

**Centre of  
expertise  
on child  
sexual abuse**

Improving understanding of the scale and nature of child sexual abuse

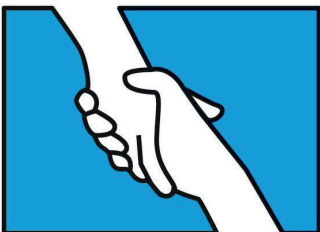
# Characteristics and experiences of children and young people attending Saint Mary's Sexual Assault Referral Centre, Greater Manchester

## A review of 986 case files

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**St Mary's Centre**



**Sexual Assault Referral Centre**



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## About the Centre of expertise on child sexual abuse

The Centre of expertise on child sexual abuse (CSA Centre) wants children to be able to live free from the threat and harm of sexual abuse.

Our aim is to reduce the impact of child sexual abuse through improved prevention and better response.

We are a multi-disciplinary team, funded by the Home Office and hosted by Barnardo's, working closely with key partners from academic institutions, local authorities, health, education, police and the voluntary sector. However, we are independent and will challenge any barriers, assumptions, taboos and ways of working that prevent us from increasing our understanding and improving our approach to child sexual abuse.

To tackle child sexual abuse we must understand its causes, scope, scale and impact. We know a lot about child sexual abuse and have made progress in dealing with it, but there are still many gaps in our knowledge and understanding which limit how effectively the issue is tackled.

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# Summary

**This report brings together evidence collected from the case files of children and young people aged 0–17 attending Saint Mary's Sexual Assault Referral Centre (SARC) in Greater Manchester for a forensic medical examination following disclosure or suspicion of sexual abuse. The data relates to all 986 forensic medical examinations of under-18s living in the Greater Manchester area who accessed the service between April 2012 and March 2015.**

Data was retrospectively extracted from the paper case file of each 'service user', including background and demographic data about them, the route by which they were referred to the SARC, the nature of the child sexual abuse (CSA) reported to have taken place, and the people suspected of committing it. The choice of data extracted was based on the 'data collection template', a core dataset developed by the Centre of expertise on child sexual abuse (CSA Centre) to standardise and improve agencies' recording of data about CSA.

This case study formed part of the pilot of the data collection template; its aim was to explore the value and practicability for agencies of collecting core data systematically about the nature of CSA, the people involved in and affected by it, and associated services. Although the data here was collected from existing records, the study serves to demonstrate what other agencies could collect and report if they adopted the data collection template as part of routine practice.

Established in 1986, Saint Mary's SARC is the UK's largest single-centre SARC. It was the first of its kind, developed to provide high-quality medical examinations in a designated and specialised space for men, women and children who had experienced sexual assault.

The findings generated through the study have wider relevance because they represent the experiences of a large number of children for whom there were concerns about sexual abuse. It is important to emphasise, however,

that they are not representative of CSA in other settings or locations. The vast majority of victims of CSA do not disclose their abuse and are not identified by professionals, and many of those who *are* identified do not attend a SARC. Furthermore, medical examinations of children at a SARC are provided following disclosure or suspicion of contact sexual abuse; experiences of non-contact CSA are, therefore, not represented in the study.

## Key findings about use of the data collection template

The CSA Centre's data collection template is designed for use by a wide range of agencies; it is not envisaged that each agency will adopt the template in its entirety, as data in some fields is more likely to be collected in some service settings than in others.

At the start of the project, Saint Mary's SARC compared its case file pro forma with the data collection template, and considered that it had been systematically collecting data in 23 of the template's 36 fields. Data in those fields was then extracted from the paper case files.

Overall, the levels of extractable data were high; for most fields, data was missing or unclear in fewer than 10% of case files. Gaps in the data tended to be in the files of service users aged 0–11; this may be inevitable because younger children are less able to disclose what may have happened to them, and are more likely to be referred to a SARC for physical symptoms which may not have been the result of abuse.

The study suggests that adopting the bulk of the CSA Centre's data collection template in future would not place additional burdens on Saint Mary's SARC, as the relevant data was being collected clearly and systematically.

As part of the study, Saint Mary's SARC reviewed the wording of questions in the data collection template. As a result, minor modifications to the template will be made before its launch later this year.

## Key findings from the data

### *About children attending the SARC*

- ▶ Girls accounted for 86% of the children and young people attending Saint Mary's SARC following disclosure or suspicion of sexual assault. Among children aged under 12, however, boys represented one-quarter of the total. The median age of boys attending the SARC was 6 years; among girls, it was 13 years.
- ▶ A large majority (79%) of service users were of white British background. Compared to the local population, minority ethnic groups were under-represented in the sample.
- ▶ More than one-quarter of service users were at the time or had previously been identified as 'children in need' or placed on a child protection plan by a local authority – a far higher proportion than among the child population in Greater Manchester.
- ▶ The proportions of school-aged children reporting physical disabilities and learning disabilities (1.5% and 16% respectively) were considerably higher than the proportions of children with those disabilities attending state schools in Greater Manchester. More than a quarter of service users of school age reported additional needs at school. Learning disabilities and additional needs at school were both more commonly reported among boys.
- ▶ Mental health issues were reported by many service users aged 12–17: 40% reported mental health difficulties, 35% self-harm and 12% suicide attempts at some time prior to their attendance at the SARC.

### *About the nature and context of reported abuse*

- ▶ Information about the nature of abuse was less likely to be recorded in the case files of younger children (those aged 0–11).
- ▶ Reflecting the fact that these were service users of a SARC, a large majority of case files – 90% – reported abuse consistent with rape or penetrative abuse.
- ▶ Three-quarters of service users reported abuse taking place in a domestic setting, with nearly two-thirds reporting abuse in their own home or the perpetrator's home (if different). Abuse outdoors was reported by 28% of those aged 12–17.
- ▶ The duration of reported abuse was unclear in 41% of the case files, including more than three-quarters of files relating to children aged 0–11. Where the information was available, attendance at the SARC after a single abusive incident was most frequently reported. Boys were more likely than girls to attend after longer periods of abuse: over one-quarter reported abuse that had lasted for more than a year.



Three-quarters of the children and young people reported abuse taking place in a domestic setting



### About individuals suspected of committing abuse

- ▶ There was no information about the suspected perpetrators of abuse in more than one-fifth of case files of children aged 0–11.
- ▶ One in eight service users reported abuse by multiple perpetrators. Strangers to or new acquaintances of the service user were the group most commonly suspected of committing abuse together or in groups: 30% of suspected perpetrators who had been known to the service user for less than 24 hours were reported to have committed CSA in pairs or groups..
- ▶ Only 3% of suspected perpetrators were female, and one-third of them were suspected of committing abuse alongside a male. Males made up a large majority of suspected perpetrators against all age groups and in all types of victim-perpetrator relationship.
- ▶ More than a quarter of those suspected of committing abuse were the service users' friends or acquaintances, and a fifth were strangers or new acquaintances. Parents accounted for one-fifth of suspected perpetrators, as did other relatives (including siblings and grandparents).
- ▶ Overall, case files recorded a near-equal split between extra-familial (52%) and intra-familial (48%) suspected perpetrators. Intra-familial figures – parents, siblings, other relatives and family friends – represented 87% of suspected perpetrators of abuse against children aged 0–11, while 81% of individuals suspected of abusing service users aged 12–17 were outside their family – friends, partners, acquaintances or strangers.
- ▶ Nearly one-third (31%) of those suspected of committing CSA were other children and young people aged under 18.
- ▶ The most commonly reported categories of abuse were abuse of girls aged 0–11 by parental figures; abuse of girls aged 12–17 by adult friends or established acquaintances; abuse of girls aged 12–17 by adult strangers or new acquaintances; and abuse of girls aged 12–17 by friends or established acquaintances aged under 18. Each of these categories was recorded more than twice as often as any other.

- ▶ In a small number of cases (5%), the suspected perpetrator was reported to have initially contacted the child or young person online.
- ▶ The suspected perpetrator was reported to facilitate contact abuse by other perpetrators in 5% of cases.

### About referral and disclosure routes

- ▶ Nearly one-third of service users attended the SARC within 24 hours of the reported abuse. Boys came to the attention of services later, with over two-fifths attending more than a month after the reported abuse.
- ▶ By far the most frequent source of referral to SARC was the police: they referred 85% of the service users, with 12% referred by local authority social services and 3% self-referrals.
- ▶ More than half (52%) of the initial contact with police or social services was made by parents. Healthcare professionals referred younger children more frequently, and teachers referred older girls.

### About Saint Mary's SARC services

- ▶ 89% of service users spoke with an independent sexual violence adviser (ISVA) following the medical examination.
- ▶ Among service users who required screening for sexually transmitted infections, two-thirds (65%) received this screening at the SARC, with the remainder referred to a local clinic.



In more than half of cases, the initial contact with police or social services was made by parents



# 1. Introduction

The Centre of expertise on child sexual abuse (CSA Centre) recognises that child sexual abuse (CSA) cannot be tackled effectively without greater understanding of its causes, scope, scale and impact. Increasing knowledge in this area is therefore one of the CSA Centre's core aims.

In July 2017, the CSA Centre published a scoping report (Kelly and Karsna, 2017) which highlighted that, despite greater awareness of the issue, significant gaps remain in how data about CSA is captured in the records of agencies working with people who experience or commit such abuse. Limitations were found in the recording and reporting of the duration and frequency of CSA, the contexts and locations in which it takes place, and even basic demographic information about the individuals involved.

In order to improve the quality of data recorded and reported, the scoping report proposed that agreement be reached on a common set of core data that all agencies working in the field of CSA could collect. Over the following months, the CSA Centre consulted a wide range of stakeholders to gather their views on what, at minimum, such a 'data collection template' should include; this enabled a draft template to be developed, containing categories related to the characteristics of CSA victims and perpetrators, the nature of abuse, and referral and disclosure routes.

As part of a series of exercises to pilot and test this template,<sup>1</sup> the CSA Centre funded Saint Mary's Sexual Assault Referral Centre (SARC) to adapt the template for the extraction of data retrospectively from the case files of almost 1,000 children and young people who had attended the SARC for a forensic medical examination over a three-year period. This data had been collected systematically by the SARC, but mostly on paper files which meant it could not easily be analysed.

## About Saint Mary's SARC

Established in 1986 as a response to deficiencies in the medico-legal response to rape, Saint Mary's SARC was the first centre of its kind in the UK; there are now more than 50 such centres across the country.

SARCs allow high-quality forensic medical examinations (also known as medical examinations, forensic evaluations or forensic assessments for sexual abuse) to take place in a designated and specialised space. In addition to providing forensic services following an allegation or suspicion of sexual assault, SARCs signpost to other supportive services such as independent sexual violence advisers (ISVAs) and counselling; some, including Saint Mary's, provide an integrated service with these professional groups on site.

Saint Mary's SARC provides this comprehensive and coordinated service to men, women and children living in Greater Manchester. There is a specialist team to support children, including a children's ISVA service which provides advice, support and advocacy in dealings with the criminal justice system by explaining the process, advocating on the child's behalf and ensuring they are kept informed of progress.

With a team of experts in advising, supporting and treating anyone who has been sexually assaulted, Saint Mary's remains the UK's largest single-centre SARC.

<sup>1</sup> Other pilots were commissioned to test the template and gather feedback from statutory children's services and police and third sector organisations. The findings from these will be published separately.



## About forensic medical examinations

A forensic medical examination involves a holistic assessment of a child's health and wellbeing after CSA has been disclosed or is suspected by other agencies. It is defined by the Royal College of Paediatrics and Child Health (RCPCH) and the Faculty of Forensic and Legal Medicine of the Royal College of Physicians (FFLM) as:

*"...[a] comprehensive assessment considering the physical development and emotional well-being of the child or young person against the background of any relevant medical, family or social history ... This enables a full evaluation of the degree of significant harm suffered, or likely to be suffered by the child ... Evaluating significant harm in sexual abuse includes not only the documentation of any genital and or anal injury but also any accompanying physical injury, the possibility of a sexually transmitted infection or pregnancy and the short/long term psychological or psychiatric sequelae. This assessment must also lead the planning of any ongoing investigation or treatment required by the child and appropriate reassurance for the child and family."* (RCPCH/FFLM, 2012)

Thus, besides potentially providing supportive evidence of abuse, a forensic medical examination can contribute to supporting the child or young person's physical and mental health needs.

More information is available on the CSA Centre website at [www.csacentre.org.uk/knowledge-practice/medical-examinations/](http://www.csacentre.org.uk/knowledge-practice/medical-examinations/)

## 1.1 Research aims

By populating fields in the data collection template with information already collected from children and young people attending the SARC, this project aimed to answer the following questions relating to the template's practicability and usefulness:

1. How applicable and adaptable was the data collection template to the data being collected by the SARC? Could the template be refined to make it more applicable by services or increase the quality of data obtained?
2. Does the data collection template provide a useful basis for understanding CSA in the SARC context? Specifically, what information does the extracted data provide about:
  - ▶ the demographic profile of children and young people who access the SARC?
  - ▶ the demographic profile of suspected perpetrators?
  - ▶ the nature and context of the CSA reported in case files?
  - ▶ the referral and disclosure routes by which children come to the SARC?

Because the data collection template focuses on the core data relating to CSA, it is expected that agencies adopting it will collect additional data according to their own priorities. Accordingly, Saint Mary's SARC included in the data extraction and analysis other data routinely collected at forensic medical examinations, relating to:

- ▶ the uptake by children and young people of its sexually transmitted infection (STI) screening and independent sexual violence adviser (ISVA) services
- ▶ the health needs – in terms of suicide risk, self-harm and substance misuse – of the children and young people using the service.

## 1.2 Research scope

In order to demonstrate the usefulness of the data collection template, this report sets out details of the characteristics and experiences of children and young people attending Saint Mary's SARC for a forensic medical examination. It is important to remember that the results are *not* representative of CSA more widely:

- ▶ The data is from only one, predominantly urban area (albeit a large one), Greater Manchester. We do not know how these results compare with the experiences of children and young people attending SARCs in other parts of the country.
- ▶ Research shows that most children and young people who experience CSA do not disclose their abuse at the time,<sup>2</sup> and not all whose abuse has been uncovered would attend a SARC. We do not know how these results compare with the characteristics and experiences of children and young people who experience CSA but do not attend a SARC.
- ▶ The data was collected from a service providing forensic medical examinations. The children and young people attending the SARC had all reported or been suspected of experiencing contact sexual abuse and, most commonly, penetrative sexual abuse. Non-contact sexual abuse is, therefore, entirely unrepresented in this study. In a small minority of case files involving suspected sexual abuse of younger children, the medical examination found an alternative explanation for the physical symptoms that had prompted concerns; not all the data, therefore, necessarily relates to incidents of CSA.

It is important to remember that the results of this study are not representative of CSA more widely

<sup>2</sup> The Crime Survey for England and Wales found that nearly three-quarters (74%) of survivors of childhood rape or penetrative abuse by adults did not tell anyone about the abuse at the time the abuse occurred (Office for National Statistics, 2016). Research by the Office of the Children's Commissioner (2015) estimated that only one in eight children and young people who experience sexual abuse are identified by professionals.

## 2. Method

Information relating to each forensic medical examination undertaken at Saint Mary's SARC is recorded and retained in paper files, following a standard pro forma developed by the SARC. Saint Mary's SARC collects detailed information about its 'service users' during the forensic medical examination. The initial basic data is recorded by the crisis worker who first sees the attending child or young person, and more detailed information about their history and the reported/suspected assault is collected by the doctor undertaking the examination.

### 2.1 Selection of case files

For this review, data was extracted from the files relating to all forensic medical examinations undertaken at the SARC between 1 April 2012 and 31 March 2015 involving children and young people aged under 18 years and living in Greater Manchester. The time period was chosen because, in addition to testing the data collection template, Saint Mary's wished to analyse subsequent uptake of the follow-up support it offers.

The addresses of the children and young people were recorded in the paper files, and those in postcodes outside Greater Manchester were excluded. All cases that related to substantiated, alleged or suspected CSA were included, both recent and non-recent. This included a small number of case files, relating to younger children, where the forensic medical examination found an alternative explanation to the physical symptoms that had prompted concerns of potential sexual abuse.

Applying these criteria, paper case files relating to 986 attendances by children and young people at Saint Mary's SARC were selected for data extraction. Nine children and young people had attended the SARC twice during this period; both attendances were included for each of them, because the attendances related to different incidences of reported abuse, taking place at different ages and suspected to be perpetrated by different people. (It is

notable that all nine service users were aged 12–17, and most were known to child sexual exploitation services.) The dataset therefore includes data on 977 service users.

### 2.2 Selection of data fields for analysis

The data available for extraction and analysis was limited to the existing data recorded in the SARC's case files over the three-year period; no primary data was collected for this project.

The CSA Centre's 'data collection template' captures information about the victims of abuse, the perpetrators, the context of the abuse, and the people and services involved in referral and disclosure:

- ▶ The sections devoted to victims and perpetrators contain data on their characteristics (including age, gender, ethnicity, disability and long-term health issues) and the relationship between victim and perpetrator.
- ▶ Data relating to the context of abuse includes the duration, frequency, nature and location of abuse, and perpetrators' control and entrapment strategies.
- ▶ The final section contains data on who disclosed or reported the abuse, which agency received the disclosure and which agencies were involved in assessing and supporting the child.

The template is designed for use by a wide range of agencies; it is not envisaged that each agency will adopt the template in its entirety, as data in some fields is more likely to be collected in some service settings than in others.

Saint Mary's SARC reviewed the data collection template and considered that, in 23 of the template's 36 fields, its case files would contain data recorded systematically using its pro forma. To extract this data from the case files, a data extraction tool (set out in Appendix 1) was developed.

Other fields in the data collection template were excluded from the data extraction tool because it was thought that the information would not be available in sufficient numbers and/or quality for analysis. These related to:

- ▶ the sexual orientation and country of birth of the service user and the suspected perpetrator
- ▶ the frequency of the reported abuse
- ▶ whether the suspected perpetrator had previously been a suspect or convicted in a CSA investigation
- ▶ whether the suspected perpetrator had been previously charged with CSA offences
- ▶ whether the suspected perpetrator used any entrapment/control strategies (e.g. drugs, alcohol, presents, promise of protection)
- ▶ whether the reported abuse involved an element of exchange (e.g. financial, or love and affection) and a perceived gain to the service user or the perpetrator
- ▶ whether the reported abuse involved trafficking of the service user
- ▶ the online medium used (where online communication was a part of the reported abuse)
- ▶ the police investigation outcome, in cases reported to the police.

It was known that the level of detail on the Saint Mary's SARC pro forma was lower in some data fields (e.g. disability) than the level recommended by the data collection template, while in other fields (e.g. the nature of abuse) it categorised the data in greater detail. The data extraction tool was adapted pragmatically from the template in order to collect the data that was available in case files; this is in line with the way the data collection template is intended to be used by services, as a tool that can be adapted to take into account the needs and priorities in each specific service setting.

## 2.3 Extraction and analysis of data

Paper files relating to each forensic medical examination were reviewed by medical students on placements at Saint Mary's SARC, to extract standardised data and record it on the data extraction tool. The medical students received training to give them a good understanding of the pro forma and an appreciation of what happens in medical examinations; they were also offered clinical supervision during the extraction process, as the SARC recognised the potential impact of reading so many case files in detail.

Following extraction, the data was first entered into an Excel spreadsheet and subsequently transferred to IBM SPSS software by the CSA Centre. Frequencies were calculated for each data field. The data was then analysed by age (grouped into 0–11 and 12–17 years<sup>3</sup>) and by gender, in order to understand any age and/or gender differences. Substantial differences are noted in this report.

## 2.4 Limitations of the research method

The data in the case files did not enable analysis of whether any individual suspected perpetrators appeared in the case files of multiple service users. Some double counting of suspected perpetrators is therefore possible within the dataset.

## 2.5 Ethical considerations

The project was reviewed and approved by the CSA Centre's Research Ethics Committee. The Health Research Authority advised that this project was exempt from ethical approval requirements and would be considered as a service evaluation, since it retrospectively reviewed non-generalisable data that had been collected as part of routine care. In accordance with data protection procedures, all data was anonymised.

3 While it is acknowledged that the age of onset of puberty varies, the age bands '0–11 years' and '12–17 years' were selected to describe the differing patterns of abuse among pre- and post-pubescent children.

## 3. Results

In this chapter:

- ▶ the term 'service user' refers to any child or young person aged 0–17 attending Saint Mary's SARC for a forensic medical examination following substantiated, suspected or alleged CSA
- ▶ the term 'reported abuse' refers to CSA that a service user said they had experienced, or that they were suspected of having experienced, as recorded in case files
- ▶ the term 'suspected perpetrator' refers to anyone (regardless of their age) who a service user said had sexually abused them, or who was suspected of having sexually abused them, as recorded in case files.

In some categories, the results are presented broken down by age and gender; this enables us to understand the differing patterns related to CSA among younger children and adolescents, and among boys and girls.

### 3.1 Levels of data collection

Because Saint Mary's SARC collects thorough data systematically during the forensic medical examination, it was anticipated that the data recorded in each case file would be reasonably complete. This proved to be the case – for most fields in the data extraction tool, at least 90% of the case files contained relevant data.

Where data was missing from a sizeable number of case files, the age of the service user often appeared to be a significant factor (see Figure 1):

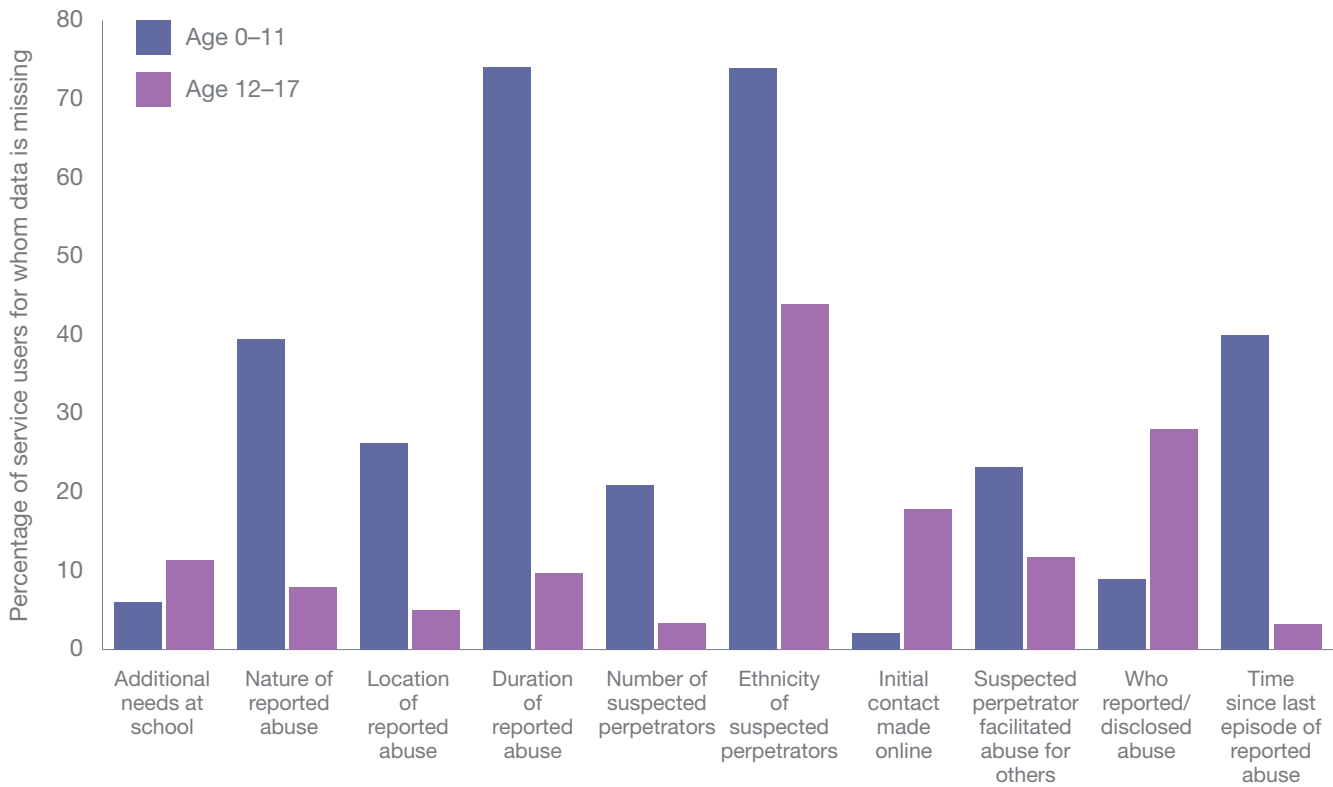
- ▶ Data relating to several aspects of the context and nature of reported abuse – the duration, location and forms of abuse, as well as the number of perpetrators – was missing from many files of younger children (aged 0–11). In some cases, this may be because the child was referred for unexplained physical symptoms (such as redness) and it was unclear whether any abuse had taken place at all. It may also be related to younger children's propensity to give unclear verbal disclosures, or not to make verbal disclosures at all, in which case it is likely to be replicated when data on CSA is collected from younger children in other settings.
- ▶ The ethnicity of the suspected perpetrator(s) of abuse was missing from 59% of the case files, including 74% of those relating to children aged 0–11. The SARC collects suspected perpetrator ethnicity data in order to make assessments regarding possible contraction of HIV or hepatitis B, and this data was not considered relevant by the clinicians in all cases (depending on the nature of the reported abuse and the time since it occurred).
- ▶ Data in two fields – whether the initial contact was made online and who disclosed the reported abuse – was more frequently missing from the files of older children (aged 12–17).



Where data was missing from a sizeable number of case files, the service user's age often appeared to be a significant factor



Figure 1. Missing data from case files



n=986. Fields shown are those for which data was missing in at least 10% of the case files relating to service users aged 0-11 and/or those aged 12-17.

### 3.2 Characteristics of service users

#### Age and gender

This study involved 986 case files representing attendances by children and young people aged under 18 at Saint Mary’s SARC for a forensic medical examination between April 2012 and March 2015.

Girls accounted for 86% (843) of these service users, and boys 14% (142). Children aged 0-11 made up 49% (483) of the total.

Boys represented approximately one-quarter of service users up to the age of 11, but only 6% of those aged 12-17 (see Figure 2). Accordingly, boys attending the SARC were younger on average than girls – the median age for boys was 6 years, and for girls 13 years.

Prevalence surveys have shown that girls are more likely to experience CSA than boys. Based on these surveys, the CSA Centre’s scoping review estimated that around 15% of girls and 5% of boys would experience some form of CSA before the age of 16 (Kelly and Karsna, 2017).

However, there is also evidence that professionals perceive abuse of girls and boys differently: they have more difficulty in viewing boys as victims of CSA compared to girls, and perceive CSA’s impact as being smaller on boys than on girls (Brayley et al, 2014; Harper and Scott, 2005; Harris and Robinson, 2007; Maikovich-Fong and Jaffee, 2010; von Weiler et al, 2010).

In the Crime Survey for England and Wales, the prevalence of CSA was found to peak at the age of 11 for boys and then drop throughout the teenage years; for girls, the rate of CSA remained stable from ages 7-15 (Office for National Statistics, 2016). However, this survey asked only about adult perpetrators and included only a limited number of questions relating to ‘sexual assault’.

**Ethnicity**

Of the 970 service users whose ethnicity was recorded, a large majority were white (82%, 794); a further 5% (46) were Asian, 5% (50) were black and 8% (75) were of mixed ethnic backgrounds.

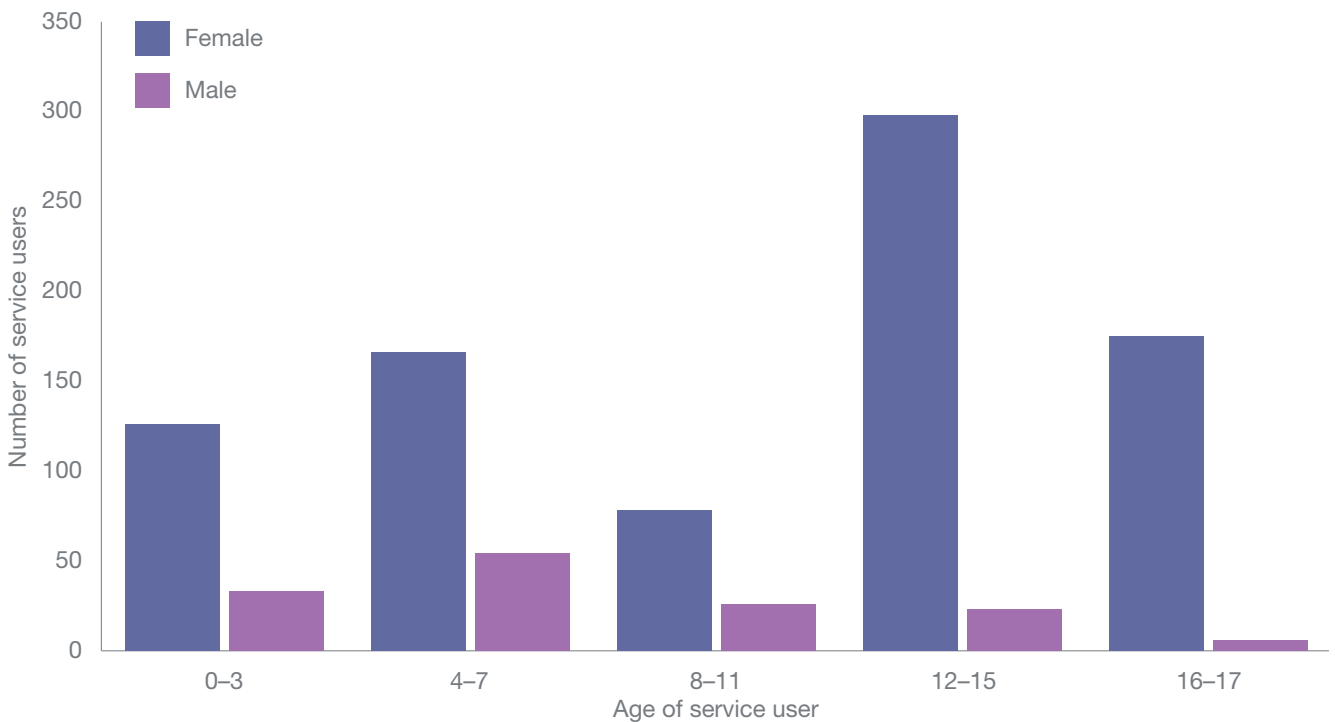
As Figure 3 shows, white British children and young people formed by far the largest group of service users (79%, 770). The largest other ethnic groups recorded were African (30), white and black Caribbean (29), 'white other' (22) and Pakistani (21). The ethnicity of 16 service users was unknown or not recorded.

Overall, 21% of the SARC's service users were of black, Asian and minority ethnic (BAME) backgrounds.<sup>4</sup> Breaking down the results by age and gender, we see that younger girls (aged 0–11) were the most diverse group, with 25% (92) of them being of BAME backgrounds.

In January 2015, 31% of children and young people attending state primary, secondary and special schools in Greater Manchester were of BAME backgrounds (Department for Education, 2015a). This suggests that BAME children and young people are under-represented among those attending Saint Mary's SARC for a forensic medical examination.

Research has found that BAME children are less likely to access CSA support services than their white peers (Gilligan and Akhtar, 2006; Allnock et al, 2012; Warrington et al, 2017). CSA occurs in all kinds of families and across all races and ethnicities (although no UK prevalence study has analysed levels of CSA in different ethnic groups), but there are differences in the extent to which abuse is reported and responded to: high levels of secrecy, shame and stigma within some BAME groups, combined with cultural assumptions by professionals, can increase barriers to disclosure (Brown et al, 2011; Gilligan and Akhtar, 2006).

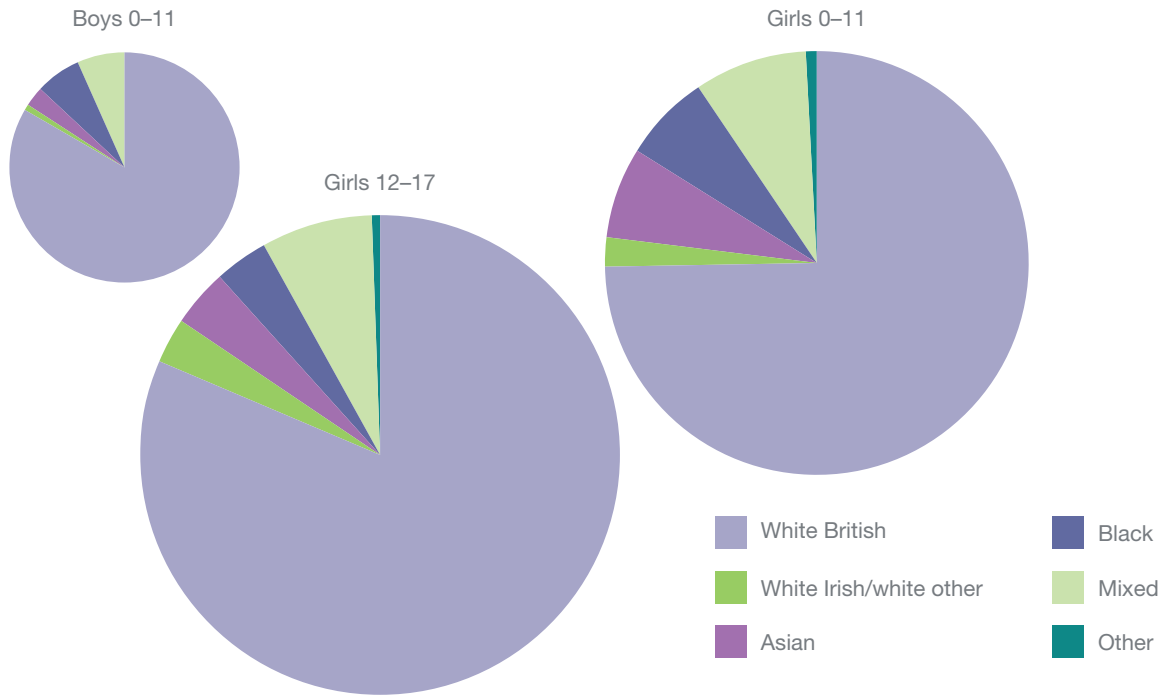
**Figure 2. Age and gender of service users**



*n=985; one file did not contain information about child's age.*

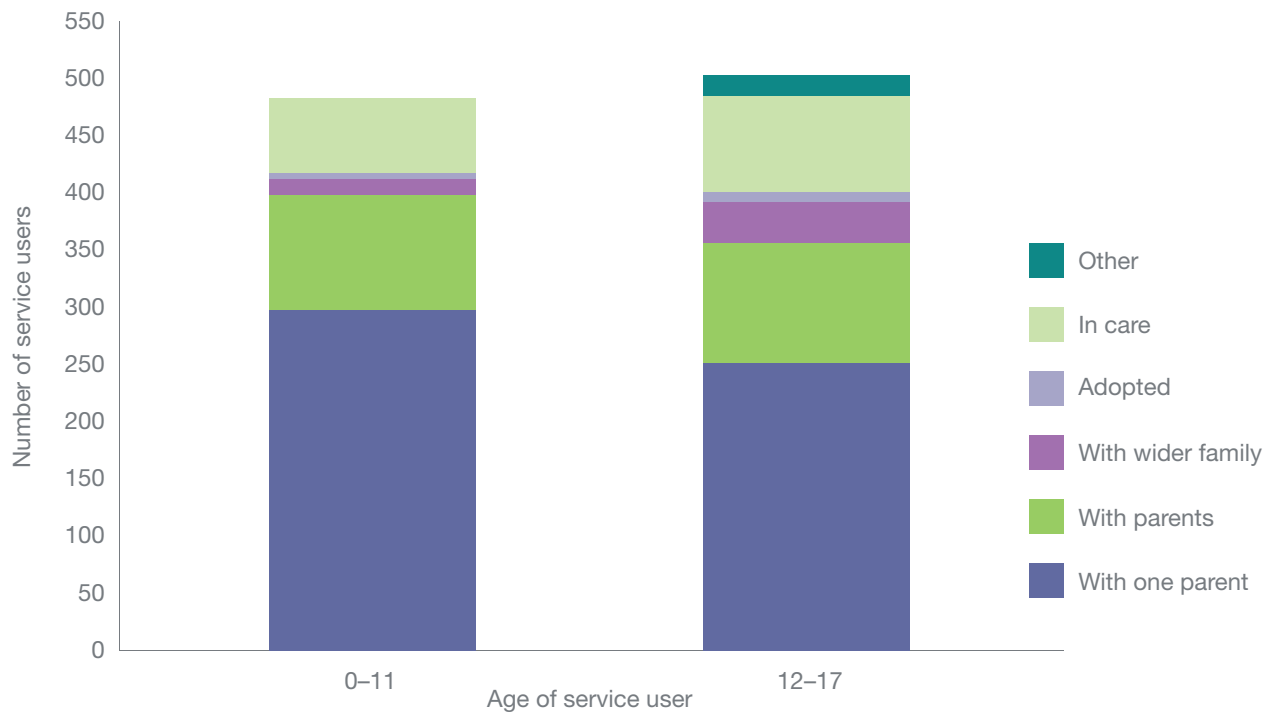
<sup>4</sup> In line with the definition used by the Department for Education (2015a), children and young people from white non-British backgrounds are included here within the definition of BAME.

Figure 3. Ethnic background of service users



Girls aged 0-11: n=364; six files did not contain information about child's ethnicity.  
 Girls aged 12-17: n=469; five files did not contain information about child's ethnicity.  
 Boys aged 0-11: n=108; five files did not contain information about child's ethnicity.  
 Insufficient data on boys aged 12-17 (n=29) for analysis.

Figure 4. Service users' living arrangements



Service users aged 0-11: n=483. Service users aged 12-17: n=503.



### Living arrangements

More than half (56%, 549) of service users lived with one parent (including single parents with partners who did not live in the family home), and one-fifth (21%, 205) with two parents (including step-parents).

The remainder did not live with either birth parent: 15% (149) were in care, 5% (50) lived with their wider family and 2% (15) were adopted. A small number (2%, 18) were girls aged 12–17 with 'other' living arrangements, including several in temporary or independent accommodation, homeless or living with a partner.

Figure 4 shows the data broken down by age of service user (but not by gender, owing to the small number of boys in certain categories): it shows that younger children were more likely than older ones to be living with at least one birth parent. The pattern of living arrangements between boys and girls aged 0–11 was similar, except that boys were less likely to be living with both parents and more likely to be living in care. Comparisons between girls and boys aged 12–17 could not be made, owing to the lack of male service users in this age group.

In the 732 case files where the information was available, more than a quarter (26%, 194) of the children and young people were at the time or had been previously on a child protection plan (CPP) or identified as a 'child in need'.

In 2015, an estimated 23% of dependent children<sup>5</sup> in the UK lived in single-parent families (Office for National Statistics, 2015); this indicates that children living with one parent were significantly over-represented among Saint Mary's SARC service users.

Although comparative figures are not readily calculated for children living in care and those who were or had been on CPPs or child in need plans, these children appear to have been over-represented among the SARC's service users. In the single year 2015, around 7.4% of children in Greater Manchester were assessed as being children in need or were on CPPs (Department for Education, 2015b).<sup>6</sup>

A review of literature on risk indicators for CSA found evidence that children in out-of-home care were more likely to have experienced CSA than those living at home (Brown et al, 2016). Children in residential care have been found to be at the highest risk (Euser et al, 2013). Research from the USA found that children living in families with a single mother and their live-in partner were 20 times more likely to experience CSA than children living with two biological parents (Sedlak et al, 2010).



More than one-quarter of service users had at some point been on a 'child in need' or child protection plan



5 'Dependent children' were defined as those who were living with their parent(s) and aged under 16, and those aged 16–18 who were in full-time education. The figure excluded children aged 16–18 who had dependent children, and/or had a partner or spouse living in the household.

6 This figure may include double counting: if a child had more than one episode of being a child in need, both episodes were counted. Additionally, the figure is not directly comparable to Saint Mary's SARC data because it does not include children who had been in need or on protection plan in previous years.

*Physical/learning disabilities and additional needs at school*

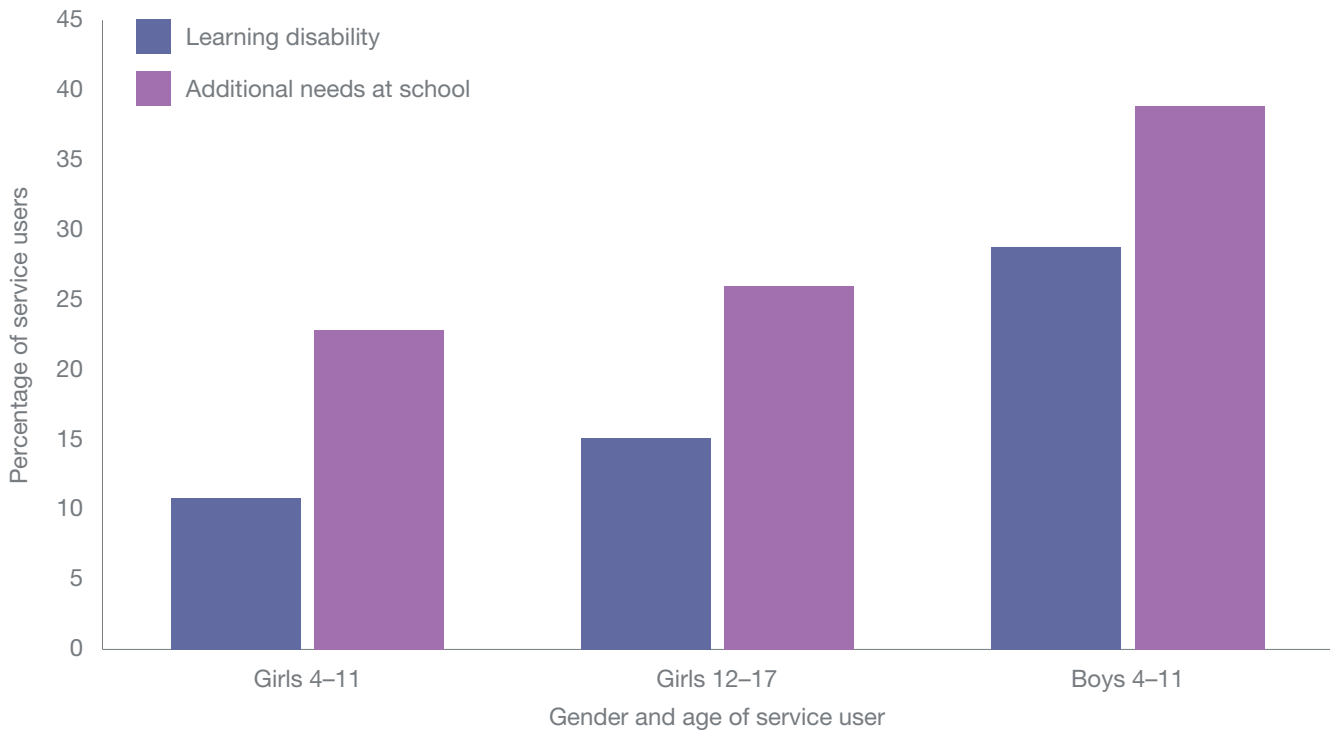
A physical disability was reported in the case files of 1.5% (12) of school-aged service users.<sup>7</sup>

A self-reported learning disability was noted in 16% (128) of the 790 case files of school-aged children (aged 4–17) which recorded this information. Of the 740 school-aged children who stated whether they had additional needs at school, more than a quarter (27%, 201) said they did. Boys were more likely than girls to have a learning disability or additional needs at school; see Figure 5.

The special educational needs census in January 2015 found that the proportions of state-school pupils in Greater Manchester with physical and learning disabilities were 0.7%<sup>8</sup> and 4%<sup>9</sup> respectively (Department for Education, 2015a) – considerably lower than the proportions of the SARC’s service users reporting such disabilities.

Jones et al (2012) found that disabled children in all settings were more likely than non-disabled children to be at risk of CSA and have experienced sexual violence (and other forms of maltreatment); children with ‘intellectual or mental disabilities’ were at higher risk than those with other disabilities.

*Figure 5. Learning disabilities and additional needs at school*



*Girls aged 4–11: n=231 (learning disability), n=223 (additional needs); information about learning disability and additional needs was missing from 13 and 21 case files respectively.*

*Girls aged 12–17: n=457 (learning disability), n=419 (additional needs); information about learning disability and additional needs was missing from 16 and 54 case files respectively.*

*Boys aged 4–11: n=73 (learning disability), n=72 (additional needs); information about learning disability and additional needs was missing from seven and eight case files respectively.*

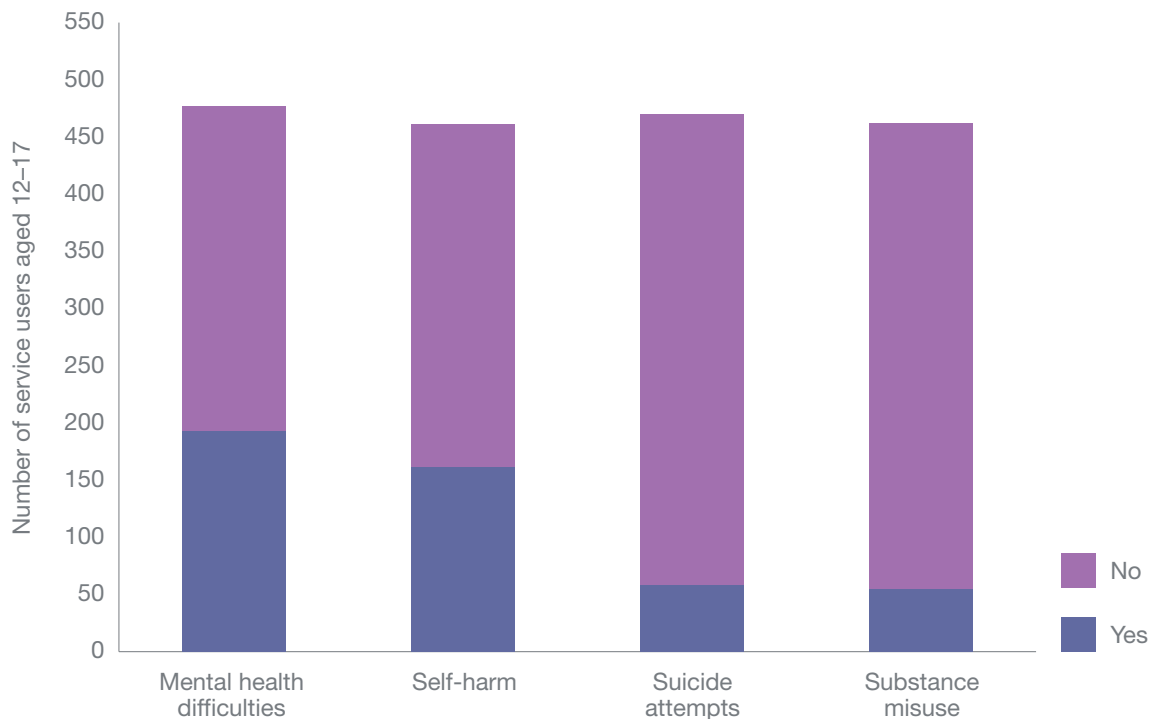
*Insufficient data on boys aged 12–17 (n=29) for analysis.*

7 'Physical disability' as recorded in Saint Mary's SARC case files includes self-reported disabilities related to vision, hearing and mobility.

8 The special educational needs census included categories for vision, hearing, multi-sensory and physical disability; these categories were combined to calculate this figure.

9 Using guidelines published by Public Health England (Learning Disabilities Observatory, 2016), the special educational needs census considered children to have a learning disability if they were recorded by their school as having 'moderate learning difficulty', 'severe learning difficulty' or 'profound and multiple learning difficulty'.

Figure 6. Self-reported mental health issues and substance misuse among older service users



Mental health difficulties: n=477; 26 case files of service users aged 12–17 did not contain information.

Self-harm: n=461; 42 case files of service users aged 12–17 did not contain information.

Suicide attempts: n=470; 33 case files of service users aged 12–17 did not contain information.

Substance misuse: n=462; 41 case files of service users aged 12–17 did not contain information.

### Mental health difficulties

As Figure 6 shows, mental health difficulties were noted among many of the older service users (aged 12–17) who provided information on this topic: 40% (193) reported having had mental health difficulties, 35% (161) reported self-harming and 12% (58) said they had attempted suicide.

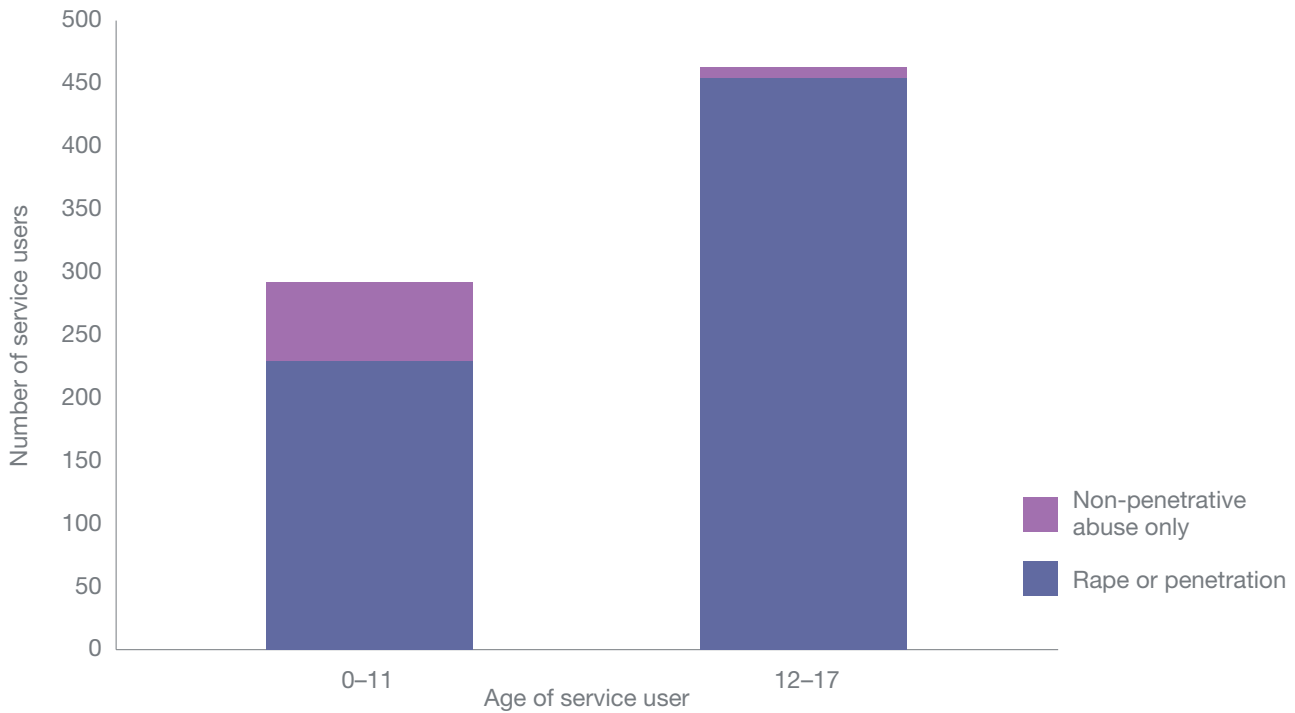
Substance misuse was also reported by the older age group: among the 462 service users aged 12–17 for whom information was available, 12% (55) reported drug or alcohol problems.

The case files of 474 children aged 0–11 contained information about their mental health; fewer than 3% (12) indicated that the child had any mental health difficulties.

From the data recorded, it is not possible to infer whether the difficulties described above preceded or followed service users' reported abuse, although such difficulties have been established as frequent coping mechanisms for CSA (Fisher et al, 2017).

Substance misuse was listed as a 'potential risk indicator' for CSA by Brown et al (2016). A study from the Havens SARC in London found a very high incidence (80%) of mental health disorders among its sample of 134 girls aged 13–17 who had been sexually assaulted (Khadr et al, 2018).

Figure 7. Types of reported abuse



'Rape or penetration' encompasses the categories 'Anal rape', 'Oral rape', 'Vaginal rape' 'Digital penetration' and 'Object penetration'.

'Non-penetrative abuse' encompasses the categories 'Forced to perform a sexual act' and 'Other non-penetrative assault'. Up to three forms of abuse could be reported by each service user. Where a service user reported both penetrative and non-penetrative abuse, the service user is recorded here under 'Rape and penetration'.

Service users aged 0-11: n=292; 191 files did not contain information about forms of abuse.

Service users aged 12-17: n=463; 40 files did not contain information about forms of abuse.

### 3.3 Nature and context of reported abuse

This section looks at the nature and context of reported abuse in the case files of Saint Mary's SARC. It is important to note that SARCs serve children and young people who disclose or are suspected to have experienced predominantly contact sexual abuse; the results are not generalisable to CSA more widely.

Further, as noted in section 3.1 above, a sizable proportion of evidence was missing in the files of younger children on the nature of reported abuse and the suspected perpetrators. This may in part have been a feature of visits to the SARC prompted by physical symptoms rather than verbal disclosure, where details of potential abuse (or, indeed, whether any abuse took place at all) were unclear.

#### Nature of reported abuse

Service users (or their parents/carers) were asked to describe the abuse they had experienced (or were suspected of having experienced where there was no verbal disclosure). Information was then categorised into types of abusive act – including different forms of rape or penetration, being made to perform a sexual act, and other kinds of sexual touching. In case files where more than one type of abuse was disclosed, up to three were recorded for this analysis. There was no disclosure in nearly a quarter (23%, 231) of case files, mostly those related to children aged 0-11.

Of the 755 case files in which types of abusive act were described, a large majority (90%, 683) contained descriptions consistent with rape or penetrative abuse – see Figure 7.

One type of abuse was described in 56% (424) of these 755 case files, two types of abuse in 30% (227) and three types of abuse in 14% (104). Older service users were more likely to report three types of abuse: 17% (79) of those aged 12–17 did so, compared with 9% (25) of younger children or their parents/carers.

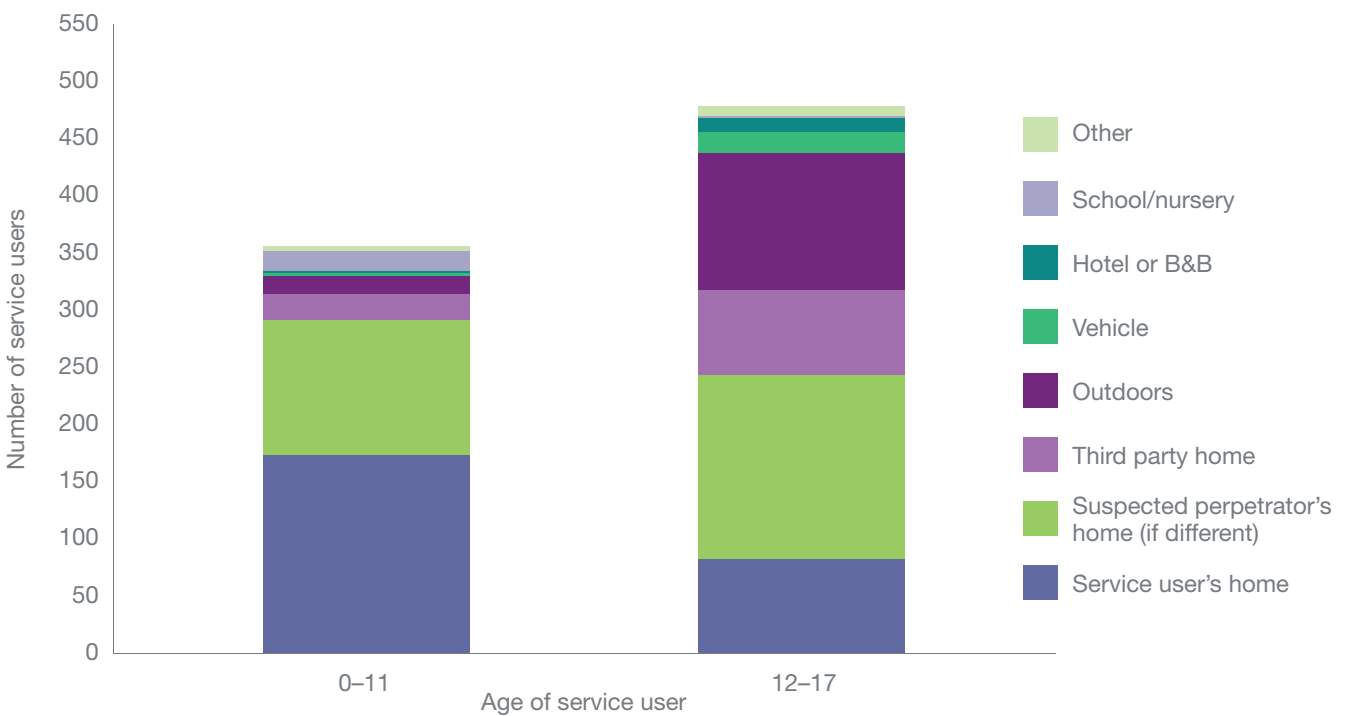
A total of 1,190 abusive acts were described across the 755 case files. Over three-quarters of these (77%, 920) related to rape or penetration. The most frequently recorded forms of rape and penetration included vaginal rape (398), digital or object penetration (279) and anal rape (132). Nearly a quarter of the abusive acts recorded (23%, 270) were categorised as non-penetrative abuse: either performing a sexual act (107) or other sexual touching (163).

The abusive acts described differed by age and gender. Older service users reported rape and penetrative acts relatively more frequently than younger ones. Gender differences were found in the type of rape or penetrative abuse reported – anal and oral rape were more commonly reported in the case files of boys

than those of girls. Vaginal rape accounted for 39% of reported abusive acts against girls, and digital penetration was also reported to be experienced by a greater proportion of girls than boys.

Surveys looking at self-reported CSA prevalence in the general population report much lower rates of penetrative sexual abuse. For example, the Crime Survey for England and Wales (Office for National Statistics, 2016) found that, of the respondents who reported sexual assault by adults in childhood, 24% said it was rape or penetrative abuse (including attempts) and 74% described 'other sexual assault' (including indecent exposure and unwanted touching). The higher incidence of penetrative abuse observed at Saint Mary's SARC may be related to the service setting (being referred for a forensic medical examination).

Figure 8. Location of reported abuse



Service users aged 0–11: n=356; 127 files did not contain information about location of abuse.  
 Service users aged 12–17: n=478; 25 files did not contain information about location of abuse.

### Location of reported abuse

Figure 8 shows that, in the 834 case files in which the location of the reported abuse was recorded, three-quarters (76%, 631) recorded it as taking place in a domestic setting – nearly a third (31%, 255) in the service user’s own home, slightly more (33%, 279) in the suspected perpetrator’s home (if this was different to theirs), and more than one-tenth (12%, 97) in a third party’s home.

The child’s own home was the most common location of reported abuse of younger children – nearly one half (49%, 173) of service users aged 0–11 reported or were suspected of being abused in their home, compared to 16% (82) of the older age group.

Other than domestic settings, ‘outdoors’ was the most frequently reported location of abuse – 16% (135) of case files recorded abuse taking place outdoors, including more than a quarter (28%, 120) of the files of service users aged 12–17.

Other settings – schools, nurseries, hotels, bed and breakfasts, and vehicles – were reported in a small number of case files. ‘Other’ locations, recorded in 14 case files, included holiday locations and cases of abuse in multiple locations.

Information about the location of the reported abuse was absent in the files of more than a quarter (26%, 127) of younger children, but only 5% (25) of the older age group.

Other research confirms domestic setting as the most common location of abuse. For example, the Crime Survey for England and Wales (Office for National Statistics, 2016) found that 45% of respondents reporting rape or penetrative sexual abuse by adults said it took place in ‘someone else’s home’ and 39% said it happened in their ‘own home’.

### Duration of reported abuse

The duration of the reported/suspected abuse was unclear or not recorded in two-fifths (41%, 407) of case files, including three-quarters of those relating to children aged 0–11.

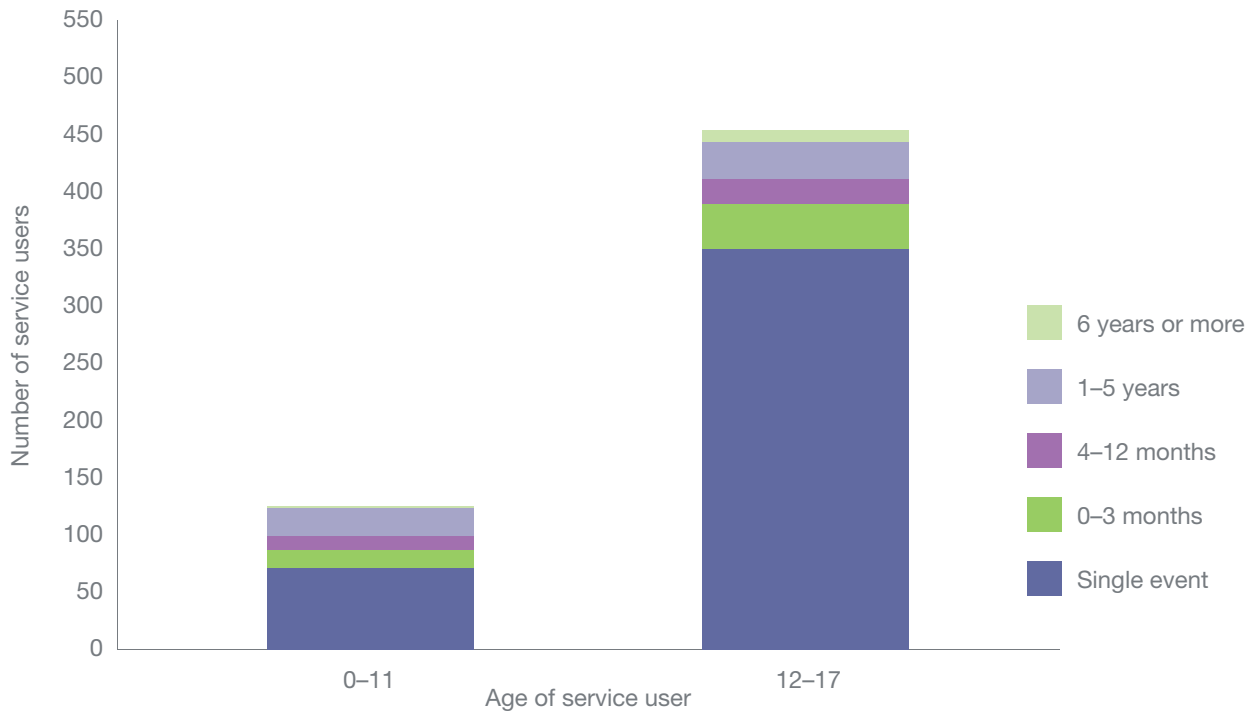
Older service users, aged 12–17, described ‘single event’ abuse incidences most frequently – 77% (350) said they had been assaulted once (see Figure 9), although this was less likely to be reported by the small number of older boys than by older girls. Both older and younger boys were more likely than girls to report abuse lasting more than a year.

The duration of abuse described in prevalence surveys is different from that observed at Saint Mary’s SARC: among respondents reporting rape or penetrative abuse in childhood by adults in the Crime Survey for England and Wales (Office for National Statistics, 2016), only 37% said it lasted ‘less than a year’, and 19% reported abuse lasting for five years or more. There was little difference in the duration of abuse reported by males and females.

However, the profile of children coming to the attention of services may differ according to gender: some studies (e.g. O’Leary and Barber, 2008) have found that boys come to the attention of services after longer periods of abuse than girls.

In three-quarters of case files, the reported abuse was described as taking place in a domestic setting

Figure 9. Duration of reported abuse



Service users aged 0-11: n=125; 358 files did not contain information about duration of abuse. Service users aged 12-17: n=454; 49 files did not contain information about duration of abuse.

### 3.4 Suspected perpetrators of abuse

This section describes the characteristics of individuals suspected of committing abuse, as described in the Saint Mary's SARC case files: their gender, their age, their relationship to the service user and whether they acted alone or in pairs/groups. As noted in section 3.1, an attempt was made to extract data about the ethnicity of the perpetrator, but this was recorded in insufficient numbers to be reported here.

#### Number of suspected perpetrators

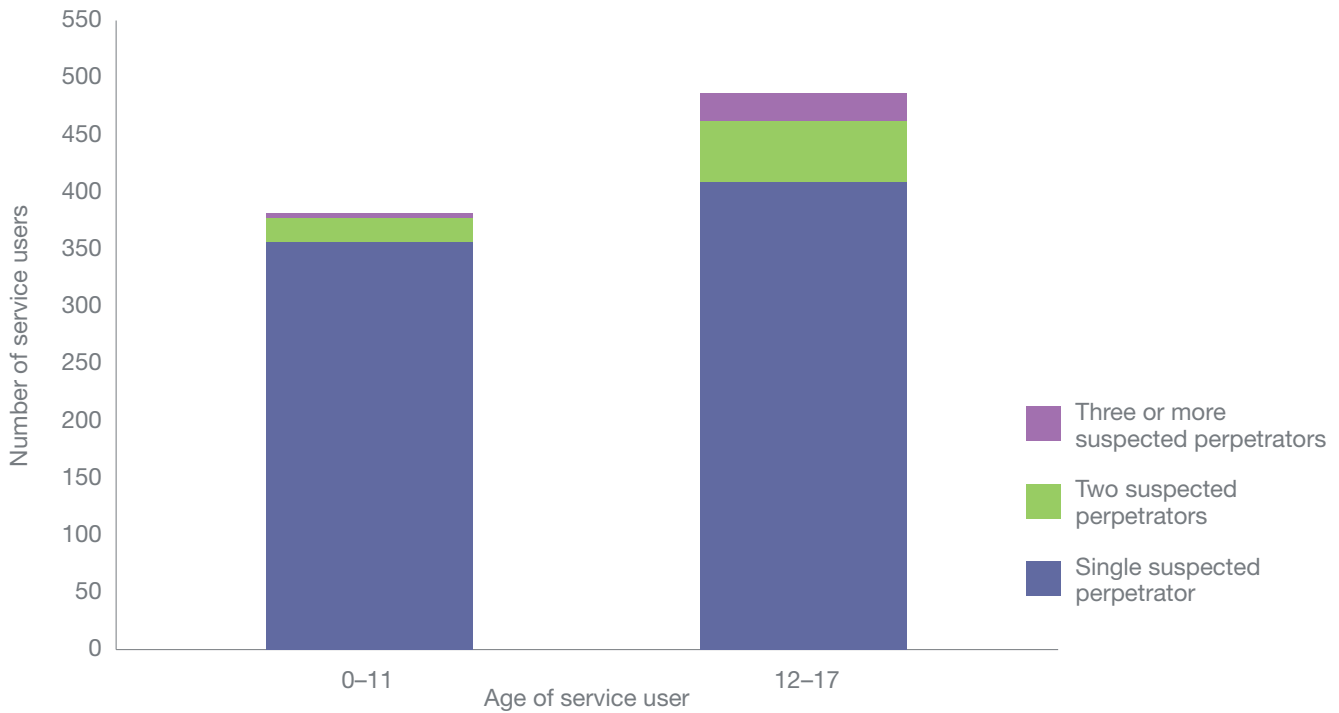
Although 118 case files – including one-fifth (21%, 101) of those relating to younger children – did not include information about the number of people involved in the reported abuse, almost one in eight (12%, 103) of the remaining 868 files featured reported abuse by multiple perpetrators who committed CSA together during the same abusive episode or incident; see Figure 10. Abuse by multiple perpetrators was reported by 16% (77) of older service users, and was more commonly reported in the case files of younger boys (15%, 14) than younger girls (4%, 12).

#### Gender of suspected perpetrators

Gender information was recorded about 1,006 suspected perpetrators in the files of 869 service users; 117 files did not contain this information. The overwhelming majority of suspected perpetrators (97%, 972) were male; this was the case for all ages and genders of service users.

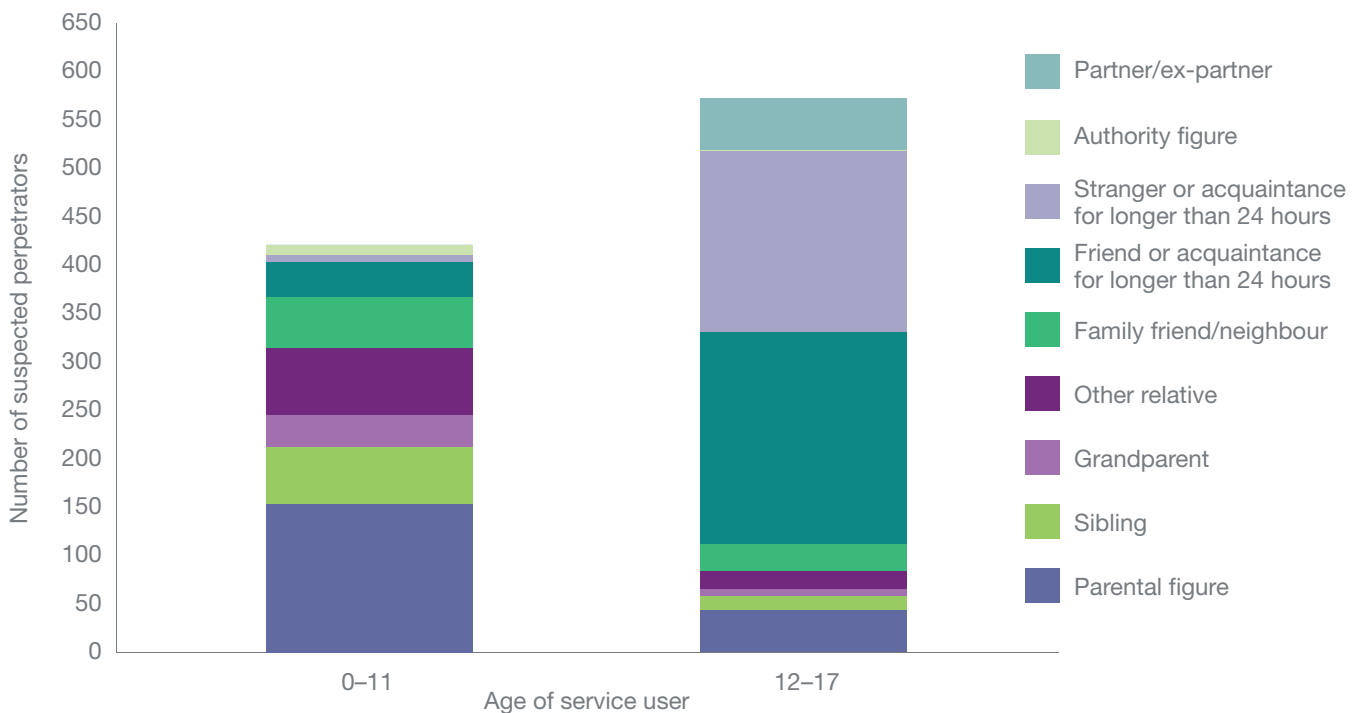
In one-third (11) of case files where a suspected perpetrator was female, she was recorded as having committed abuse together with a male perpetrator. The case files of 7% (28) of younger children involved a female suspected perpetrator; the proportion was lower for service users aged 12-17.

Figure 10. Number of suspected perpetrators in reported cases of abuse



Service users aged 0-11: n=382; 101 files did not contain information about number of suspected perpetrators.  
 Service users aged 12-17: n=486; 17 files did not contain information about number of suspected perpetrators.

Figure 11. Relationship between suspected perpetrator and service user



Service users aged 0-11: n=421 suspected perpetrators. 95 files did not contain information about suspected perpetrator's relationship to service user.  
 Service users aged 12-17: n=572 suspected perpetrators. 25 files did not contain information about suspected perpetrator's relationship to service user.



It is firmly established in international surveys that males form the majority of perpetrators of CSA (Kelly and Karsna, 2017). However, neither of the two UK prevalence surveys (Radford et al, 2011; Office for National Statistics, 2016) published information on the respective proportions of male and female perpetrators.

Some research has indicated that children abused by a female family member can face higher levels of disbelief from professionals, who may also minimise the seriousness of such abuse (Clements et al, 2014).

### *Relationship between suspected perpetrators and service users*

Where multiple individuals were reported to be involved in abuse, each case file recorded information about up to three of them. In total, case files contained data on the relationships between 993 suspected perpetrators and their victims; 120 case files did not contain any information about the suspected perpetrator's relationship to the child or young person.

Figure 11 shows that, overall, the case files recorded slightly more extra-familial (52%, 515) than intra-familial (48%, 478) suspected perpetrators of abuse. Abuse by intra-familial perpetrators (parents, siblings, other relatives and family friends) was much more frequently reported in the case files of the younger age group: 87% (374) of those suspected of abusing children aged 0–11 were people in their family environment. Conversely, 81% (461) of suspected perpetrators of abuse against service users aged 12–17 were people outside their family (partners/ex-partners, friends, acquaintances or strangers). Authority figures – in most cases, nursery or school staff – made up a small number of extra-familial suspected perpetrators (13).

Parental figures (including birth parents, step-parents and foster carers) were the intra-familial perpetrators most commonly recorded for all gender/age groups of service user, making up one-fifth of all suspected perpetrators and more than one-third (36%, 153) of those suspected of abusing children aged 0–11. Siblings were also recorded more commonly in the case files of younger children, representing 14% (59) of suspected perpetrators of abuse against this age group.

A 'friend or acquaintance' of the child or young person was the most frequently recorded type of extra-familial suspected perpetrator: they accounted for one-quarter (26%, 256) of all suspected perpetrators, and the vast majority of them (86%, 220) featured in the case files of service users aged 12–17. One-fifth (19%, 193) of all suspected perpetrators were 'strangers or lesser-known acquaintances', with 96% (186) of them featuring in the older age group's case files.

The individuals reported most frequently to have offended together or in groups were strangers or new acquaintances of the child or young person: 30% (57) of suspected perpetrators who had been known to the service user for less than 24 hours were recorded as committing CSA in pairs or groups. Multiple abusers were sometimes reported to be a feature of intra-familial abuse too: 9% (8) of 'other relatives' identified as suspected perpetrators in case files were reported to have committed abuse in pairs or groups. Eight case files reported both intra-familial and extra-familial suspected perpetrators.

Males made up a large majority of suspected perpetrators in all relationship categories. Where information about female suspected perpetrators' relationship with the service user was recorded, two-thirds (19) of them were intra-familial.

In the Crime Survey for England and Wales (Office for National Statistics, 2016), intra-familial perpetrators (parents or other adult relatives) were described by 42% of respondents reporting rape or penetrative abuse in childhood; 30% said the perpetrator was a 'friend or acquaintance', and 14% a 'stranger'. This survey asked only about adult perpetrators.

There is also evidence that abuse in the family generally starts at a younger age than extra-familial CSA (Fischer and McDonald, 1998).

**Age of suspected perpetrators**

Information about the age of 918 suspected perpetrators of abuse was recorded in 819 case files. As Figure 12 shows, nearly one-third (31%, 284) of suspects were aged under 18.

Under-18s made up a higher proportion (40%, 41) of individuals suspected of abuse against boys aged 0–11; against both younger and older girls, they represented approximately 30% of suspects.

Information about both the age of the suspected perpetrator and their relationship with the service user was available for 902 suspected perpetrators.

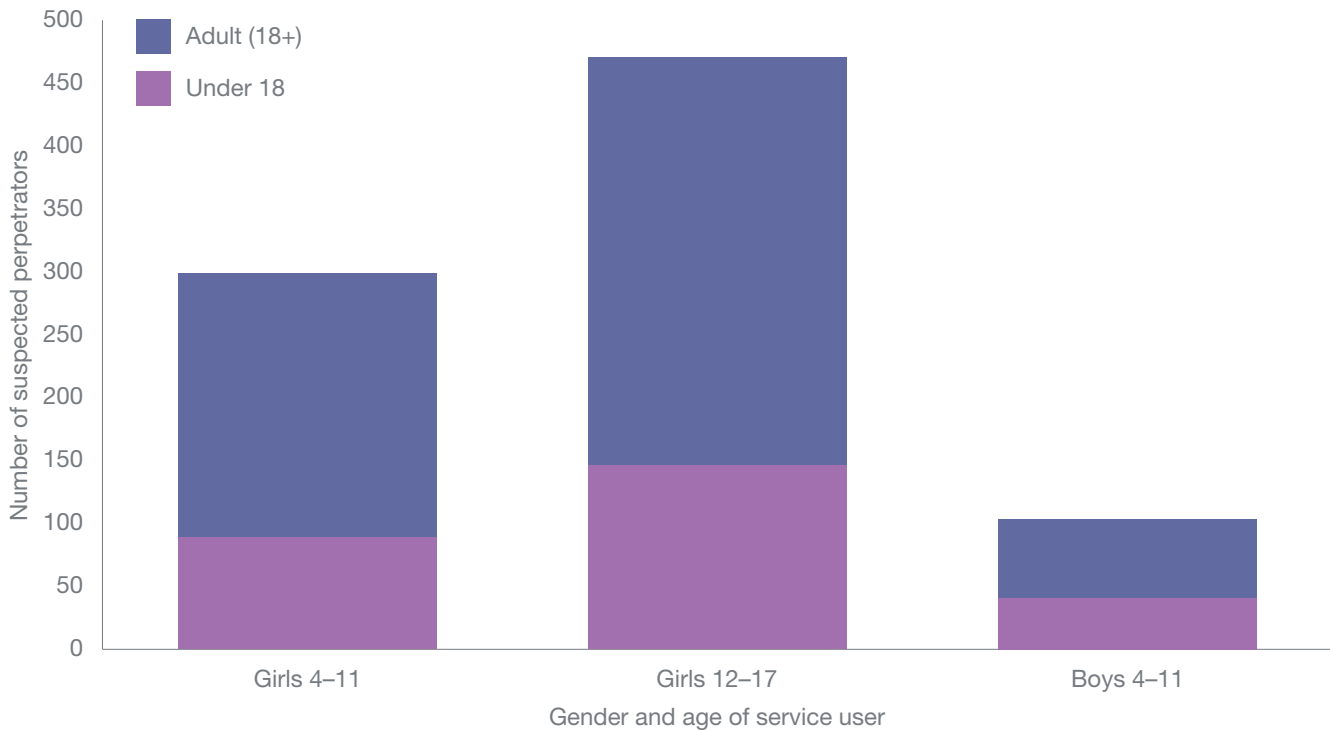
Figure 13 shows that, among individuals aged under 18 suspected of committing abuse, the most frequently recorded type were ‘friends or acquaintances for more than 24 hours’ of the service user (43%, 120); the majority (60%, 88) of under-18s suspected of abusing older girls were friends and acquaintances. In total, almost three-fifths (58%, 164) of all under-18s suspected of abuse were extra-familial

(the service users’ friends or acquaintances, strangers or new acquaintances, or partners/ex-partners). Siblings accounted for a further 20% (57) of under-18s suspected of abuse.

Among adults, parental figures accounted for almost one-third of suspected perpetrators (31%, 193), and more than three-quarters of them were suspected of abusing children aged 0–11 – see Figure 14. Where abuse by adults was reported in the case files of service users aged 12–17, the suspected perpetrators were far more likely to have been strangers (34%, 118) or adult friends/acquaintances (32%, 111). Intra-familial figures – parental figures, siblings, grandparents, other relatives and family friends – accounted for 55% (344) of adult suspected perpetrators.

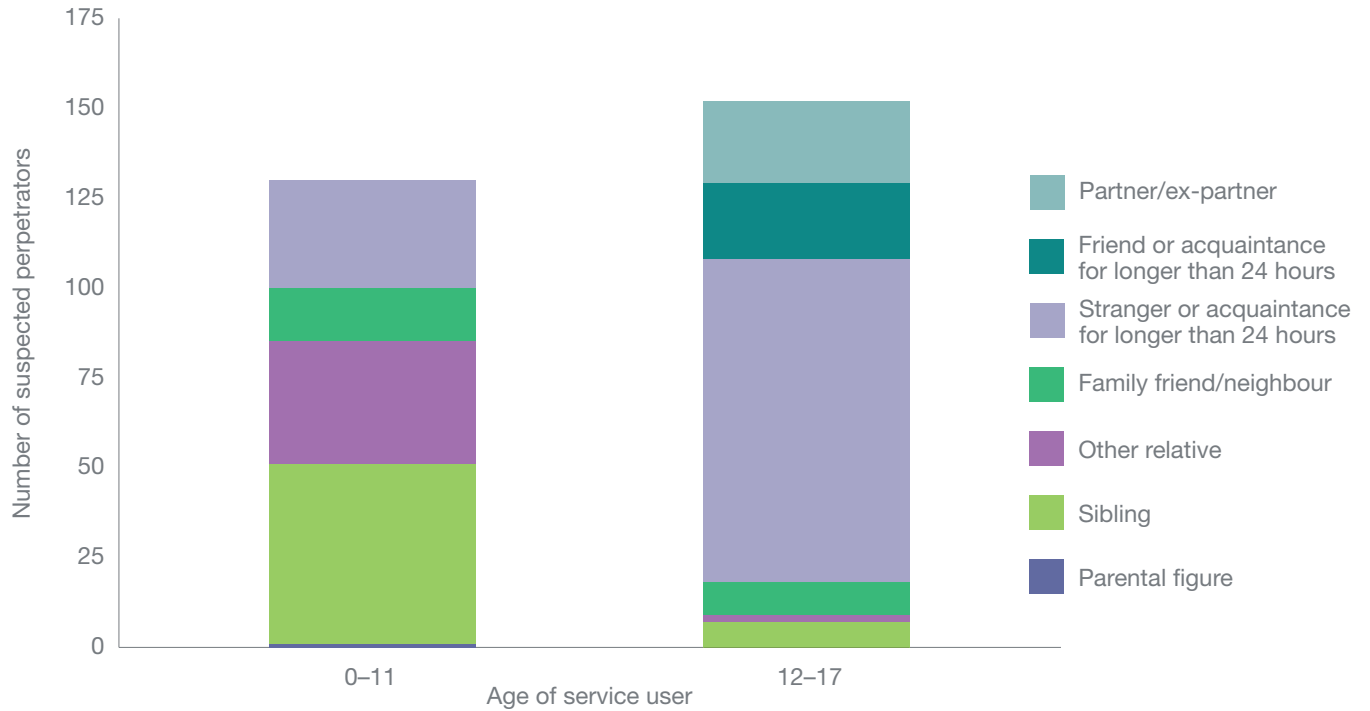
Overall, while friends and acquaintances suspected of committing CSA were almost equally likely to be aged under 18 (120) and over 18 (113), strangers and new acquaintances suspected of abuse were far more likely to be adult (124) than aged under 18 (21).

**Figure 12. Age of suspected perpetrators of abuse**



Girls aged 0–11: n=300 suspected perpetrators. 84 files did not contain information about the age of suspected perpetrator(s). Girls aged 12–17: n=483 suspected perpetrators. 57 files did not contain information about the age of suspected perpetrator(s). Boys aged 0–11: n=103 suspected perpetrators. 22 files did not contain information about the age of suspected perpetrator(s). Insufficient data on suspected perpetrators from the case files of boys aged 12–17 (n=32 suspected perpetrators) for analysis; 4 files did not contain information about the age of suspected perpetrator(s).

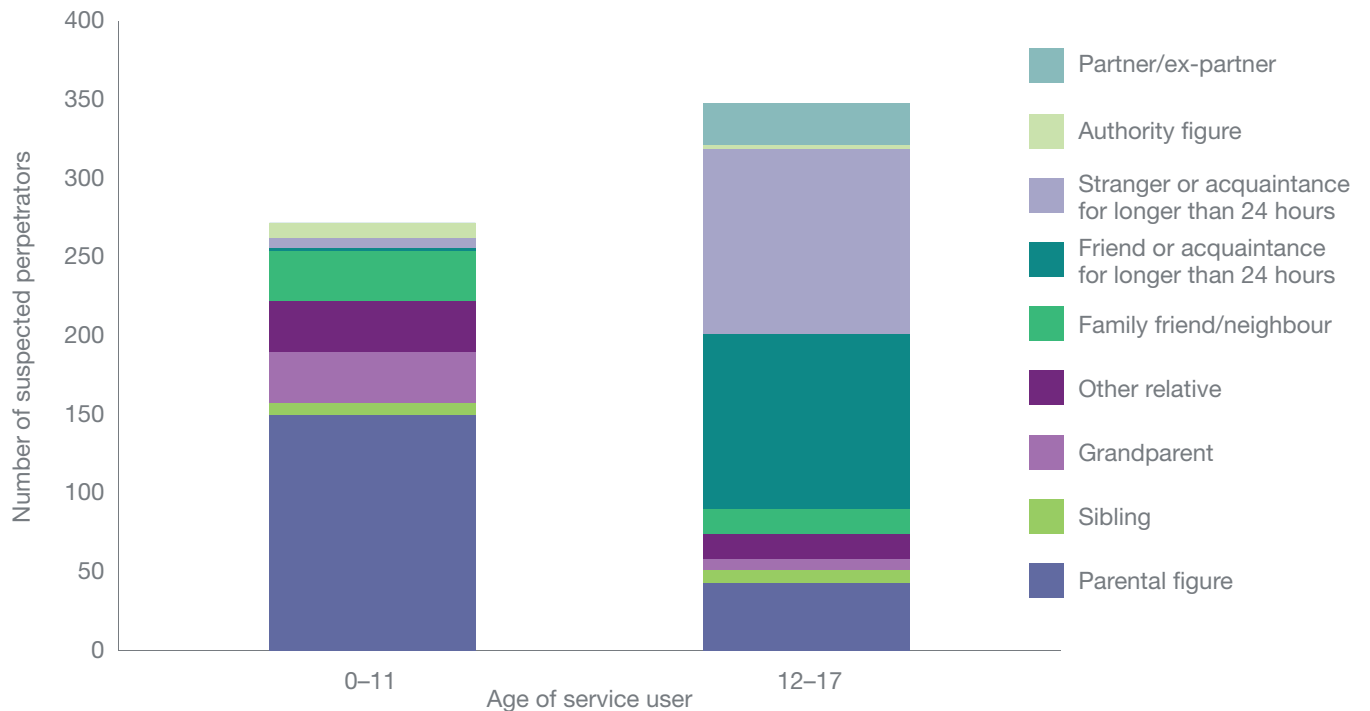
Figure 13. Relationship between suspected perpetrators aged under 18 and service users



Service users aged 0-11: n=130 suspected perpetrators. 107 files did not contain information about suspected perpetrator's age and relationship to service user.

Service users aged 12-17: n=152 suspected perpetrators. 70 files did not contain information about suspected perpetrator's age and relationship to service user.

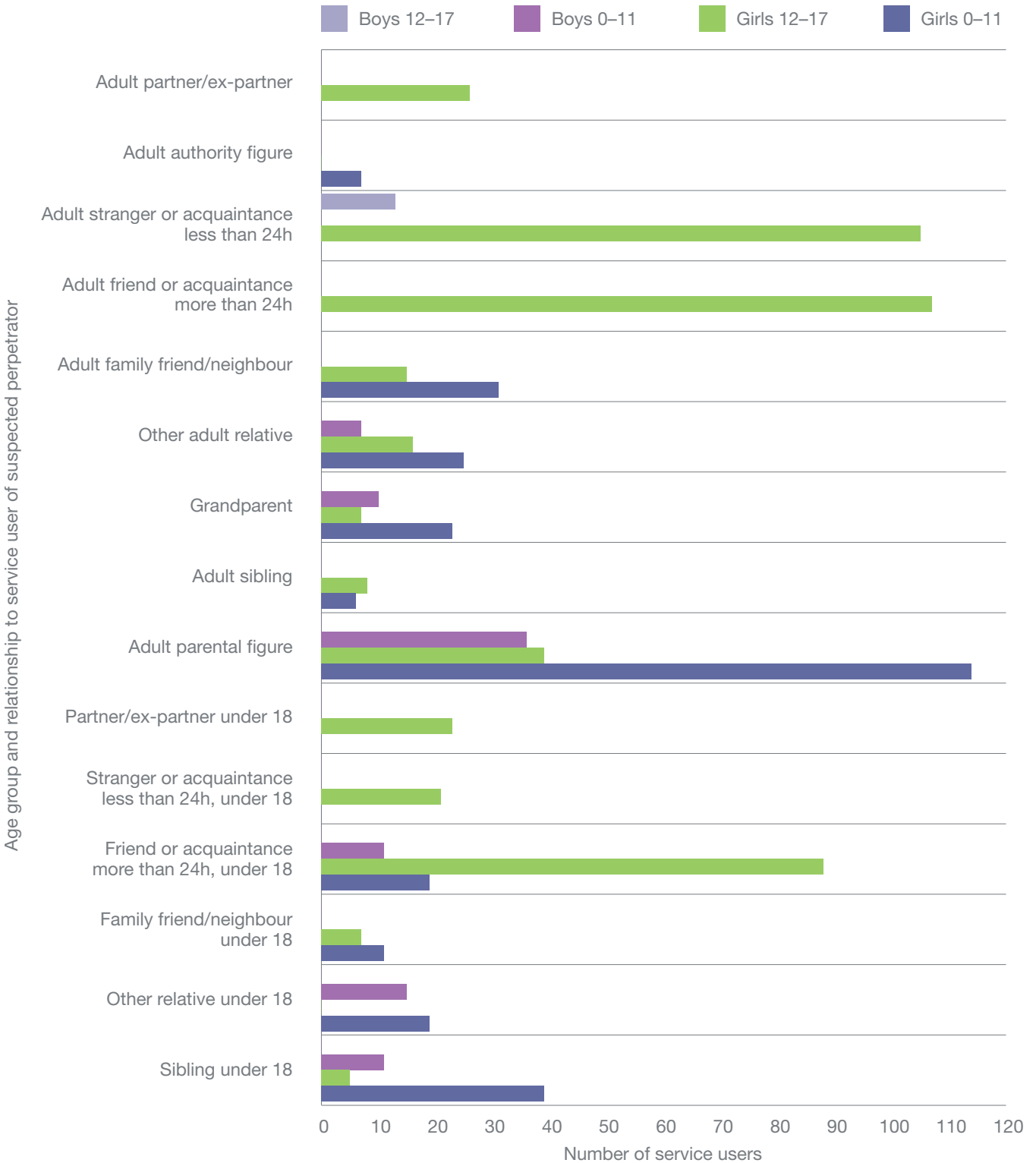
Figure 14. Relationship between adult suspected perpetrators and service users



Service users aged 0-11: n=272 suspected perpetrators. 107 files did not contain information about suspected perpetrator's age and relationship to service user.

Service users aged 12-17: n=348 suspected perpetrators. 70 files did not contain information about suspected perpetrator's age and relationship to service user.

Figure 15. Most commonly observed relationships between suspected perpetrator and service user



Girls aged 0-11: n=299 suspected perpetrators. 85 files did not contain information about age and relationship to service user.  
 Girls aged 12-17: n=471 suspected perpetrators. 64 files did not contain information about age and relationship to service user.  
 Boys aged 0-11: n=103 suspected perpetrators. 22 files did not contain information about age and relationship to service user.  
 Boys aged 12-17: n=29 suspected perpetrators. 6 files did not contain information about age and relationship to service user.  
 Data not shown in categories where number of cases was <5.

As shown by Figure 15, the most commonly observed categories of reported abuse at Saint Mary's SARC during the three-year period were, in decreasing order of frequency:

- ▶ abuse of girls aged 0–11 by parental figures
- ▶ abuse of girls aged 12–17 by adult friends or established acquaintances
- ▶ abuse of girls aged 12–17 by adult strangers or new acquaintances
- ▶ abuse of girls aged 12–17 by friends or established acquaintances aged under 18.

Each of these was reported more than twice as often as any other category of abuse.

Radford et al (2011) found that two-thirds of contact sexual abuse was committed by other children and young people under the age of 18. Drawing on research into harmful sexual behaviour (HSB), the NSPCC estimated that around one-third of those who commit CSA are other children and young people (Hackett, 2014) – similar to the finding in this research.

### *Suspected perpetrator behaviours*

Among the 886 case files where this data was recorded, the initial contact between the service user and the suspected perpetrator occurred online in 41 (5%) of them – including nearly one-tenth (9%, 39) of the case files of service users aged 12–17.

In 815 case files, information was recorded about whether the suspected perpetrator of abuse had acted as a facilitator for other abusers. This was reported as having happened in 5% (42) of case files, most of which involved older children and young people: 7% (33) of service users aged 12–17 said they had been abused by someone who also facilitated abuse by others.

Research is emerging on the role of digital technology as a means for perpetrators to identify and target potential victims of CSA (e.g. Wager et al, 2018; Berelowitz et al, 2012). Research evidence from the USA suggests that between 1% and 6% of sexual requests received online involved an invitation to an offline meeting (Mitchell et al, 2004).

## 3.5 Referral pathways

Data on the agencies and professionals involved in the identification and referral of suspected victims of abuse was available in all 986 case files. By far the most frequent source of referral to Saint Mary's SARC was the police, who had referred 85% (838) of children and young people attending the SARC. A further 12% (120) had been referred by social services, and 3% (28) – almost all of them in the 12–17 age group – were self-referrals.

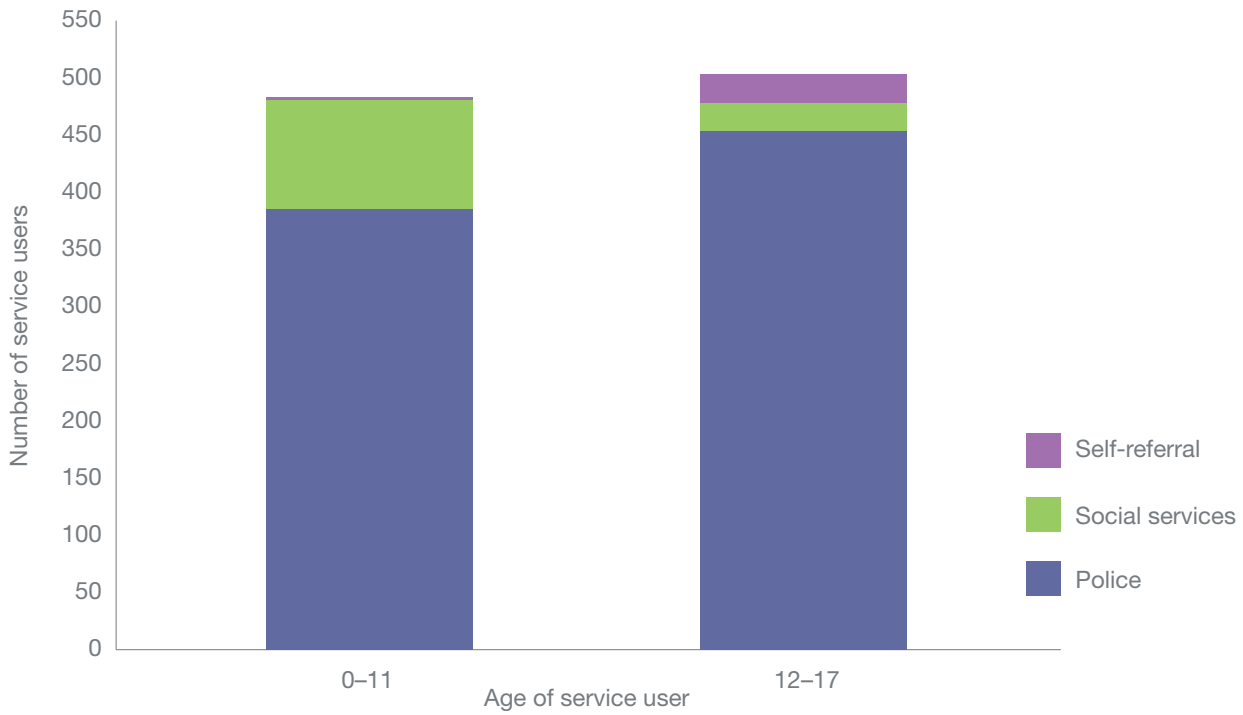
Social services accounted for 20% (95) of referrals of younger children, while 90% (453) of older service users had been referred by the police (see Figure 16).

Figure 17 provides details of the 802 case files which recorded information on who had made the initial disclosure to the police, social services or the SARC; this data was not recorded for more than a quarter (28%, 141) of older service users.

The service user's parent(s) or carer(s) contacted public services in one-half of cases (52%, 415), and more commonly in cases involving children aged 0–11. Older service users were more likely than younger ones to contact the police, social services or SARC themselves, with one in six (17%, 60) doing so. Public services were first contacted by healthcare professionals in 21% (93) of cases involving younger children but only 11% (39) of those involving older ones; teachers were more likely to raise concerns about older girls than other groups, being the source of disclosure for 14% (48) of girls aged 12–17.

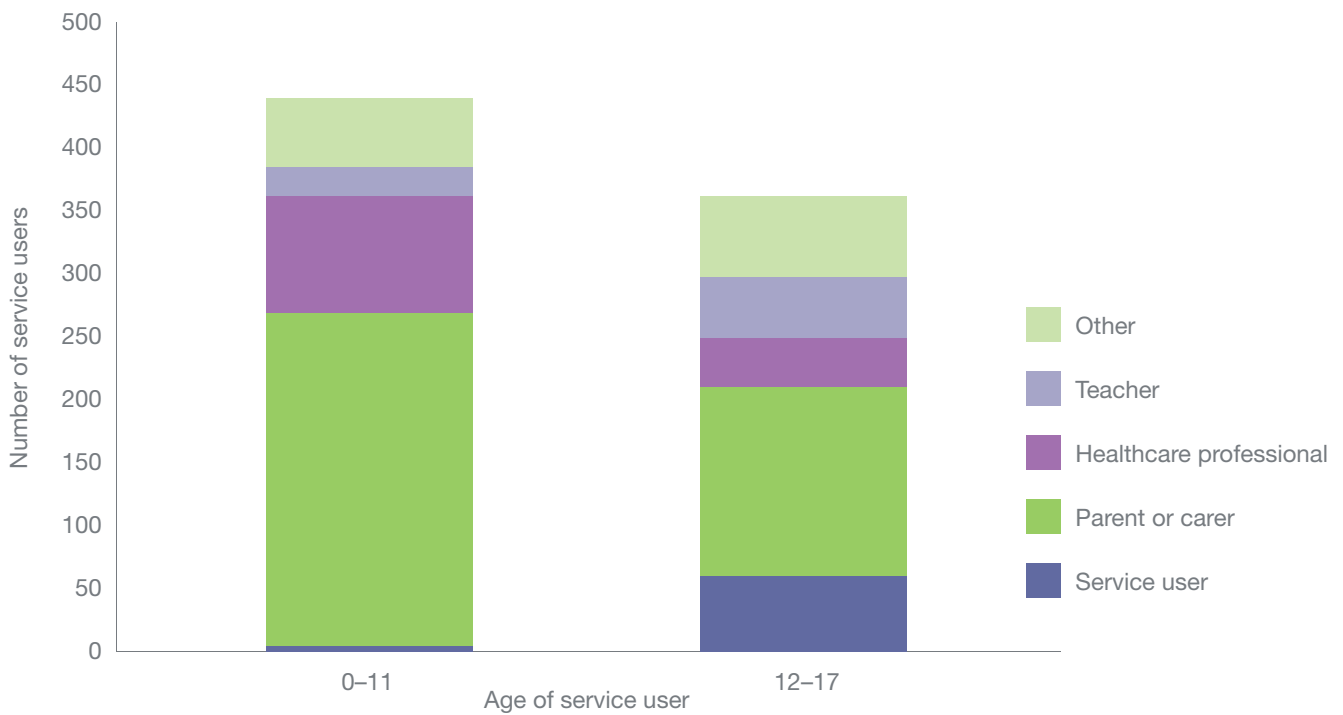
For nearly one-tenth of service users aged 12–17, the suspected perpetrator initiated contact online

Figure 16. Source of referral of service user to Saint Mary's SARC



Service users aged 0-11: n=483. Service users aged 12-17: n=503.

Figure 17. Source of disclosure of reported abuse to public services



Service users aged 0-11: n=440; 43 files did not contain information about source of disclosure/reporting.  
 Service users aged 12-17: n=362; 141 files did not contain information about source of disclosure/reporting.

While the pattern of disclosure/reporting sources was similar for boys and girls aged 0–11, older boys appeared far less likely than older girls to self-refer or to be the subject of concerns raised by a teacher, and considerably more likely to be brought to public services' attention by a parent or carer. However, inferences cannot be drawn given the small number of older boys in the study.

Several other disclosure pathways were noted in case files, including the case coming to attention during a police operation, or disclosure by another relative, a friend of the service user or a bystander.

Information about the length of time between the reported assault (or most recent assault) and the child or young person's attendance at the SARC was recorded in 776 case files, representing 97% of older service users but only 60% of those aged 0–11.

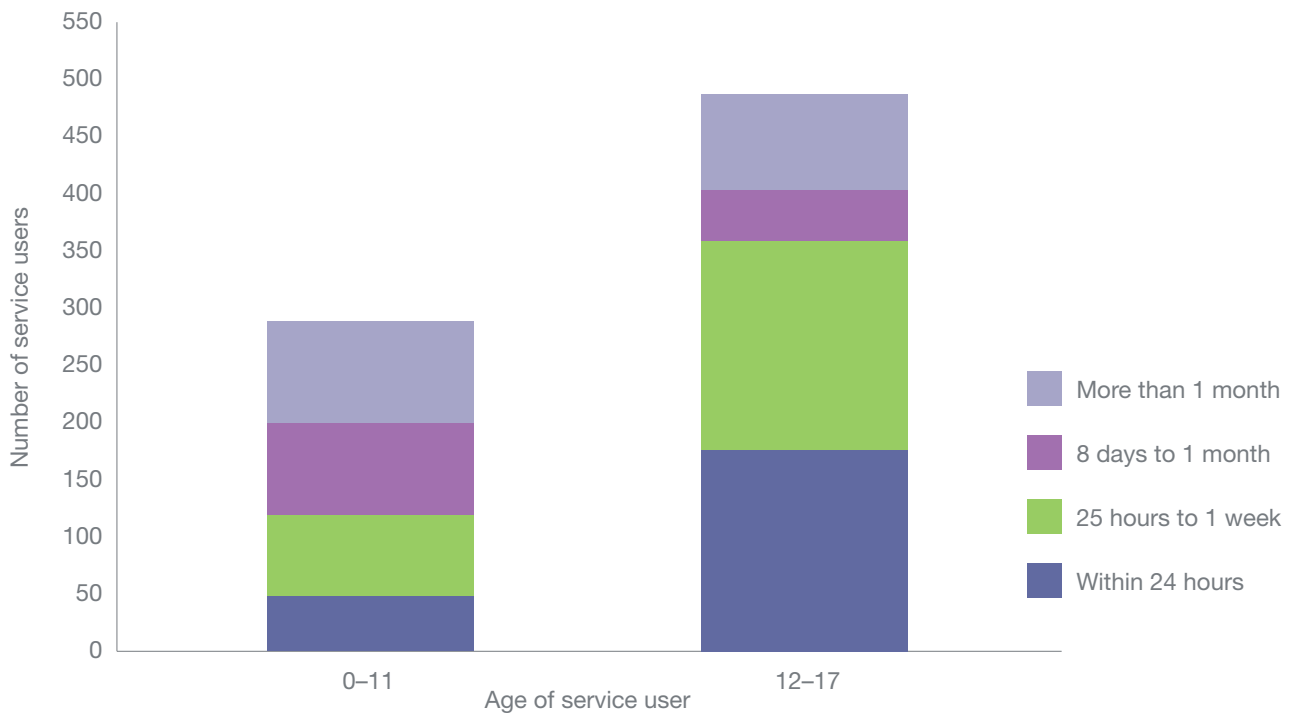
Nearly one-third (29%, 224) of these children and young people attended the SARC within 24 hours of the reported assault; as Figure 18 shows, this was far more common among

older service users (36%, 176) than younger ones (17%, 48). Boys of all ages were more likely than girls to attend the SARC more than a month after the reported assault. The large number of non-recent cases is not unusual; gender and age differences in attendance patterns merit further research.

Research by the NSPCC found that, on average, it took seven years for young people to disclose their abuse – and the younger the child was when the abuse started, the longer it took for them to disclose (Allnock and Miller, 2013). Other research has suggested that boys are less likely than girls to disclose the abuse at the time it occurs, and also take longer to discuss their childhood abuse later in life (e.g. O'Leary and Barber, 2008).

Research has also found that children are more likely to disclose to their non-abusing parent than to anyone else (Warrington et al, 2017).

Figure 18. Time between most recent reported assault and SARC attendance



Service users aged 0–11: n=289; 193 files did not contain information about time since reported assault.  
 Service users aged 12–17: n=487; 16 files did not contain information about time since reported assault.

### 3.6 Engagement with follow-up services

Saint Mary’s SARC has a team of independent sexual violence advisers (ISVAs) – support workers who assist service users in the weeks, months and sometimes years after an assault. In addition to explaining things to the service user and (where applicable) helping them make informed decisions about what will happen next, ISVAs can also liaise on their behalf with the police, Crown Prosecution Service lawyers and the courts.

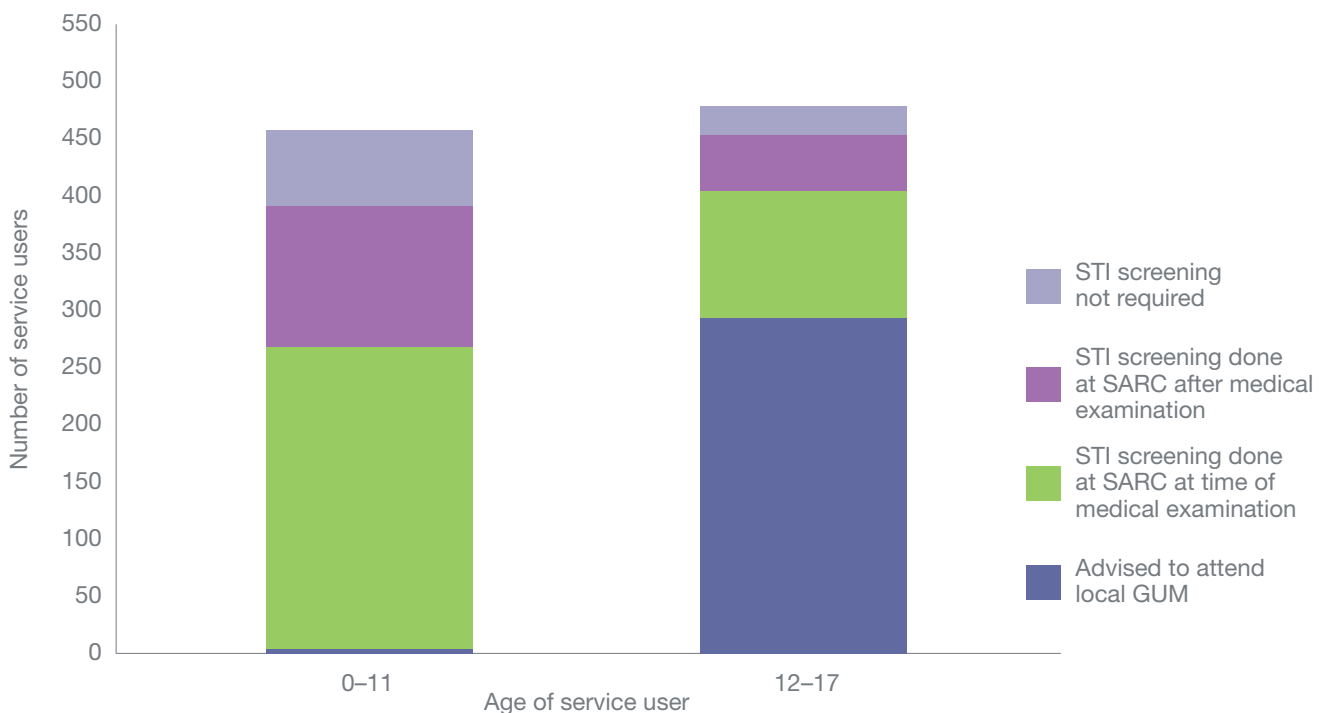
Every child and young person living in Greater Manchester who attends Saint Mary’s SARC is automatically provided with support from a Saint Mary’s ISVA, who will contact them within five days of their forensic medical examination. In the 977 cases where data was available, 89% (868) of children and young people (or their carers) spoke with an ISVA during this period.

As a further part of the integrated service at Saint Mary’s SARC, all service users who require it are screened for sexually transmitted infections (STIs) or, if this is more convenient, referred to a local sexual health or genitourinary medicine (GUM) clinic for the screening. Information about screening was available in 935 case files, and is set out in Figure 19.

Younger children are commonly screened at the SARC, either at the time of the medical examination or at a later date: this was the case for 99% (387) of the 391 children aged 0–11 in the study who required STI screening.

Among the 453 service users aged 12–17 who required STI screening, one-third (35%, 160) were screened at the SARC and the remainder advised to attend a local GUM clinic.

Figure 19. Screening for sexually transmitted infections



Service users aged 0–11: n=457; 26 files did not contain information about STI screening.  
 Service users aged 12–17: n=478; 25 files did not contain information about STI screening.



## 4. Conclusions

This study aimed to assess whether the data collection template, a tool developed by the CSA Centre to help agencies improve collection of data on CSA, would form a useful and practical basis for understanding CSA in the context of a SARC. Applying the template, the study examined the profile of children and young people accessing the UK's largest single-centre SARC, the profile of suspected perpetrators, the nature and context of the CSA reported or suspected in case files, and referral routes by which children and young people present to the SARC.

### 4.1 Insights from the data

Although the findings from this study cannot be generalised to CSA more widely, they have provided insights into the children and young people who attend Saint Mary's SARC, and the experiences that result in their attendance there.

The findings (many aspects of which reflect findings from other studies, as highlighted in Chapter 3) also have implications for CSA services beyond the SARC. And they demonstrate how agencies in the field of CSA are recording significant information about the characteristics and experiences of the people they work with, and about the nature of CSA being experienced – which indicates that these agencies can improve their own understanding of their service users, and contribute to wider understanding, if they collect and analyse such data systematically and consistently.

Below we summarise the main insights from the findings, their implications for CSA services generally, and some actions that Saint Mary's SARC has taken to address the issues highlighted by the findings.

#### *Service users*

The retrospective data extraction and analysis generated a comprehensive dataset, enabling the cohort of children and young people attending Saint Mary's SARC for a forensic medical examination between April 2012 and March 2015 to be described in detail.

Comparisons with the local population revealed that BAME children and young people were under-represented among the SARC's service users.

There were fewer boys, and particularly older boys, among the service users than might have been expected based on self-reported CSA rates from prevalence surveys – and when they came to the attention of services, boys had suffered longer periods of abuse than girls.

The findings also enabled the SARC to understand the needs of its service users: they were more likely than the school population in Greater Manchester to have learning or physical disabilities, and rates of mental health difficulties and substance misuse among those aged 12–17 were very high.

Relatively high rates of children living in single-parent households and/or having received support from child protection services were also highlighted. This supports findings from other research that these groups are at increased risk of abuse.



The findings highlight the significant information being recorded by agencies in the field of CSA



## Implications for practice

Numerous explanations for professionals' failure to identify and address CSA in BAME communities have been identified: professional resistance to recognising that CSA victims come from all ethnic and religious groups (Berelowitz et al, 2013), fear of being viewed as culturally insensitive, and fear of intrusion into cultures that are different from the dominant (Ward and Patel, 2006).

Barriers to disclosure among BAME groups include the fear of family shame and of being ostracised in the community (Gutierrez and Chawla, 2017; Harrison and Gill, 2017), mistrust of statutory services, and reluctance to shed public light on issues that may have a negative impact on the wider community (Gutierrez and Chawla, 2017).

Services need to consider whether their service users reflect the make-up of the local area, and review their referral sources. Service provision that is flexible, offers choice and is staffed with professionals who demonstrate cultural awareness can improve outreach in BAME communities (Warrington et al, 2017). **Saint Mary's SARC has set up open days, with invitations extended in particular to voluntary and third-sector organisations working with BAME communities, as one way of raising awareness of the SARC service among those communities.**

Research has raised issues of stigma and masculine shame that cause male victims of CSA to be even more silenced than female survivors (Corbett, 2016). It has also been highlighted (e.g. in Brayley et al, 2014; Harper and Scott, 2005) that professionals are less likely to recognise signs of abuse in boys, which may be 'externalised' (as aggression, for example) rather than 'internalised' (as mental health difficulties etc). Professionals working with children and young people need to remain mindful that boys too experience CSA, including in adolescence, and that they may present with different behaviours from girls.

Besides being at greater risk of sexual abuse, disabled children may have more limited means of communication; this, combined with a lack of specialised professional knowledge, can lead to inadequate responses from services (Jones et al, 2012; Stalker et al, 2010). Agencies

need to think about the adaptations and training required for these children to be able to disclose CSA and access CSA services. For example, children with learning disabilities will need explanations about the forensic medical examination according to their individual needs and learning styles. **Saint Mary's SARC has developed easy-read information leaflets (available at [www.stmaryscentre.org/professionals/people-learning-disabilities](http://www.stmaryscentre.org/professionals/people-learning-disabilities)), designed with people with learning disabilities and limited literacy in mind, which have built-in 'augmented reality technology' allowing video explanations to be launched through smartphones.**

CSA can lead to depression, anxiety and post-traumatic stress (Fisher et al, 2017; Khadr et al, 2018). This points to the vital role played by sensitive risk assessments for self-harm and suicide as part of the forensic medical examination, and mental health needs should be addressed in other CSA services. There should be clear and timely pathways for appropriate mental health support offered within all services that work with victims of CSA.

## *Reported abuse and those suspected of committing it*

The dataset also describes the nature of reported abuse that resulted in children and young people attending the SARC, and the individuals suspected of perpetrating it.

As could be expected given the nature of the service, the vast majority of the SARC's attendees described abuse consistent with rape or penetrative abuse. A large share of this abuse was reported to have taken place in a domestic setting (either the service user's own home or the perpetrator's home, if different). Among those aged 12–17, a single incident of abuse was most commonly reported.

Individuals in the family environment were mostly suspected of committing abuse against younger children (aged 0–11), while those from outside the family were more commonly suspected of abusing those aged 12–17; intra-familial and extra-familial suspects featured in approximately equal numbers in the sample. One-third of suspects were other children and young people, who in many cases were the service user's friends or acquaintances. A very small share (3%) of suspected perpetrators were female.

### Implications for practice

Information about the perpetrator or the nature of abuse was absent or unclear in the case files of many younger children in particular. It is important for professionals to refer children and young people for a forensic medical examination if there is any indication of abuse (for example, through behavioural changes), rather than waiting for a verbal disclosure to be made (National Institute for Health and Care Excellence, 2017).

In the absence of clear information about the perpetrators of abuse of some children, including those who are non-verbal, professionals should focus their assessments on the history of abuse and associated child and family-related factors.

While males form the majority of those perpetrating CSA, professionals need to be mindful that abuse by females does happen, and is likely to be more under-reported than abuse by males.

The level of abuse carried out by other children and young people aged under 18 highlights the importance of education and support around harmful sexual behaviours in schools, and whole-school approaches to healthy relationships education. The CSA Centre's *Key Messages from Research on Children and Young People Who Display Harmful Sexual Behaviours*, available at [www.csacentre.org.uk/research-publications/key-messages/harmful-sexual-behaviour/](http://www.csacentre.org.uk/research-publications/key-messages/harmful-sexual-behaviour/), points to good practice in this regard.

### Disclosure and referral

The vast majority of referrals of children and young people to Saint Mary's SARC were made by the police, with social workers accounting for the bulk of the remainder. However, only one in six service users aged 12–17 (and fewer than 1% of those aged 0–11) contacted the police or social services themselves. Parents were the main source of disclosure of CSA concerns to public services; younger children were more likely than older ones to be the subject of concerns raised by health professionals, while girls aged 12–17 accounted for a large majority of cases where teachers raised concerns..

### Implications for practice

Research with both children (e.g. Allnock and Miller, 2013) and adult survivors of CSA (e.g. Smith et al, 2015) has stressed the need for greater professional vigilance to ask questions about CSA rather than relying on self-disclosure. Young survivors in Allnock and Miller's study wanted someone to notice that something was wrong, to be asked direct questions, and to be kept informed about what was happening.

Important facilitators for children to tell include having access to safe adults with the skills to listen, and having the opportunity to obtain information and explore confidentially the consequences of disclosure (Jackson et al, 2015).

Improving skills among adults with whom children build trust, such as teachers, is therefore crucial – including in primary schools, which appeared to refer few children in this study.

**Part of the purpose of the Saint Mary's SARC open days is to inform professionals about the SARC's work and the role of forensic medical examinations, and encourage them to be more active in identifying signs of possible abuse and encouraging disclosure.**

## 4.2 Insights into use of the data collection template

Extraction of the collected data demonstrated that, in general, note-taking in case files had been thorough at Saint Mary's SARC. In particular, for each of the fields in the tool relating to the characteristics of service users, relevant data was recorded in at least 90% of the case files. Data related to the nature of reported abuse and the suspected perpetrators was more likely to be missing, especially from the case files of younger children; in many cases this was probably unavoidable (because, for example, it resulted from the child's non-disclosure or unclear disclosure of the information).

The experience of applying the data extraction tool to the case files suggests, therefore, that adopting the bulk of the CSA Centre's data collection template in future would not place additional burdens on Saint Mary's SARC.

Because the data collection template is designed for use by a wide range of agencies, it is not envisaged that each agency will adopt the template in its entirety; approximately one-third of the data fields in the CSA Centre's data collection template were excluded from the data extraction tool at the beginning of the study. Data in fields relating to a suspected perpetrator's history may, for example, be collected by the police during their investigations. Additionally, at the point when they attend a SARC for a forensic medical examination, children or young people may not be aware of some perpetrator behaviours such as entrapment/control strategies, so asking them about such behaviours might yield data of limited value; this data may more usefully be gathered by agencies providing therapy to survivors of CSA. Some data, such as the platform used if initial contact by the suspected perpetrator occurred online, has been collected more systematically by the SARC since the study.

Use of the data extraction tool did highlight the potential for the data collection template to capture more detail in relation to service users' living arrangements and their relationship to the suspected perpetrator of abuse. In the published version of the template, the living arrangements field will include an extra category 'Living with one parent (whose partner does not live in the family home)', and the relationship field will feature the additional category 'Parent's partner'.

Additionally, following feedback from Saint Mary's SARC, the data collection template's field 'Was the child or young person trafficked?' will be revised to 'Did the perpetrator take the victim or pay for travel to locations of abuse?'

When the data collection template is published later this year, detailed guidance will be provided to help ensure that professionals collecting data interpret the questions consistently.

### Implications for practice

Consistent recording and analysis of data relating to CSA is important to make sure that services are accessible for all who need it. Without precise data on who the victims or perpetrators are, and on how sexual abuse is perpetrated and where, it is difficult to respond to abuse and to develop and commission services that meet victims' needs.

Basic data that can be shared and compared among local services and statutory agencies can help to build a more comprehensive picture of abuse locally, identify gaps in services and ultimately provide better services to victims. It can help to inform prevention and disruption strategies, and determine the appropriate allocation of resources.

This study suggests that the consistent and systematic collection of data, based on the CSA Centre's template, need not place additional burdens on services.

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# Appendix 1: Data extraction tool

See Chapter 3 for analysis of the data collected in the fields below.

Fields not present in the CSA Centre's data collection template are denoted \*.

## Characteristics of service user

*Postcode	
Age	
Gender	<ul style="list-style-type: none"> <li>• Male</li> <li>• Female</li> <li>• Not known</li> </ul>
Ethnicity	<p>White:</p> <ul style="list-style-type: none"> <li>• White British</li> <li>• White Irish</li> <li>• White other</li> </ul> <p>Asian:</p> <ul style="list-style-type: none"> <li>• Indian</li> <li>• Pakistani</li> <li>• Bangladeshi</li> <li>• Asian other</li> <li>• Chinese</li> </ul> <p>Black:</p> <ul style="list-style-type: none"> <li>• African</li> <li>• Caribbean</li> <li>• Black other</li> </ul> <p>Mixed:</p> <ul style="list-style-type: none"> <li>• White and Asian</li> <li>• White and Black African</li> <li>• White and Black Caribbean</li> <li>• Mixed other</li> <li>• Other ethnic group</li> <li>• Not known/refused</li> </ul>
Living arrangements	<ul style="list-style-type: none"> <li>• With parent</li> <li>• With parents</li> <li>• With wider family</li> <li>• Adopted</li> <li>• In care</li> <li>• Other</li> </ul>
Been on child protection or child in need plan	<ul style="list-style-type: none"> <li>• Yes, currently</li> <li>• Yes, previously</li> <li>• No</li> <li>• Not known/unclear</li> </ul>
Physical disability	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> <li>• Not known/unclear</li> </ul>
Learning disability	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> <li>• Not known/unclear</li> </ul>
*Additional needs at school	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> <li>• Not known/unclear</li> </ul>

History of mental health difficulty	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> <li>• Not known/unclear</li> </ul>
*History of self-harm	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> <li>• Not known/unclear</li> </ul>
*History of suicide attempts	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> <li>• Not known/unclear</li> </ul>
*History of substance abuse	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> <li>• Not known/unclear</li> </ul>
Comments	

## Context and nature of reported abuse

Nature of abuse <i>(recorded for up to three types of abuse)</i>	<p>Rape or penetration:</p> <ul style="list-style-type: none"> <li>• Anal rape</li> <li>• Oral rape</li> <li>• Vaginal rape</li> <li>• Digital penetration</li> <li>• Object penetration</li> </ul> <p>Non-penetrative abuse:</p> <ul style="list-style-type: none"> <li>• Forced to perform a sexual act</li> <li>• Other non-penetrative assault</li> </ul> <p>No disclosure:</p> <ul style="list-style-type: none"> <li>• Ano-genital bleed, no disclosure</li> <li>• Ano-genital redness, no disclosure</li> <li>• Ano-genital warts, no disclosure</li> <li>• Ano-genital discharge, no disclosure</li> <li>• UTI, no disclosure</li> <li>• Unknown – cannot remember</li> <li>• Unknown – no disclosure</li> </ul>
Location of abuse	<ul style="list-style-type: none"> <li>• Victim’s home</li> <li>• Perpetrator’s home (if different)</li> <li>• Third party home</li> <li>• Outdoors</li> <li>• In a vehicle</li> <li>• In a hotel or B&amp;B</li> <li>• In a school/nursery</li> <li>• Other</li> <li>• Not recorded/unclear</li> </ul>
Duration of abuse (by current suspect/s)	<ul style="list-style-type: none"> <li>• Single event</li> <li>• 0–3 months</li> <li>• 4–12 months</li> <li>• 1–5 years</li> <li>• 6 years or more</li> <li>• Not recorded/unclear</li> </ul>
Comments	



## Characteristics and behaviours of suspected perpetrators

Number of suspects	
Suspect's gender <i>(recorded for up to three suspects)</i>	<ul style="list-style-type: none"> <li>• Male    • Female    • Not known/not recorded</li> </ul>
Suspect's relationship to service user <i>(recorded for up to three suspects)</i>	<p>Intra-familial:</p> <ul style="list-style-type: none"> <li>• Parental figure</li> <li>• Sibling</li> <li>• Grandparent</li> <li>• Aunt/uncle</li> <li>• Cousin</li> <li>• Neighbour</li> <li>• Babysitter</li> <li>• Other relative</li> <li>• Family friend/neighbour</li> </ul> <p>Extra-familial:</p> <ul style="list-style-type: none"> <li>• Partner/ex-partner</li> <li>• Child's friend or acquaintance for longer than 24 hours</li> <li>• Child's acquaintance for less than 24 hours</li> <li>• Stranger</li> <li>• Authority figure</li> <li>• Not recorded/unclear</li> </ul>
Suspect's age <i>(recorded for up to three suspects)</i>	<ul style="list-style-type: none"> <li>• Under 18    • 18+    • Not known/not recorded</li> </ul>
Suspect's ethnicity <i>(recorded for up to three suspects)</i>	<p>White:</p> <ul style="list-style-type: none"> <li>• White British</li> <li>• White Irish</li> <li>• White other</li> </ul> <p>Asian:</p> <ul style="list-style-type: none"> <li>• Indian</li> <li>• Pakistani</li> <li>• Bangladeshi</li> <li>• Asian other</li> <li>• Chinese</li> </ul> <p>Black:</p> <ul style="list-style-type: none"> <li>• African</li> <li>• Caribbean</li> <li>• Black other</li> </ul> <p>Mixed:</p> <ul style="list-style-type: none"> <li>• White and Asian</li> <li>• White and Black African</li> <li>• White and Black Caribbean</li> <li>• Mixed other</li> <li>• Other ethnic group</li> <li>• Not known/refused</li> </ul>
Initial contact made online	<ul style="list-style-type: none"> <li>• Yes    • No    • Not known/unclear</li> </ul>
Suspect was facilitator for other abusers	<ul style="list-style-type: none"> <li>• Yes    • No    • Not known/unclear</li> </ul>
Comments	

## Service information

Source of referral to SARC	<ul style="list-style-type: none"> <li>• Police</li> <li>• Social services</li> <li>• Self-referral</li> <li>• Not recorded/unclear</li> </ul>
Source of disclosure to public services	<ul style="list-style-type: none"> <li>• Service user</li> <li>• Parent or carer</li> <li>• Healthcare professional</li> <li>• Teacher</li> <li>• Other</li> <li>• Not recorded/unclear</li> </ul>
*Date of forensic medical examination	
Time between abuse (or most recent abuse) and attendance at SARC	<ul style="list-style-type: none"> <li>• Less than 24 hours</li> <li>• 25–48 hours (2 days)</li> <li>• 49–72 hours (3 days)</li> <li>• 73–96 hours (4 days)</li> <li>• 97–120 hours (5 days)</li> <li>• 121–144 hours (6 days)</li> <li>• 145–168 hours (7 days)</li> <li>• 8–21 days</li> <li>• 22–31 days</li> <li>• 32 days to 1 year</li> <li>• 1 year 1 day to 3 years</li> <li>• 3 years 1 day to 5 years</li> <li>• 5 years 1 day to 10 years</li> <li>• Unclear</li> </ul>
*ISVA made contact with client/carers	<ul style="list-style-type: none"> <li>• Yes</li> <li>• No</li> <li>• Not recorded/unclear</li> </ul>
*STI screening	<ul style="list-style-type: none"> <li>• Screening at SARC at time of medical examination</li> <li>• Screening at SARC after medical examination</li> <li>• Advised to attend local GUM</li> <li>• Screening not required</li> <li>• Unknown/not recorded</li> </ul>
Comments	





**Centre of  
expertise  
on child  
sexual abuse**

The photograph on the cover was taken using actors  
and does not depict an actual situation.

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