specialist Assessment Outcomes are understood and promoted to inform critical threshold decision making
- Create greater clarity regarding Legal Threshold Expectations when working with ICSA and approaches to evidence building
- Seek Opportunities to Strengthen Practice Understanding of the Role and Purpose of CSA specific Safety Planning

Further Reading

- Centre of Expertise on child sexual abuse
- Signs and indicators of CSA
- National review into child sexual abuse with the family environment
- The Independent Inquiry into Child Sexual Abuse
- The Child Safeguarding Panel Report (Nov 2024): "I wanted them to Notice"
- The Home Office Progress Update (April 2025) – "Tackling Child Sexual Abuse"

Identifying and responding to disclosures of child sexual abuse | CSA Centre – *"Allegation"* is reserved for **formal/legal usage**, not everyday safeguarding language, as it may undermine trust or suggest disbelief

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