Child Sexual Abuse Policy & Practice Guide

Purpose

This policy document outlines how practitioners across the Supporting Families Division address Child Sexual Abuse Concerns.

Additional Information, Advice and Guidance

NSPCC 'Protecting Children from Sexual Abuse'

IICSA 'The Report of the Independent Inquiry into Child Sexual Abuse'

LSCP, London Safeguarding Children Procedures 'PG37. Sexual Abuse'

Centre of Expertise on Child Sexual Abuse 'Signs and Indicators Template'

Practice resources | CSA Centre

1. Child Sexual Abuse (CSA)

Child 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. 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."*
>
> Working Together to Safeguard Children (2023), p. 162

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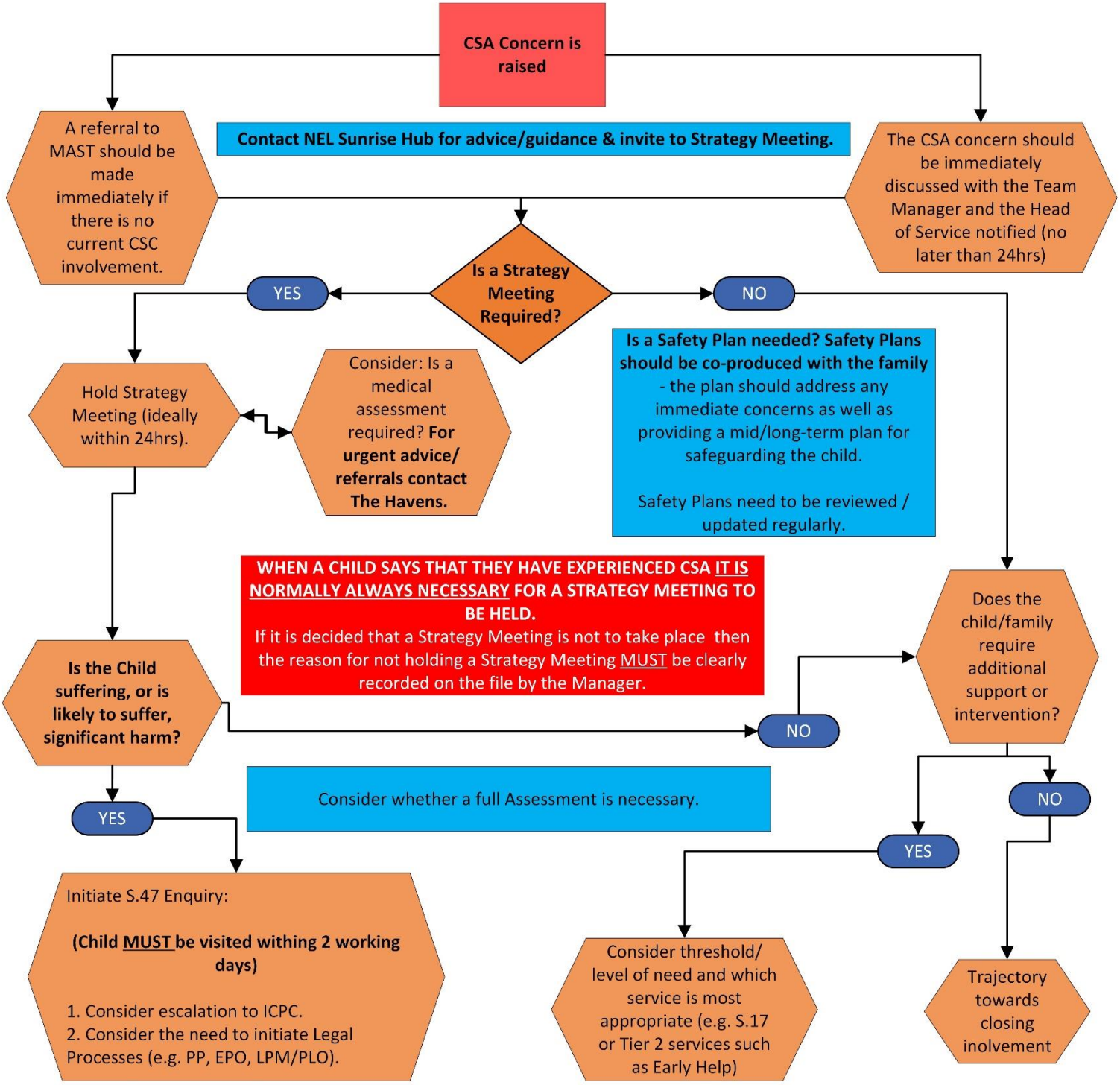
TOWER HAMLETS

Child Sexual Abuse (CSA) Pathway



CSA concerns need to be addressed on a child-by-child basis - ensuring assessments and interventions are bespoke and tailored to the specific needs of the child and family.

It is of the highest importance that interventions and safeguarding action to address CSA concerns are taken in a timely manner without delay.

It is important that, when decisions and actions are taken, the decision making rationale MUST be clearly recorded on the child's file.

Child Sexual Abuse (CSA) Pathway

CSA is a serious form of harm that can cause extreme trauma. For professionals, addressing CSA is complex as each child, incident or situation requires a bespoke safeguarding approach, tailored to the child/family's needs.

The CSA Pathway above provides a framework for the key decision-making 'points' (and associated timescales) that must be considered when responding to CSA concerns. Applying this CSA pathway ensures that, across our service:

- We have a consistent baseline response to CSA concerns.
- Key issues/decision points are always considered as a standard part of the CSA Pathway, and decision-making rationale is captured in case recording.
- The CSA pathway forms the foundation upon which a bespoke safeguarding response (e.g. assessment and intervention) is developed.

The information below explains further what additional information/action needs to be considered and included at different stages of the CSA Pathway.

1. **Convene Strategy Meeting:** When a CSA concern is raised it is normally always necessary for a Strategy Meeting to be convened. The timescale for a Strategy Meeting is determined by the level of risk and need; ideally the Strategy Meeting should be convened within 24hrs, and no later than 3 working days, of a concern being raised. When it is decided that a Strategy Meeting is not necessary the reason for not holding a strategy meeting must be clearly recorded in the child's file. Reasons for not holding a Strategy Meeting are limited and, for example, might include:
    a. The CSA concern is a repeat and has already been investigated.
    b. CSA concerns have been raised in quick succession and the initial concern has already resulted in a Strategy Meeting and the initiation of a S.47 investigation (and there is no new information raised as part of the subsequent CSA concern that requires/would benefit from being discussed at a Strategy Meeting).

The NEL Sunrise Hub should be invited to the Strategy Meeting (by the Social Worker or other lead safeguarding professional) – the NEL Sunrise Hub's attendance is dependent on practitioner availability.

2. **Achieving Best Evidence (ABE):** The Strategy Meeting record should evidence that an Achieving Best Evidence (ABE) interview has been considered (e.g. by Police). The ABE interview is designed to assist in criminal prosecution where an offence is alleged to have been committed against a child and to act as the child's statement. The ABE interview is facilitated by the Child Abuse Investigation Team (CAIT).

3. **CSA Medical:** The Strategy Meeting record should evidence that a CSA Medical has been considered.
    a. When the CSA incident is alleged to have taken place within 7 days, it is best practice for a specialist Child Protection Doctor/CSA Doctor to be present at the Strategy Meeting to provide a view on the immediate

medical response. The Havens should be invited and are best placed to provide advice regarding the immediate medical response. The Havens will typically be referred to, and invited to the Strategy Meeting, by the Police (it is good practice to confirm with the Police in advance of the Strategy Meeting whether the Havens have been referred to – and, if not, to record in case records why the Havens are not required). If a doctor cannot be present, their view should be sought separately and included in the meeting record.

b. When a CSA incident is alleged to have taken place more than 7 days ago, the medical response can be guided by specialist consultation/advice from The Havens and/or the NEL Sunrise Hub. It is likely that the Havens will only be involved if the Police believe there is still potential for forensic evidence to be collected (which 7+ days after an alleged event is unlikely).
c. The NEL Sunrise Hub can be invited to the Strategy Meeting whether or not the Havens will also be present.
d. Referrals to the Havens are usually undertaken by the Police (particularly for children under the age of 13). It is best practice for the allocated Social Worker (or other safeguarding professional) to confirm with the Police – in advance of a Strategy Meeting – that a referral to the Havens has been made (and ensure, if no referral is made, the reason for no referral is clearly recorded in the case file). The Social Worker/other lead safeguarding professional can contact the Havens directly if required.

London Safeguarding Children Procedures

The London Safeguarding Children Procedures (LSCP) outline a 'continuum of needs matrix' which provide a framework for professionals who are working with children, young people and families. The continuum of needs matrix is not an exhaustive list. It does provide examples that can be used as a tool to assist assessment, planning and decision making for professionals working to safeguard and promote the welfare of children. The LSCP continuum of needs matrix for Sexual Abuse/Activity is outlined in the table below.

The LSCP Threshold Document and full Continuum of Needs Matrix is accessible online:
Threshold Document: Continuum of Help and Support (londonsafeguardingchildrenprocedures.co.uk)

LSCP Continuum of Needs Matrix: Sexual Abuse / Activity			
Level 1 (No Additional Needs)	**Level 2 (Early Help)**	**Level 3 (Children with Complex Multiple Needs, Children in Need)**	**Level 4 (Children in Acute Need, Child Protection)**
Nothing to indicate child is being sexually abused by their carer.	Concerns relating to inappropriate sexual behaviour / abuse within the family / network but does not amount to a criminal offence.	Allegation of non-recent sexual abuse but no longer in contact with perpetrator.	Concerns re possible inappropriate sexual behaviour from carer / carer sexually abuses their child. Offender who has risk to children status is in contact with Family. Child who lives in a household into which a registered sex offender or convicted violent offender subject to MAPPA moves.
Good knowledge of healthy relationships and sexual health.	Emerging concerns of possible sexual activity of a child.	Suspicions of peer on peer sexual activity in a child over 13 years old. Child under 16 is accessing sexual health and contraceptive services.	Suspicions of sexual abuse / sexual activity of a child. Direct allegation of sexual abuse/assault by child and belief that child is in imminent danger and in need of protection.
Good knowledge of healthy relationships and sexual health.	Single instance of sexually inappropriate behaviour.	Send/receive inappropriate sexual material produced by themselves or other young people via digital or social media, considered as peer-on-peer abuse. Evidence of	Child is exhibiting harmful, sexual behaviour. Early teen pregnancy. Risk taking sexual activity.

		concerning sexual behaviour – accessing violent / exploitative pornography.	
Good knowledge of healthy relationships and sexual health.	Age appropriate attendance at sexual health clinic.	Sexually transmitted infections (STI's). Consent issues may be unclear. Verbal or non-contact sexualised behaviour. Historic referrals in regard concerning sexual behaviour.	Multiple / untreated sexually transmitted infections (STI's). Concerning sexual activity (behaviour that is upsetting to others). Allegations of non-penetrative abuse. Harmful sexual behaviour. Child exploited to recruit others into sexual activity. Repeated pregnancy, miscarriages and/or terminations. Increase in severity of concerning sexual behaviour.

LSCP Practice Guidance

The LSCP also outlines a CSA response pathway, developed by the CSA Centre, as a guide to approaching and addressing CSA concerns.

- The LSCP guidance can be found here: PG37. Sexual Abuse (londonsafeguardingchildrenprocedures.co.uk)
- The CSA Centre response pathway (endorsed by The LSCP) can be found here: pathway (csapathway.uk)

Acute/Recent/Non-Recent – Co-Working With The Havens & NEL Sunrise Hub Guidance

Acute: Alleged abuse/assault within the last 7 days

Contact the **Havens** for advice if there is any uncertainty (020 3299 6900 (urgent)/020 3299 1599). The Havens team are available to provide advice 24/7. Consider referral for assessment by the Havens if the child is unsure if there was an assault or not: for example, intoxicated with associated loss of consciousness and circumstances that might suggest a possible assault.

Refer to **NEL Sunrise Hub**.

Consider the need for the following, particularly if not being seen immediately at the Havens or if declines medical assessment: emergency oral contraception, post exposure prophylaxis for HIV and Hep B vaccination, treatment for any symptomatic Sexually Transmitted Infection (STI) – this care can be provided in a Hospital Emergency Department or by the GP.

Referral to MAST must be made (if CSC is not already involved) and/or CSC must be informed of the allegation.

Recent: Alleged abuse/assault >7 days but <3 weeks

Most children will need to be offered a non-urgent health assessment through the **NEL Sunrise Hub**. There are occasionally circumstances where the **Havens** will assess these children such as if there are long wait times at the NEL Sunrise Hub.

Refer to NEL Sunrise Hub.

If there is any uncertainty, contact the Havens and NEL Sunrise Hub for advice as needed.

Referral to MAST must be made (if CSC is not already involved) and/or CSC must be informed of the allegation.

Non-recent: Alleged abuse/assault >3 weeks

Referrals for CSA Medicals for non-recent abuse/assault are only accepted by **Haven**s from Children's Social Care. If the allegation of CSA is made to someone in a non-statutory safeguarding setting (e.g. health professionals or Early Help), they must refer to MAST to ensure safeguarding procedures are initiated. The **NEL Sunrise Hub** will always liaise with the relevant Local Authority to ensure Safeguarding procedures have been followed.

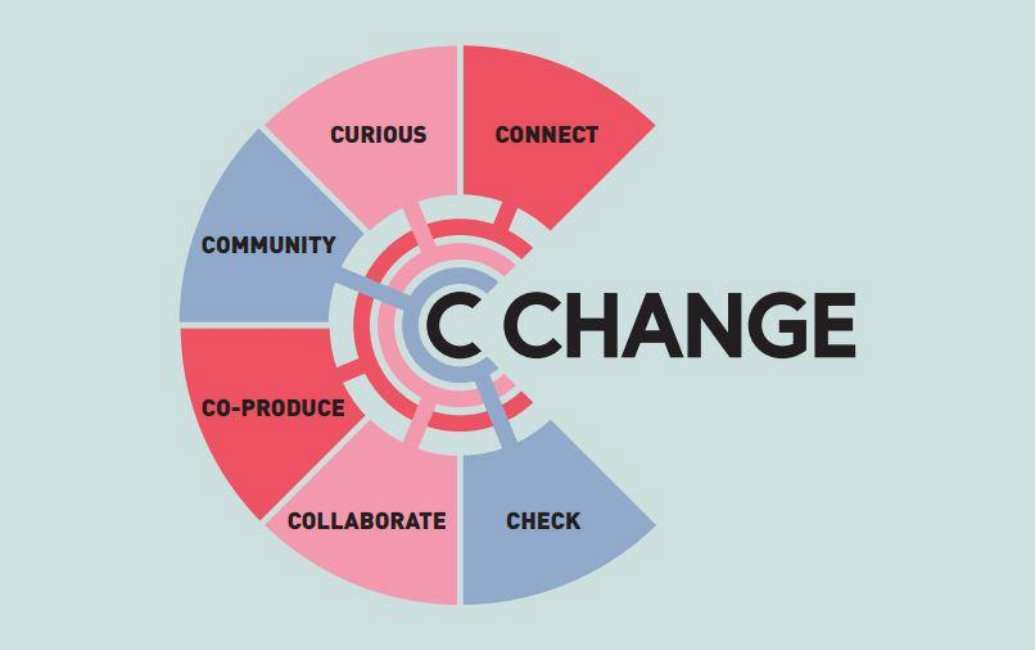
Refer to NEL Sunrise Hub.

If there is any uncertainty regarding the referral and advice is needed, please contact LBTH MAST or NEL Sunrise Hub.

Referral to MAST must be made (if CSC is not already involved) and/or CSC must be informed of the allegation.

2. CSA: Better Together Informed Practice

It is important that we apply the Better Together Framework when working with children who may have been sexually abused. The Better Together Framework sets out how we want all staff in the Supporting Families Division in Tower Hamlets to work with children, their families and each other. Below is a summary of how this is applied in the area of sexual abuse.



Connect: Spend time getting to know the child and building trust. Using direct work tools can help you to do this.

Be Curious: Undertake assessments (at whichever level of need) with curiosity, always considering what is being said and not said, paying attention to non-verbal as well as verbal communication. Reflective supervision is particularly important when considering the needs of children who may have been sexually abused.

Build a community: Supporting children to stay safe, raise concerns, and recover from trauma requires support from a range of people – including professionals and people within the child's own family and friends network (arranging a Family Group Conference can help to identify and strengthen the support available to a child through their family and friends network). Make use of specialist services and don't forget to consider and include safe adults who the child identifies as significant, such as aunties, teachers and family friends (etc.).

Co-produce a plan: Work with children and their families to create a realistic safety plan that reduces risks and increases support. Ensure all plans, whether those made in supervision or as part of multi-agency meetings are co-produced with those involved in delivering them.

Collaborate for change: It is likely that specialist services will be needed to help children recover from any sexual abuse they have experienced and enable perpetrators of abuse to make the changes they need to reduce the risk.

Check back: Make sure plans (whether safety plans or multi-agency plans of support) are regularly reviewed to consider if the support in place is working as intended and achieving the right outcomes; if not, consider what changes are needed.

3. Addressing CSA Concerns - Summary

The Local Authority Safeguarding Duty

When a CSA concern is raised it often results in many professionals being involved with a family. The involved professionals might include specialist CSA services (e.g. Police, The Havens, NEL Sunrise Hub, specialist therapeutic support, etc.), as well as other multi-agency professionals (e.g. school/education, Family Support/Early Help professional, GP, etc.). It is important that the professionals involved, and the work undertaken, is always focused on safeguarding the child and ensuring their needs are met.

It is the responsibility of the lead safeguarding professional (usually the Social Worker, or other lead professional if a Social Worker is not involved) to ensure that that the support and intervention provided by the multiagency network is focused on safeguarding the child and meeting their needs.

Child Sexual Exploitation (CSE)

Child Sexual Exploitation (CSE) is a form of Child Sexual Abuse. When a CSE concern is raised, it is expected that the CSA safeguarding response – outlined in this document – is applied. When a CSE concern is raised, practitioners should consider including the Local Authority Exploitation Service in the multiagency safeguarding response.

Multiagency working with the Exploitation Service might include:

- Arranging a professionals' meeting/consultation with the Exploitation service.
- Inviting the Exploitation Service to the Strategy Meeting.
- The Exploitation Service to be engaged to support the professional network as part of ongoing work.
- To invite the Exploitation Service to review meetings.
- An Exploitation Support worker allocated for the at risk child.
- Arranging a one-off parenting information session about Harm Outside the Home and Exploitation delivered by Exploitation Service support workers.

The full CSE definition can be found in the Working Together 2023 document, pp. 154-155.

Risk Assessments & Safety Plans

When CSA concerns have been raised it is good practice for a stand-alone Risk Assessment and Safety Plan to be completed (where possible, in partnership with the child/family) and clearly uploaded to the child's record. The Risk Assessment and Safety Plan should be shared with the multi-agency professional network; children may be known to a range of services (e.g. Youth Justice Service, Early Help, Education, etc.), it is important for these services to be included in Risk Assessment and Safety Planning work.

Risk Assessments: 'Risk' is essentially the probability that something will happen causing someone to experience harm. 'Risk Assessment' focuses on understanding the likelihood of something happening and the factors that increase or decrease the likelihood of harmful outcomes occurring. Assessing risk is fundamental to the work we do with children and families and permeates many of our interactions with the people we work with. It is important that the analysis and assessment of risk is clearly outlined at every available opportunity (e.g. in visit write-ups, meeting minutes, and Assessment documents – etc.).

When undertaking a Risk Assessment consider:

1. *Who is involved?*
    a. Who is the person/people/child at risk?
    b. Have all the at-risk children been identified?
    c. Who can increase or decrease the risk?
    d. Do the important people (e.g. the child, caregivers, family/support network, professionals, etc) have a shared understanding of the risk (if there are different perspectives, or disagreement – why)?
    e. How does personal identity influence risk (consider John Burnham's Social GRACES)?
    f. What are the relationship dynamics between the people involved? Are these helpful/unhelpful? Consider power dynamics.
    g. What professionals are involved?
2. *What has happened up to now?*
    a. How has this contributed to the risk/harm.
    b. Has harm already been experienced?
    c. What action has already been taken to mitigate risk and has this been effective (if effective/if not effective – why?)?
    d. Has the risk increased/decreased over time – why?
3. *What is happening now?*
    a. What is the current status of the risk/harm?
    b. Are we concerned that harm is happening in the present, or that harm may happen in the future (even if harm has not happened yet)?
    c. What are people doing to mitigate risk in the present (is this effective – why)?
    d. If the risk/harm is historic (e.g. relates to an allegation of an historic incident), how is this impacting the child/family in the present and does the historic concern raise concerns regarding risk/harm in the present?
4. *What will happen in the future.*
    a. Consider the short-, mid-, and long-term future.

b. What will happen if no action is taken to address risk/harm (or if the action taken is ineffective)?
c. If safety is achieved in the short-term, how can this be guaranteed in the mid-/long-term?
d. How will the child's experience of risk/harm impact them over time (consider – trauma, sense of self, trust, relationships with others, stability)?

Safety Plans: A 'Safety Plan' outlines how risk can be mitigated to prevent harm. To be effective it is recommended that Safety Plans are concise, explicitly address risks, clearly outline what actions need to be taken (by whom), and are reviewed and updated regularly and/or in light of new information or a significant incident. The actions outlined in a Safety Plan should be realistic and achievable. It is important that the people identified as 'protective' in a Safety Plan have a clear understanding of what their role in the Safety Plan is and the actions they need to take. Once a Safety Plan is developed it should be communicated to the child in an age-appropriate way (tools such as 'Words and Pictures Safety Plans' can help with this).

When creating Safety Plans consider:

1. *Be specific.*
    a. Break-down the overall concern (CSA) into the different risk factors that make up the whole, so the Safety Plan is tailored to address risk factors specifically (e.g. rather than simply referring to and using 'CSA' as a general term in the Safety Plan; outline what the CSA looks like for this particular child/family – e.g. is it online or in person? Community based or intra familial? Is a child displaying Harmful Sexual Behaviours – and, if so, in what context? What makes this child particularly vulnerable to CSA? Etc.). The specific character of the CSA will significantly shape the Safety Plan – e.g. action to address intra-familial CSA will differ from action to address CSA that is taking place online.
    b. Clearly outline what action needs to be taken to address different risk factors (and who is best placed to take this action)?
    c. Who is responsible for completing different actions – is everyone aware of their role in the Safety Plan?
    d. Clearly outline timeframes for actions to be completed.
2. *Short-, mid-, and long-term safety.*
    a. What needs to happen immediately to ensure a child is not experiencing/at risk of experiencing harm?
    b. Once immediate risk/harm has been addressed, what needs to happen to ensure the child is protected from experiencing risk/harm in the mid-/long-term?
    c. In the long-term, professional services may no longer be involved (e.g. Children's Social Care may close involvement), what can the family/carers/support network do to keep a child safe when professional services are no longer involved?
    d. Trauma associated with experiencing risk/harm can emerge and manifest over time (even when it is not immediately obvious/evident at the time of the risk/harm). Does the Safety Plan outline what the family/carers/support network can look out for in the future which may indicate a child is acting out past trauma; and does the Safety Plan outline

what action can be taken in these circumstances (e.g. signposting to support services).

3. *Identify Support Services and outline the role of different professionals.*
    a. Identify which professionals are currently involved and clearly outline what their role in the Safety Plan is.
    b. Consider if additional support services need to be referred into – does the Safety Plan outline timeframe/responsibility for making referrals to support services?

Risk Assessments and Safety Plans should be reviewed regularly. It is advised that both are reviewed and updated at intervals of no more than every 3 months (the child's case record should clearly evidence that the Risk Assessment and Safety Plan has been reviewed). Risk Assessments and Safety Plans should also be reviewed and updated in response to, and to account for, new information or a significant incident. The case record (e.g. meeting minutes) should demonstrate that the Risk Assessment and Safety Plan is being discussed by professionals and the family.

Remember, risk exists on a continuum, rather than being a 'fixed-point'. Risk is dynamic and can change over time and work to address risk should be alive to this. It is usually impossible to eradicate all risk entirely – when used appropriately, Risk Assessments and Safety Plans will help to reduce and manage risk, preventing the need for escalation. When thinking about risk reduction it can be helpful to consider Barry Mason's work around 'Safe Uncertainty': PSDP – Resources and Tools: Safe Uncertainty

Where possible, try to include the child in the Risk Assessment and Safety Planning process. Consider – do the completed documents reflect the child's view (even if the child disagrees with parts of/all the final documents)?

Our Better Together Practice framework is particularly helpful when completing Risk Assessments and Safety Plans. Think about:

- Engaging in Risk Assessment and Safety Planning work can be difficult and stressful for children and families. This work can bring-up difficult feelings such as embarrassment, shame, and fear. Try to *CONNECT* with the child/family; building a strong relationship with the child/family will help you to facilitate their participation and engagement in this work.
- Show *CURIOSITY* about the risk/harm and what needs to happen to secure the child's safety.
- Explore what *COMMUNITY* support the child/family can access (e.g. though a Family Group Conference) to help mitigate risk/harm.
- Work with the child and family to *CO-PRODUCE* the Risk Assessment and Safety Plan, promoting the child/family's ownership of this work.
- *COLLABORATE* with the professional network to coordinate safeguarding work and the multiagency response to the risk/harm.
- *CHECK-BACK* with the family and other professionals regularly to reflect on how effective the Risk Assessment and Safety Plan is in addressing the risk/harm – use check-back to consider what needs to change to better support and protect the child.

Harmful Sexual Behaviour from One Child to Another

The Centre of Expertise on Child Sexual Abuse recommends using the phrase 'Harmful Sexual Behaviour' when naming CSA between children (rather than phrases like 'peer-perpetrated abuse' or 'peer-on-peer abuse'): Communicating with Children: A Guide for Those Working with Children Who Have or May Have Been Sexually Abuses

With this in mind, 'Harmful Sexual Behaviour' is the language we will use when describing behaviour that if undertaken by an adult would be described as Child Sexual Abuse.

Harmful Sexual Behaviour can take place between children (e.g. within friendship/community groups, sibling groups, and within gangs and other criminal contexts) – everyone under the age of 18 is a child; just like younger children, teenagers can experience CSA/Harmful Sexual Behaviour (both from adults and other children). When addressing allegations of Harmful Sexual Behaviour between children, it is important to remember that all the parties involved (e.g. the 'perpetrator' and the 'victim') in the allegation are children and are therefore vulnerable.

When Harmful Sexual Behaviour concerns are raised it is important that – where possible – both/all children involved are considered as part of professional assessment, intervention, and support. Efforts should therefore be made to identify all children involved in an allegation of Harmful Sexual Behaviour so that appropriate assessment and intervention can be undertaken (identifying all children may not always be possible). When a professional is working with a child in the context of Harmful Sexual Behaviour and another child is alleged to have been involved in the Harmful Sexual Behaviour concern, the other child (if identified) should be referred to MAST (if there is no current social care involvement); or (if the child is currently known to social care) the allocated social worker should be informed of the Harmful Sexual Behaviour concern – the CSA Pathway outlined in this document should then be implemented.

Additional Information: Key Messages from Research on Children and Young People Who Display Harmful Sexual Behaviour

Written Recording

When CSA concerns are raised by a child it is extremely important that the allegation/account given is recorded as accurately as possible – using the child's own words and language. To ensure this is done – a written record should be made/recorded by the professional to whom the allegation is made as soon as possible.

Building a clear picture of the child's life and lived experiences can help when confronting CSA – this can also help other services (e.g. Police) better understand and address concerns. Ensuring the child's record is updated regularly is therefore important – efforts should be made to ensure case notes, assessments, safety plans, genograms, chronologies, etc. are reviewed and updated frequently.

Language

It is important to use appropriate language when working with CSA concerns. Appropriate language ensures that professional records accurately reflect the concerns raised and that work to address concerns is appropriately child and family centred. It is also important to avoid euphemisms and vague terms that could mean different things to different people. When using the child/family's language, which may be more colloquial, ensure recording includes analysis/explanation so it is clear what the child/family are referring to, to avoid misunderstanding and prevent a lack of clarity.

Other considerations are:

1. Try not to use the word 'disclosure' when recording/referring to something a child/family member has said in relation to CSA. Using the word 'disclosure' is unhelpful (this view has been affirmed by the Courts and government reviews) as it implies uncritical acceptance and precludes the need for scrutiny, assessment and evaluation. Instead of 'disclosure' it is more helpful to use:
    a. 'Allegation' – this can be used instead of 'disclosure' as 'allegation' implies a caution about whether something happened or not and conveys the responsibility to try to establish what happened. However, this term can be associated with 'false' allegation and imply that the starting point is that it didn't happen. In Tower Hamlets we therefore encourage some caution in using the term 'allegation' especially in relation to Child Sexual Abuse.
    b. The preferred way of recording is therefore to use language such as: 'the child/their name said…', 'the child/their name shared…', 'told me…', and 'I am concerned that…'. These phrases help to avoid using 'disclosure' while maintaining a position of curiosity that also appreciates the seriousness of Child Sexual Abuse concerns.

Our language matters – Why we should stop using the term 'Disclosure' in child protection - AOCPP - Association of Child Protection Professionals

2. Talking and Listening to Children – The Talking & Listening to Children project provides good insight into different ways professionals communicate with children in a safeguarding context and offers a range of useful resources and tools.

Decision Making

Clear decision-making rationale needs to be recorded at every stage when working with CSA concerns. Management Supervision/Oversight must be included (and clearly evidence) in the child's record whenever case discussion about the child's situation has taken place (e.g. even if this falls outside of normal 'Supervision' meetings). When a CSA concern is raised there should be a clear and evident response from the allocated manager discussing risk assessment with the practitioner; outlining actions; and explaining decision making (e.g. decision making around level of need/Strategy Discussion etc.).

Direct Work

CSA is a form of extreme trauma. Children who experience CSA will likely need specialist therapeutic interventions to overcome this trauma. Direct Work undertaken around CSA concerns must be approached with caution to avoid retraumatising children. It is appropriate to refer children who have experienced CSA to specialist agencies for targeted support. It is advised that practitioners working with CSA concerns also seek support, advice, and consultation to ensure direct work undertaken is appropriate for the child.

Consider: if a child has already given a detailed account/history of the CSA to the Police or another professional service, can this account/history be used by other professional services. This can help avoid professionals requiring a child to answer the same questions or repeat their account/history in different settings and to different professionals. Minimising the need for a child to re-tell their story can help mitigate the risk of direct work retraumatising the child. If details of the child's account/history are clearly shared with specialist agencies (e.g. The NEL Sunrise Hub) when referrals are made this can help these services not need to clarify anything further about the CSA allegation which will be helpful for the child.

Using Direct Work effectively can help to understand the nature of the CSA concerns, and help children process and overcome trauma. Direct Work tools can also be used to help manage and address CSA safeguarding concerns.

For advice on appropriate Direct Work tools contact the Learning Academy (learningacademy@towerhamlets.gov.uk) or discuss with the Direct Work Working Group. Useful Direct Work resources can also be found on the NSPCC's website, The Centre of Expertise on Child Sexual Abuse's website, and CAFCASS's website. The NEL Sunrise Hub can also provide information, advice, and guidance on appropriate Direct Work tools (see details below).

North East London Sunrise Hub (NEL Sunrise Hub)

The NEL Sunrise Hub (formerly NEL Child Sexual Abuse Hub) provides a holistic, child-centred and integrated approach to supporting the recovery of children and their families when there have been concerns about CSA. NEL Sunrise Hub provides a service across 7 North East London boroughs (including LBTH).

The NEL Sunrise Hub is a multi-disciplinary team comprised of:

- Specialist paediatricians who are trained on recognising indicators of abuse.
- A family liaison nurse who supports children and families through the health assessment.
- A health play specialist who provides support to children throughout the CSA medical assessment.

- A social care liaison officer (SCLO) who provides communication and partnership working with the allocated practitioner/s (e.g. social workers) and expert advice to clinicians and other professionals.
- NEL Sunrise Hub is integrated with the Barnardo's TIGER (Trauma Informed Growth and Empowered Recovery) Service – this means that referrals into NEL Sunrise Hub will also be considered for support from the Barnardo's TIGER service.

When CSA concerns are raised, contact should be made with NEL Sunrise Hub – this contact should be recorded in the child's record. The NEL Sunrise Hub should be invited to Strategy Meetings. Where appropriate, NEL Sunrise Hub will be able to provide information, advice, guidance, and partnership working.

The Havens

The Havens are specialist hubs providing emergency support and intervention to those who have experienced CSA. The Havens conduct Emergency CSA medical assessments (within 7 days of abuse occurring or if the need is urgent). The Havens are open 24 hours a day, 7 days a week. The Havens offer emergency appointments when there is a need for acute medical and forensic assessments for evidential purposes.

Referrals to the Havens should typically be made by the Police (particularly for children under 13 years old). The allocated social worker (or lead safeguarding professional) should check with the Police (as soon as possible in advance of a Strategy Meeting) that the Police have completed a referral to the Havens (if no referral is required, the reason for no referral should be clearly recorded in the child's case file). You can also contact the Havens directly (e.g. for information and advice). When it is unlikely that forensic evidence will be able to be collected (e.g. if an alleged CSA incident took place more than 7 days ago), there may be no role for the Havens (advice can be sought from the NEL Sunrise Hub when the Havens are not involved – the Social Worker/lead safeguarding professional can refer into the NEL Sunrise Hub directly).

For more information: https://www.thehavens.org.uk/

4. Support Services: Contact Information

Multiagency work is vital when working with CSA concerns and is equally important when helping a child overcome trauma associated with CSA. Engaging the most appropriate multi-agency team is therefore important.

Key Services:

Tower Hamlets Exploitation Service - Exploitation.Team@towerhamlets.gov.uk

North East London Sunrise Hub Social Care Liaison Officer – 020 8227 3373 (Mon-Fri, 9am—5pm)

North East London Sunrise Hub - bartshealth.nelcsahub@nhs.net

The Havens (available 24/7) – 020 3299 6900 (urgent) / 020 3299 1599 (non-urgent) / https://www.thehavens.org.uk/

CAMHS in Social Care - CiSCreferrals@towerhamlets.gov.uk

Barnardo's TIGER (Trauma Informed Growth and Empowered Recovery) Service – 07519294000 / tigerservices@barnardos.org.uk

Other Key Contacts

LBTH MAST – Mash@towerhamlets.gov.uk / 020 7364 5006 (option 3) / 020 7364 5606/5601/5358/7786

LBTH Emergency Duty Team (EDT) - 020 7364 4079

Female Genital Mutilation (FGM) Service (University College London Hospitals NHS Foundation Trust takes pan London referrals) - UCLH.paediatricsafeguarding@nhs.net

CSA Policy – Document Information

Division: Supporting Families Division

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