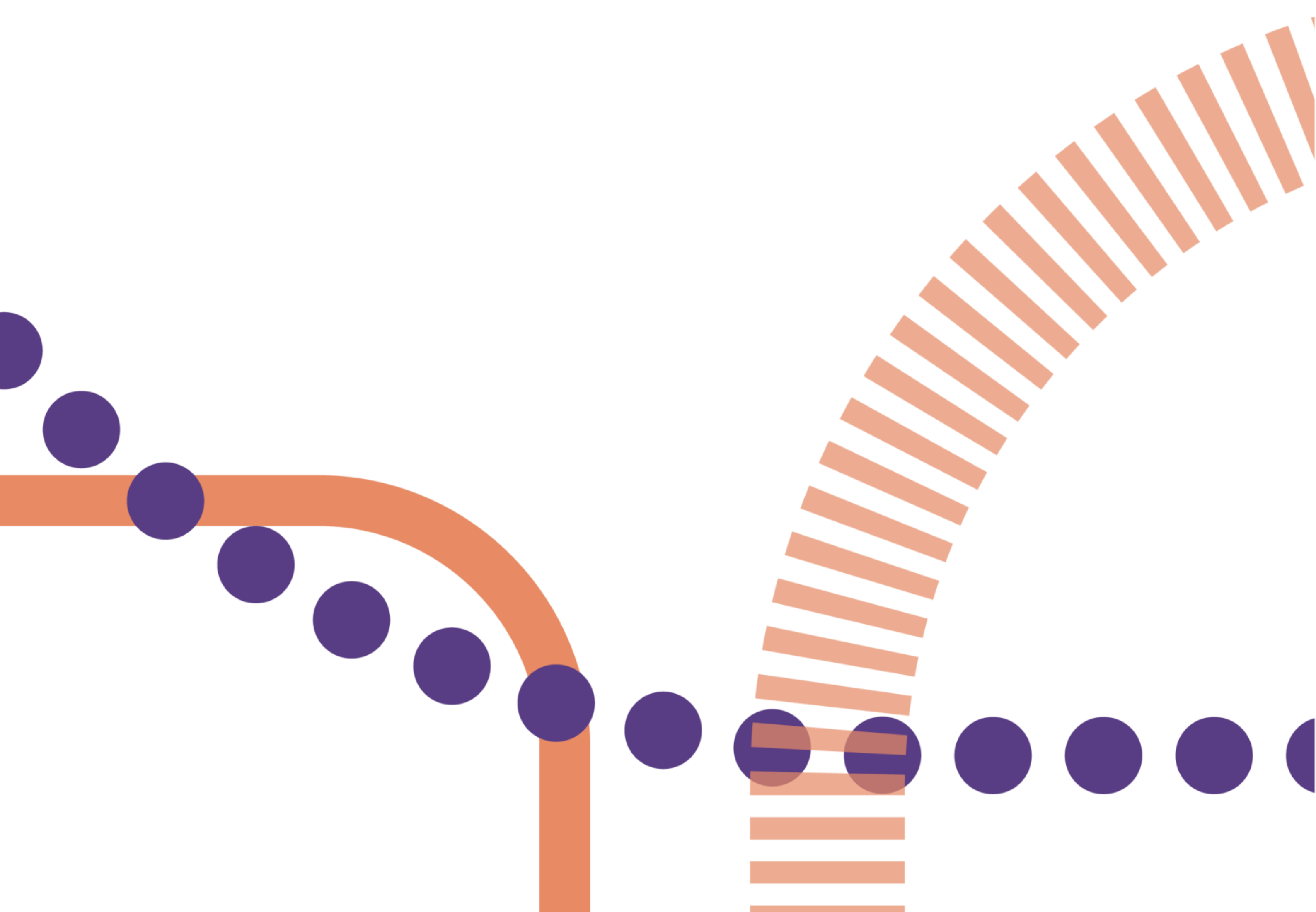
THE CHILD **SAFEGUARDING**
PRACTICE REVIEW PANEL

Child sexual abuse

Information sharing: No further police action at this time

March 2026



Introduction

The national Child Safeguarding Practice Review Panel (the Panel) published a national review into child sexual abuse within the family environment in November 2024.

Where practitioners had recorded concerns in case files and an investigation had taken place and been concluded, the reasons for the police not taking any further action were often not shared with practitioners. In many cases it was subsequently recorded simply as ‘no further action’. We saw repeatedly that when police had decided to take no further action due to the higher evidential threshold for criminal proceedings not being met, children’s social care and other agencies often understood this to mean that the child had not been sexually abused and that there were therefore no safeguarding concerns or other actions needed. This left children at risk and without support.

Who is this document for?

Multi-agency practitioners, managers and front-line professionals working in universal services such as schools, health services, police and early years settings, and practitioners in specialist safeguarding and child protection roles (including fostering and adoption).

How to use this resource

This resource is designed to support practitioners and managers in understanding and responding to cases where police investigations into child sexual abuse conclude with “no further police action at this time.” Use it as a practical guide to clarify what this outcome means, explore the difference between criminal and safeguarding thresholds, and strengthen multi-agency decision making. You can refer to specific sections when preparing for strategy discussions, supervision, or case reviews, or use the whole document to inform team learning and reflective practice. The examples and prompts included will help challenge assumptions, improve recording standards, and ensure safeguarding responsibilities continue even when criminal proceedings do not.

Why is it important for children and young people?

This issue matters because misinterpreting “no further police action” as an absence of harm can leave children without protection or support, increasing the risk of further abuse and long-term trauma. Young people need professionals who understand that safeguarding thresholds differ from criminal thresholds and who act decisively to provide care and protection regardless of criminal outcomes. By applying the guidance in this paper, practitioners can ensure that children’s voices are heard, their experiences are taken seriously, and their safety remains the highest priority. This approach helps prevent systemic gaps and promotes better outcomes for every child.

What is the evidence base?

The Panel's national review included:

- Analysis of 136 rapid reviews, 40 related SCRs and LCSPRs, and one thematic review relating to child sexual abuse in the family environment received by the Panel between June 2018 and November 2023.
- 10 online reflective group discussions with 107 practitioners in 9 local safeguarding partnerships who had been involved in 10 of these reviews.
- One-to-one interviews with 2 of the children at the heart of these reviews and 5 people who had been convicted for sexually abusing children in these reviews.
- Reflective discussions with experts by experience, multi-agency senior leaders, and practitioners from policing, probation, children's social care and health services.
- A review of recent research and practice guidance, summarising what is known about child sexual abuse in the family environment and the response to it.

Key facts and figures

The review's analysis looked at 193 children who had been sexually abused.

- In over a third of the reviews, the people who harmed children (98% of whom were men) were known to pose a risk of sexual harm. The risk of harm was known (and often over many years) but was ignored, denied or deflected.

- In 2022/23, 3.6% of children on child protection plans had those plans instigated because of a primary concern about child sexual abuse (this is at its lowest since records began 30 years ago).

- In 72% of reviews, there was evidence that children had told someone about the abuse, sometimes on multiple occasions, although it was not always clear who they had told.

- In 2022/23, 89% of cases involving child sexual abuse ended without a charge or summons.

- In nearly half of the reviews (47%), children had also been subject to neglect. Nearly a third (32%) had experienced physical abuse, over a quarter (29%) had experienced domestic abuse and nearly a quarter (23%) had experienced emotional abuse. In nearly a fifth of reviews (17%), children had been abused in 3 or more different ways in addition to the sexual abuse.

Common issues

- Decisions by Police not to take further action were often due to the higher evidential threshold for criminal proceedings, **not** the absence of harm. This misinterpretation results in children being left at risk of further abuse and with a lack of support for recovery, both immediately and in the future. This issue was also highlighted within the Office of the Children's Commissioner report (2015) and the JTAI (2020).

- Systemic recording issues. Recording "No Further Action" without context reinforced incorrect assumptions. Practitioners lacked guidance on how to interpret or respond to these outcomes.

- Practitioners were not always clear about the need for collaborative working. There were also times when police acted on concerns before discussing these with children's social care or holding a strategy discussion, which then undermined the assessment of risk.

- Rigidity in the ABE or VRI evidence process, with an emphasis on verbal interviews, leading to police investigations either ending with 'evidential difficulties', or with no further police action being taken.

Hallmarks of promising practice

Understanding thresholds:
Agencies must understand the difference between criminal and safeguarding thresholds.

- Criminal investigations require evidence that meets the higher standard of beyond reasonable doubt, meaning a realistic prospect of conviction in court.
- Safeguarding decisions under Section 47 use the balance of probabilities threshold, acting where there is reasonable cause to suspect significant harm.

This means that even when police take "no further police action at this time" because evidential thresholds are not met, further safeguarding must be considered by the lead practitioner, with other agencies involved in the child's life. On many occasions "no further action" by the police led children's social care to conclude there was nothing they could do as they didn't have the evidence. Furthermore, it was at times interpreted, particularly by other agencies, as 'it didn't happen', 'the adult's version was believed' that or worse, 'the victim was lying' meaning the harm was minimised and agencies were left unsure of what they could do to support or protect the child. This left children subject to further abuse, without the necessary safeguarding arrangements and with a lack of support to aid recovery.

Recording information:

- Use "**no further police action at this time**" to clarify that the decision relates to evidential thresholds for prosecution, not safeguarding concerns, and that the police

may act if further information comes to light. Avoid using the term “no further action” or “insufficient evidence” because it is often misinterpreted as meaning the abuse did not happen.

- Ensure there is a clear record of why the criminal investigation was closed, including the evidence considered.
- Share this rationale with all relevant agencies so decisions are transparent and understood.
- Ensure the child and their family understand the reasons for the police decision, the importance of other agencies continuing to be involved.

Multi Agency discussions:

- Agencies should ensure that Working Together guidance is followed and that, at the conclusion of section 47 enquiries and police investigations, there is a multiagency discussion to consider risk to the children and how they will be protected and supported.
- Multi-agency safeguarding arrangements (MASAs) must be robust, clearly understood by all partners, and deliver consistent communication and recording standards to prevent misunderstandings between all agencies involved.

Victims’ Code of Practice:

- When an NFPA decision is made, practitioners should ensure compliance with the Victims’ Code of Practice (VCOP), which grants enhanced rights to children under 18. In line with Right 6, children (and their parents/carers where appropriate) must be informed of the decision within one working day, using clear, age-appropriate language.
- Communication should include the reason for the decision, next steps, and available support services.
- Practitioners should record the notification and check understanding to maintain transparency and trust.

Victims’ Right to Review scheme:

- Partnership agencies should ensure children and their families are clearly informed about the VRR Scheme when an NFPA decision is made. Information must be provided in accessible, age-appropriate language, explaining who can request a review (parent/guardian or, where appropriate, the child).
- Practitioners should offer support to navigate the process, including signposting to advocacy services.
- Systems should be in place to record that families were informed, check understanding, and provide follow-up assistance to make exercising this right straightforward and transparent.

The Criminal Injuries Compensation Scheme

This is for victims of violent crime, including sexual abuse, that has been reported to the police, and it is not necessary for there to have been a prosecution or conviction. There are criteria that must be met, however, including the length of time since the crime took

place. (For example, if abuse was reported to the police before the child turned 18, a claim can be made up until their 20th birthday.) You can help the family to make an application, or apply on their behalf; the Ministry of Justice has produced guidance on applying for compensation under the scheme.

Reflective questions and discussion points

Questions for practitioners

- Are we confident as practitioners and strategic leaders that information sharing and recording standards prevent misunderstandings across agencies?

> *The lead practitioner (social worker) is responsible for deciding what action to take and how to proceed following section 47 enquiries. They should make these decisions based on multi-agency discussions informed by the voice of the child.*

- How do you ensure consistent language is applied during cases?

> *No single practitioner can have a full picture of a child's needs and circumstances so effective sharing of information between practitioners, local organisations and agencies is essential for early identification of need, assessment, and service provision to keep children safe. All partners should use professional curiosity and appropriate challenge when a criminal case is subject to 'No further police action at this time'.*

Understanding thresholds

- How confident are you in the knowledge of strategic and front-line practitioners in understanding the difference between criminal and safeguarding thresholds?
- Can you be confident that decisions throughout the system are based on the safeguarding threshold, as opposed the criminal threshold, for example: whether referrals are accepted at the Front door/MASH; whether children are made subject to child protection plans under the category of sexual abuse; during legal planning meetings.
- What steps can we take to ensure that 'no further police action at this time ' is not misinterpreted as 'no safeguarding concern'?

The Victims' Code of Practice

> *Under the Victims' Code of Practice, children under 18 have enhanced rights, including being informed within one day of an NFPA decision.*

- How can we ensure this happens in practice, and who, alongside the police, is best placed to meet with the child and parent/carer to explain the decision sensitively, consider its emotional impact, and assess any ongoing safeguarding concerns?
- Do I understand the enhanced rights for children under 18 under VCOP?
- How can this conversation be handled to minimise emotional harm and maintain trust?
- What support or signposting can I offer to help them cope with the outcome?

The Victims' Right to Review (VRR) scheme

> *The Victims' Right to Review (VRR) Scheme gives victims the right to ask for a review when the police or Crown Prosecution Service (CPS) decide not to charge a suspect or discontinue a prosecution. For children, this means that a parent or guardian can request a review, and in some cases, the child themselves can apply if they understand the process.*

- Do I fully understand the VRR process and eligibility criteria for children and families?
- Am I confident in explaining the VRR scheme in clear, age-appropriate language?
- Have I considered the emotional impact on the child and family and offered appropriate support?

Recording and information sharing

- Are our recording practices clear enough to prevent misunderstandings across agencies?
- How do we ensure that the rationale for closing a criminal investigation is consistently shared with all relevant agencies?
- Do we use consistent language when documenting outcomes, and how do we check this?

Multi-Agency collaboration

- How do we make sure multi-agency discussions happen at the right time and include all relevant voices, including the child's?
- Is the partnership's multi-agency safeguarding arrangements robust enough to prevent gaps in communication and decision-making?

Practice and systemic issues

- How do we support practitioners and their managers to interpret outcomes correctly and continue safeguarding even when criminal thresholds are not met?

These questions and discussion points can be used by multi-agency practitioners to reflect on in team meetings, or to use as a checklist, when responding to incidents of child sexual abuse.

- Consider how intrafamilial child sexual abuse, and practice to prevent it, is influenced by factors specific to families from different communities or backgrounds (including different race, ethnicity and faith backgrounds).
  (For discussion in team meetings)

- Multi-agency working should include applying an intersectional lens to consider the way in which inequalities linked to issues including race are intertwined facets of some children's lives and can create a context of increased levels of risk for some children.
  (In team meetings, consider discussion of current or previous safeguarding practice examples to see if this lens was applied).

- Strategy discussions should include someone who knows the child and how best to communicate with them, taking account of disability, ethnicity, race and racism, language and culture.
  (Consider if this happens routinely in your local area).

- Do you as practitioners recognise the impact of racism, including bias and wider systemic experiences of discrimination on how children and families perceive and experience barriers to disclosing and reporting child sexual abuse.
  (Consider cases where this might have happened and how you can learn from it).

- Do you feel confident in exploring and understanding children's ethnic and cultural contexts, including family structures, and how these may impact the harm they have suffered and their help seeking.
  (Consider how confidence in this area would enable you to provide a considered and culturally sensitive response, taking account of other vulnerabilities or contexts that intersect with children's ethnicity or culture.)

- At a strategic level, do safeguarding partners consider that all practitioners in their area (including foster carers) understand and are confident in talking directly to children, and families, about concerns about sexual abuse, taking due account of ethnicity and race.

- How is intrafamilial child sexual abuse, and practice to prevent it, influenced by factors specific to families from different communities or backgrounds (including race, ethnicity and faith backgrounds)

Questions for leaders

- Do I fully understand the difference between "no further action" and "no further police action at this time," and have I ensured this distinction is embedded across our partnership's practice and recording?
- Have we put in place clear expectations that all NFPA outcomes trigger a timely multi-agency review of the child's safety plan, rather than signalling case closure or reduced vigilance?
- How do we, as a partnership, ensure that children and their families are informed and supported to exercise their right to review NFPA decisions, and what systems do we have in place to make this accessible and understandable for them?
- Under the Victims' Code of Practice, children under 18 have enhanced rights, including being informed within one day of an NFPA decision. How will our partnership ensure this is consistently achieved in practice? Who, alongside the police, should take responsibility for meeting with the child and parent/carer to explain the decision sensitively, address emotional impact, and review any ongoing safeguarding needs?
- Are practitioners aware of the Victims' Right to Review (VRR) Scheme, which gives victims the right to ask for a review when the police or Crown Prosecution Service (CPS) decide not to charge a suspect or discontinue a prosecution?
- What audit mechanisms do we have to check not only compliance with process but also the quality of decision-making, communication, and support offered, and how do we use this learning to strengthen practice across agencies?
- Do we have effective systems to continue assessing and managing risk from adults in the family network after NFPA, including information sharing, home visits, supervision, and appropriate use of civil orders?
- Do we have clear internal escalation routes for NFPA decisions that cause professional concern, and am I satisfied these are understood and routinely used?
- How well do I ensure that partnership relationships with police, health and probation support ongoing risk management after NFPA, including rapid information-sharing if new concerns emerge?
- Have I assured myself that health pathways, including forensic medical, therapeutic support, and clinical consultation, remain available and are not prematurely closed when police take no further action?

Case studies

Example 1:

The brother of a 7-year-old child told a social worker that his sister was being sexually abused by her father and the whole family was ignoring it. Police and child protection enquiries were initiated. The family reported that both children had misunderstood the actions of the father. It was noted the brother had learning disabilities and this had caused the confusion. The 7-year-old confirmed she had been sexually abused by her father and 2 uncles however the adults denied what she had said. The 7-year-old was interviewed, but the police decided the ABE or VRI interview did not provide enough evidence and closed their investigation, with no further action taken by any other agencies.

Example 2:

A child who initially disclosed to a family support worker that her stepfather had sexually abused her was subject to a child protection investigation. The stepfather denied the allegations, and her prior reports were deemed ‘unsubstantiated concerns’, requiring no further action. Ultimately, it was concluded she had not been abused, yet she was later placed with the stepfather, who then sexually assaulted her.

Example 3:

A child reported that he had been sexually abused by his older brother. This was shared by the school with the police and children’s social care. However, there was a delay in the strategy discussion being convened and the police visited the child and conducted an interview without children’s social care and without any joint planning taking place. The subsequent confusion resulted in the child being asked to repeat the interview as part of joint police and child protection enquiries, which he refused to do on the basis that he had already provided a witness statement. At this point, the joint enquiries faltered and ultimately led to no further action from the police, or other agency.

Example 4:

A child who had told a friend that she had been sexually abused from a young age agreed to an ABE or VRI interview but because of the long-term trauma was selectively mute. She communicated that she wished to write her answers down with support from a friend but was told this was not allowed. However, another review described how a child who had reported sexual abuse from the age of 5 years was facilitated to provide written answers because she could not speak about what had happened to her at a young age.

Where can I find out more?

Find more information on the Panel's new learning hub: www.childsafeguarding.independent-panel.uk, where you can access videos, webinars, podcasts and other content, including the full report: "I wanted them all to notice".

- **Working Together to Safeguard Children (2023)**: Statutory guidance on multi-agency working to protect children Read the guidance
- **MASA Guidance and Examples**: How agencies should work together under Working Together Guidance
- **CSA Centre Practice Resources**: Guides for practitioners on responding to child sexual abuse CSA Centre Publications [csacentre.org.uk]
- **NSPCC Learning**: Protecting children from sexual abuse NSPCC CSA Guidance