Title: Peer on Peer Review Herefordshire MASH 2017 – 2019

DRAFT REPORT 7th September 2020

1 PURPOSE

1.1 The purpose of this review is to assess Herefordshire Council's handling of peer on peer sexual abuse (as defined in the terms of reference below) allegations referred to MASH in its schools since 2017. The definition of what constitutes peer on peer sexual abuse and what MASH is are set out below. It was commissioned by the Chief Executive following agreement for the review to take place with the Leader of the Council in autumn 2019 initially and requested for review as a result of the Herefordshire Council's Children and Young Persons scrutiny committee Spotlight Review December 2019. In addition to ensuring children are safeguarded, the Review looks at:

a) How extensive peer on peer sexual abuse is within Herefordshire schools over a defined time period.

b) Whether over that time there had been careful and correct application of the national guidance in place, and if that alone was enough to protect children or whether there is a need to improve monitoring and support practices.

c) What response Herefordshire Council took following an incident at a Herefordshire school in April 2017.

d) Seeks to provide an answer to the question of whether an assurance can be found that children who have experienced peer on peer sexual abuse will not end up in the same educational setting together in the future and that they are kept safe.

e) Provides assurance how children in Herefordshire Schools are safeguarded in this regard.

1.2 This review considers the number and type of cases that were referred to MASH (see below for a definition of MASH) during a specific period (between January 2017 and November 2019) to see if the advice given was robust enough, the actions taken by the schools and the council were appropriate and whether or not the council could have done anything differently. This period was then split into two periods as the national guidance and statutory provisions changed in December 2017, again in May 2018 and then again in September 2019.—The two review periods are January 2017- October 2018 and October 2018 to November 2019. It is also the case that prior to October 2018 the

council did not routinely keep a record of all the details of peer on peer referrals - hence the split time period.

The specific Terms of Reference commissioned for this review were:

a) Identify cases that were referred to MASH that were peer on peer sexual assault/rape cases/alleged cases. Start with 2019, then work back for 2018, then 2017.

b) Assess the advice given, taking into account the national guidance available at the time.

c) Contact the school/college to confirm if advice was followed or what action was taken.

1.3 In addition to establishing how robust our processes have been and if guidance given was appropriate, as discussed above, the review crucially, establishes that no children were put or left at risk.

1.4 It will also summarise what are the next steps for Herefordshire Council and its other partners need to take, including questions asked nationally, in order to further strengthen the statutory and wider provisions and guidance in dealing with peer on peer abuse in schools

2 INTRODUCTION

2.1 The time period used in this review was selected as it covered the period when national awareness of the issue was growing and guidance was changing nationally. In addition, Herefordshire had experienced a growing incidence of reporting of peer on peer cases during the time, although numbers remained low. The reasons behind the growing trend are not fully known but are attributed to promoting wider awareness locally and better quality recording on MOSAIC (an internal secure recording system). Also Herefordshire Council had started to implement several changes to practice involving advice and guidance.

2.2 In essence how did Herefordshire compare with wider national bench marking? Did we have a higher or comparable incidence of cases? Were we acting in line with guidance or could we have done better?

2.3 The seriousness and scope of peer on peer sexual abuse has attracted national attention in recent years. This is partly as a result of a better awareness of individual cases and also as a result of better quality reporting. However, Ofsted say (Ofsted published blog, 4 October 2019) that it is hard to say how widespread a problem it is. There is no reliable national benchmarking data available. It is therefore difficult to compare across local authority areas. As a consequence we are unable to compare the levels of incidence in Herefordshire with other areas easily. Ofsted do not hold such data either. This is a gap in the national system of recording.

2.4 A survey study conducted by The University of Bedfordshire in partnership with the Institute of Applied Social Research (Beyond Referrals, June 2020) provides some sense of the scale and extent of the national problem. The study looks at wider harmful sexual behaviour than this report. It shows some bleak figures. 64% of girls aged 13-21 experienced some kind of sexual harassment in school for example, and around one quarter have experienced some kind of unwanted sexual touching. It also highlights some very specific contexts (it is more likely to happen at the end of a school day and off site). Only around 49% of victims would speak to an adult about it and it is more likely to be a parent than a school teacher they speak to. The study also reports that irrespective of where sexual harm takes place, 'a focus on the individual young people is insufficient and it must be accompanied by a recognition of the broader context and culture that facilitates and can prevent, harm occurring'.

2.5 Ofsted report that they believe it is a growing problem. In Autumn 2018 they reported a 29% increase in children seeking help from Childline due to peer on peer sexual abuse. Ofsted do not specifically inspect this aspect during their routine inspections of schools but report if it comes up under any wider safeguarding concerns.

2.6 This growing trend led to specific guidance being established and published by the Department for Education. This has been updated since the early versions. In addition, the statutory guidance, **Keeping Children Safe in Education,** was updated in September 2019 and again in June 2020 with minor modifications.

2.7 That guidance, since September 2019 says that in the event of an alleged rape or assault by penetration, schools/colleges are expected to remove the alleged perpetrator immediately from both the classes and the transport that they may share with the alleged victim whilst an investigation into the case takes place. They are also expected to organise break times and mealtimes to avoid further contact. Separation of both the alleged victim and alleged perpetrator(s) during the investigation appears to be the main national mechanism for dealing with the issue as well as writing a risk assessment/safety plan and ensuring support is offered to all children.

2.8 There is no national guidance on how long these arrangements should continue, especially if any police investigation proves inconclusive. Therefore any separation arrangements must be continued for 'as long as necessary'. There is a recognition that schools and colleges cannot deal with this issue alone. There is little awareness nationally that this separation could last almost indefinitely, with the subsequent impact on both alleged victim and perpetrator and their families (and indeed the schools).

2.9 Given this national guidance, could Herefordshire Council have implemented any better advice than was minimally required? In particular in the light of learning from one particular case during 2017.

2.10 This review will summarise the extent and severity of the issue locally during the period in question (see exempt appendix table 1).

2.11 This review does not seek to ask individuals to revisit experiences that might cause them damage or harm. Although individual schools have been contacted to discuss what actions they took, no individuals involved in any cases have been contacted.

Multi Agency Safeguarding Hub (MASH) and Section 47

2.12 The review involved identifying referrals, (January 2017-November 2019), into MASH following allegations of peer on peer sexual abuse cases where the *pupils were in the same educational setting*. MASH is the Multi Agency Safeguarding Hub which has on it representation from all agencies involved in protecting children, including for example, social care, health, police and education. A Section 47 enquiry refers to Section 47 of the Children Act 1989 requires councils to undertake enquiries if they believe a child has suffered or is likely to suffer significant harm.

2.13 Once cases were identified, the advice on each case was reviewed in light of the national guidance from the Department for Education (DfE) in place at the time, to assess if the advice was compliant with national guidance. Following the Children and Young People's Scrutiny meeting on 2nd June 2020 it was further requested that the recommendations from a report commissioned in April 2017 into a specific incident (see above) were also taken into account when reviewing the cases, given the learning that had been identified in that local case. Each of the settings identified were contacted to confirm if the advice had been followed and what action was taken as a result of the referral. What could we, as a council, have done better?

2.14 The review was undertaken by reviewing officers with limited or no connection with any previous cases, heads of service, the principal social worker(s), the quality assurance manager and the case progression officer in the children and families directorate. As such it was an objective, but internal, review process.

2.15 Contacting the schools/colleges was led by the Assistant Director Education, Development and Skills and involved staff within that division of the directorate.

2.16 This review also offers some recommendations for future activity which will themselves become subject to further scrutiny and review.

Key Documentation and Guidance

2.17 There are key documents which are mentioned in this review and which cover the period in question - some are national guidance and others are 'best practice' toolkits:

a) Keeping Children Safe in Education, September 2019
b) Brook Traffic Light Tool
c) Herefordshire school and college safeguarding policies
d) Sexual Violence and Sexual Harassment in Schools and Colleges (December 2017 and May 2018)
e) West Midlands Policy: Children who abuse others
f) Contextual safeguarding Network: Beyond Referrals
g) NSPCC Let's Talk Pants campaign and tools
h) Link to most recent update of KCSIE 2020 : https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892394/Keeping_children_safe_in_education_2020.pdf

2.18 This review looked at all cases of peer on peer sexual abuse reported to MASH within the time frame. Whilst all such cases are serious events there are varying levels of severity and different contexts surrounding the events. They are all not the same. Of those reviewed here, some took place out of school, some involved very young children and some involved multiple agencies. Similarly, some were disclosed long after the alleged events. Trying to respond in a proportionate and equitable way is not straightforward. However this review has looked at every case that fits the definition of peer on peer abuse (in the terms of reference above) that took place within the timeframe and where the victim(s) and alleged perpetrator(s) attended the same educational establishment. The definitions used in this review for sexual violence and harassment are taken from the Sexual Offences Act 2003 and explained further in an appendix to this report.

Peer on Peer abuse incident – Herefordshire School 2017

2.19 In 2017 a significant report was commissioned by the school, but funded by the Local Authority (who were provided with a copy), following an incident at a Herefordshire school. The report produced some recommendations for changes. A key part of this review is to see if those recommendations were implemented widely, or could we have, as council, have done more.

Summary of Peer on Peer Cases referred to MASH

2.20 The total number and nature of events are collated in a table attached to this review. It is anonymised however due to the fact that some of the detail may still identify individuals. This Appendix is exempt from publication for the public and press for that reason.

2.21 Although below there is a detailed analysis of the two periods under review, there is a tabular appendix which summarises the totals provided (appendix attached).

2.22 Taken together over the 33 months, there were 28 cases of differing severity and complexity. Of these 28 cases there are 7 where the records were not completed adequately or did not show if the advice was followed. This does not mean no advice was given or followed. The review shows that in only 1 case was advice not followed and although the appropriate actions had been taken they had not been recorded in a written format.

2.23 The detail of the numbers and nature of the incidents in the review are contained in an appendix published with this report. In summary however, there were 10 cases logged for the period January 2017 to October 2018 and a further 18 cases for the period November 2018 to November 2019. Of the 28 cases in total 18 took place outside of school. 14 were logged as no further action needed by social care as other agencies had provided support. Police investigations were held for 10 of the cases and in 9 no prosecution was brought with one case still under review.

2.24 In no case are the alleged victims and perpetrators now integrated in the same institution.

2.25 **Analysis of the outcomes of the referrals found that:**

a) 14 cases are recorded as 'NFA' (no further action for social care). In these cases records indicate that support was put in place from other agencies which included support from the schools, the NSPCC, WMRSASC, Early Help assessments, keep safe work by social workers, family support workers or schools.

b) A section 47 single agency investigation was conducted in one case resulting in a CIN Plan (child in need plan) being implemented.

c) Section 47 joint enquiries (multi-agency) were conducted in one case resulting in a child and family assessment being completed. The case was closed 3 months after the initial referral.

d) Strategy meetings were held for 3 further cases at which the presenting issues were deemed not to be high enough for a section 47 enquiry. Child and family assessments were subsequently completed and the cases closed to social care.

e) Police investigations were completed for 10 of the cases. In 3 of these cases the alleged victims did not want to pursue the investigations any further. In 9 of these cases it is recorded that, following police investigations, no charges were brought. 1 case is listed as still open to investigation whilst we await a decision on prosecution.

2.26 **Was the advice given at the time accurate and in line with National guidance? Could we have done more?**

a) The DFE guidance on Sexual Harassment and Sexual Violence in schools and colleges that applied during this period was the December 2017 version (updated in May 2018). It essentially centres on the need for completing risk assessments or a safety plan in cases of sexual violence (based on separation) and schools being advised to refer to another service, which may include the police or children and young people's sexual advisors (ChISVAs)

b) In 12 of the 18 cases the advice given by MASH complied with the guidance and was recorded fully.

c) In 2 of the 18 incidents, however there were no recorded actions on the internal system (MOSAIC) for a school to take regarding putting in place a risk assessment or safety plan (this is only compulsory if the incident is sexual violence) or advice to refer on another agency. **This does not mean that appropriate advice was not given, it was however not recorded adequately and in enough detail.**

d) In one instance, the school had already put in place the safety plan before being advised to do so.

e) In the other of these incidents, this was because the disclosure involved an historic incident that had occurred two or more years before the actual disclosure was made.

f) In 4 incidents the advice given was correct: Appropriate advice was given regarding referrals or support for the children involved, but it is not recorded whether a safety plan was advised or not.

g) In one of these 4 incidents where the victim and alleged perpetrator were no longer at the same school, a safety separation plan was not deemed appropriate.

h) In another one of these 4 incidents (a disclosure about an alleged historic event), the alleged perpetrator and alleged victim did remain in the same school for a month after the disclosure was made and the review found that safety planning and the need for risk assessments was not recorded as being discussed by the MASH. In this case, separation was put in place however and advice given and followed but not fully recorded. One on the individuals then moved schools. However no written risk assessment was completed. The school now knows what requirements are required and are diligent in applying them. It is recommended that this school be visited again to check the current status of the case. No prosecution took place.

i) This review then contacted the schools/colleges to confirm if advice was followed and what action was taken. These conversations were with the most appropriate staff member (usually the Designated Safeguarding Lead). This was partly to see if the advice was issued and also to check what subsequent actions were taken. No families were contacted.

j) The advice given in the 16 cases where the MASH recorded the advice given was followed by 15 of the schools.

k) In the remaining case, advice was to complete a written risk assessment/safety plan. The school did ensure that the two pupils were in separate classes and safe areas for break and lunch times were made available. However, the written risk assessment was not completed.

l) This failure by the school to write a risk assessment had been discovered due to multi agency working. It resulted in a safeguarding visit from Herefordshire Council education team on 13 December 2019.Consequently the school has been advised in writing about the requirements to undertake written risk assessments/safety plans in cases of sexual violence.

m) To avoid this happening again in another setting, we are asking schools to send their risk assessments to the Education MASH team.

n) Overall for the review there is clear evidence of the schools involved in these 18 incidents working with multi agencies e.g. the police, West Mercia Rape and Sexual Abuse Support Centre (WMRSASC) and the Early Help Team and ensuring support is offered to the victim and/or the perpetrator.

2.27 **What should we have done differently?**

a) The quality of recording of referrals and subsequent activity was not consistently good enough in the period covered by this review. This includes the record of actions taken on MOSAIC, the internal recording system. As a consequence a historic review such as this is of less value - with the passage of time details have been missed.

b) Herefordshire could have insisted on safety plans/risk assessments being completed by schools and colleges for incidents of alleged sexual violence from May 2017 and those risk assessments/safety plans being submitted to the MASH for recording and quality assurance checks. Given that the 2017 review recommendations were available, these recommendations were not more widely shared. Even allowing for the context that schools are self-governing and autonomous institutions, sharing of good practice would, in general, help.

c) The dependency on implementing the national guidance - but crucially, not looking to go beyond this in a systematic and published fashion - was a potential

weakness. For example, there was no full consideration or advice given at that time about additional human rights or equalities legislation. This is however also the case nationally and not just locally and national guidance was not clear about separation at that time. This is complex as balancing the rights of both alleged victim and alleged perpetrator can be a difficult judgement. There was an opportunity for a greater consideration of what more could be done to support the families of victims which takes into account the rights of both and in the light of equalities legislation.

d) Although much has been done - it is now timely to refresh the risk assessment proforma policy for schools again - not least because the national guidance has been updated in July 2020 - but also because this provides an explicit opportunity to include wider legislation, especially equalities and human rights considerations as outlined above. It is also timely to create and issue a model policy and risk assessment process. Although any local authority cannot impose any policy on all schools it can - and we should - seek to reassure ourselves that if a school actively decides not to adopt it they are required to explain their reasoning. In the summer of 2020 Herefordshire appointed a new safeguarding officer, the national guidance has been updated and in September 2020 the new national Sex and Relationships Education programme is being implemented. Taken together this is the opportunity to integrate better practice into a broader picture of better contextual safeguarding for Herefordshire.

e) In 2017 there was an independent review commissioned into one case - this was carried out by an organisation outside of the council. As part of that review, a helpful risk assessment process was shared with the school. It was not however shared more widely across the council. It should have been, although that moment has now passed. It was not shared as a view was taken that it belonged to the school and that there were other tools that schools could use. This risk assessment is not now fit for purpose in view of up to date guidance and legislation. It was also the case that the risk assessment was itself deemed not as robust as it could have been. However, the delay in passing on the advice was unhelpful. Peer on peer awareness training was provided to schools in the Autumn of 2017 but this didn't go as far as the content of the report.

f) The way in which Herefordshire Council (and partner agencies) engages with families affected by peer on peer sexual abuse was inconsistent and potentially lacking in structure. This is not to say that support was not offered - indeed it is now given via MASH and other partner agencies. Officers have met with some families but there is no deep awareness of the structured response plan now in place to engage with and support families or schools facing an event such as this. Schools do engage with Herefordshire Council and yet a case by case basis can lead to inconsistency. Whilst recognising that this would require

specialist support skills it is not clear what would be the response in the event of a future case. This is not to say that this is not better now - it is - and there is a system in place which rests on good guidance and advice. However it remains the case that it is potentially variable. A flowchart is attached to show the expected process now which has been widely shared during 2020. This has helped improve consistency.

g) Schools and settings do receive good quality and accurate advice now but they themselves do not have easy access to a support network - particularly where long term segregation needs to be in place. Support (including financial support to help with separation and the provision of on line learning) to schools facing a long term or contentious case could be strengthened.

h) The lack of national comparative data is a concern. At present we have no robust way of comparing levels of abuse in Herefordshire to other areas. This is a national and remaining weakness. Whilst we have no reason to assume that levels are higher or lower locally, we cannot be sure.

i) The measures above are aimed at providing advice and assessing risk - but more could be done to identify any preventative work that agencies could do. This is evident in schools where training in early preventative work is provided but less so in the sharing of information and support across agencies. More could be done to broker support for schools who experience this for the first time by being more systematic in the sharing - confidentially - of experience.

j) When new members of staff join the Children and Families Directorate they are given a helpful induction period. This does not always include an emphasis on safeguarding risks and prevention, including an awareness of peer or peer sexual abuse. This could be included as a greater priority.

k) Finally, the issue of prompt and rigorous responses to any disclosure should be improved. We could have listened more and acted more quickly in ensuring guidance was being followed and the recommendations from the 2017 report implemented. The timeliness of any action is crucial and a reliance on broad national guidance brought delay into some of the proceedings.

2.28 **What have we done since?**

What steps has the council already taken to improve how incidents of peer on peer abuse are dealt with?

a) In 2019 we introduced an annual school safeguarding conference for designated safeguarding leads and safeguarding governors in schools. A key focus of this conference in 2019 was peer on peer abuse. This was led by

national experts in the field. Attendance was high with almost all schools represented by school leaders, governors and safeguarding leads attending.

b) All briefings to Chairs of Governors, Head Teachers and Designated Leads for Safeguarding include updates and guidance on best practice for dealing with peer on peer abuse. Briefings are often termly. They have taken place over a number of years now and are more usually provided by staff within the Children and Families Directorate but on occasions have national expertise also.

c) Learning opportunities for designated safeguarding leads have been created using case studies of previous incidents of peer on peer abuse in order to highlight good practice and what lessons can be learned.

d) A peer on peer abuse risk assessment pro forma has been issued for schools to use (autumn 2019). However a pro forma is only that - the process of risk assessment is more profound than the paperwork and council officers now support schools in this area more than previously. The newly appointed Education Safeguarding Officer will be expected to take a lead in this work. This is a significant move forward.

e) The Children and Young People's Scrutiny Committee has undertaken a spotlight review into peer on peer abuse and Herefordshire Council has begun to implement the recommendations from this review.

f) Participated in an audit into harmful sexual behaviour organised by the Safeguarding Children and Young People in Herefordshire Partnership using the NSPCC.

g) There is greater support (via clearer guidance and associated toolkits) on offer now to schools and teachers than was the case previously. An exemplar policy has been produced by other Local Authorities (for example, Suffolk and Nottinghamshire). Herefordshire has included much of this in advice to schools but, given the significance of this issue, it should produce a similar local model.

h) Multi-agency MASH thematic audits of peer on peer abuse referrals into the MASH take place. The most recent audit of a sample of cases has found improvements since the previous audit in both the approach and response to peer on peer abuse cases. Clear actions are in place for any highlighted areas for development.

i) The council has reviewed the section 175/157 audit to ensure it includes a question on peer on peer abuse (the 2019 audit results show that all schools have policies and procedures in place to minimise the risks of peer on peer abuse). A number of quality assurance visits take place annually to ensure schools are robustly self-assessing their practice.

j) The restructuring of the Learning and Achievement Team has created a new post: Education Safeguarding Officer. This post has now been recruited to and

we are awaiting for the successful candidate to take up their post in August 2020. This is a significant development.

k) We have also undertaken a 'lessons learned' exercise through discussions with Designated Safeguarding Leads at the most recent education safeguarding meeting to establish current challenges schools face when dealing with peer on peer abuse.

l) Safeguarding visits to schools and desk top reviews of policies are undertaken.

m) The Learning and Achievement Team's school visit form has been reviewed and whilst they have always included a section on safeguarding, they now ensure an additional focus on peer on peer abuse as well.

n) Herefordshire Council has worked more closely with wider partner agencies and experts since 2017. For example, this includes WMRASASC (West Mercia Rape and Sexual Abuse Support Centre) - these agencies are now working in schools and supporting them in their work. This work could be extended and developed, particularly in the area of policy renewal and post incident support.

o) There is a clear referral pathway process in the MASH for dealing with peer on peer abuse.

p) We have recommended and supported the use of the Brook traffic light tool (a tool to aid prevention and early identification of cases that meet the threshold of concern based on age appropriate sexualised behaviour).

q) So - having done all this - can we give an assurance that children who have experienced peer on peer sexual abuse will not end up in the same educational setting together again?

r) It remains the case that if no one knows about an incident (for example it has not been disclosed) it cannot be guaranteed the children will not be in the same setting. However once disclosure has been made, the evidence now supports the view that children are separated. This is not easy in some smaller settings, but schools have gone to great lengths recently to maintain the separation and now know this is required as a minimum. The issue emerges when children then move between settings, for example when transitioning between primary and secondary school or from secondary to tertiary colleges.

s) The process of sharing of information between settings to prevent children meeting their alleged perpetrator is not straightforward. It is especially complex if no conviction has been made or with the passage of time. The process by which this could happen, confidentially and sensitively, exists but could be improved.

2.29 **The review has provided the following assurance-**

a) Given the efforts that have been made in recent months, including the conferences and guidance, I believe that children are more safe now in Herefordshire schools than may have been the case previously. This can now be built on to become a best practice authority in this regard. To do this Herefordshire must involve the expertise and awareness of those who have lived through this experience.

b) Where advice was given and recorded, it was found to be the correct advice, based on the national guidance from the DfE at the time with one exception (for which Herefordshire Council has issued an apology). Although the recommendations and risk assessment form issued in the report commissioned by Herefordshire Council in 2017 was discussed in Chair of Governor Briefings, the specific circumstances or documentation were not shared. The Brooks Traffic Light Tool that supports professionals to assess and work with preventing sexual behaviours of children and the NSPCC "Let's Talk Pants" campaign were highlighted as useful tools as part of briefings on peer on peer abuse. Herefordshire Council subsequently shared a peer on peer risk assessment template with schools in the autumn of 2019. Other recommendations such as raising staff awareness through training have been now been completed and can be evidenced in the section 175/157 annual audit.

c) With the exception of one school, all other settings have followed the advice given by the MASH. In the one example, the school was advised to separate and indeed pupils were separated, but this was not recorded fully.

d) Record keeping is improving but MASH must ensure that all advice given to schools relating to peer on peer abuse is recorded in MOSAIC.

e) There are now regular audits co-ordinated by the Safeguarding Children and Young People in Herefordshire Partnership Quality and Effectiveness group - the latest is called a MASH thematic audit specifically on peer on peer sexual abuse (dated March 2020) which showed improvements in the quality of recording continue.

f) Ofsted conducted a focussed inspection visit in December 2019 - as part of that visit they looked at the issue of peer on peer abuse. The report is now published on the Ofsted website - but the relevant paragraph is reproduced below. It is complimentary about the recent work in this area.

g) There has been a significant strategic focus by the local authority since the last inspection on contextual safeguarding, and, in particular, peer-on-peer abuse and ensuring that there are appropriate responses to risk in this area. The local authority has worked closely with schools to ensure that that all have policies and procedures that both help to identify peer-on-peer abuse concerns and help to limit risks. The local authority has ensured that these issues have been the subject of practice reviews, including through a recent multi-agency spotlight

review on peer-on-peer abuse. The local authority has also undertaken audit activity in relation to service responses, including looking at school safety planning. The responses of children's services indicate that thresholds for services are appropriate and that schools are using the multi-agency hub to appropriately refer concerns. They are also using both social care staff and education officers to discuss issues and plan further work with children and families.

2.30 **Next steps**

a) The council has committed to keeping training and guidance to schools and officers and council members as a priority in all such cases for the future - and has accordingly led training for all Designated Safeguarding Leads in all schools and colleges and is planning for the next education safeguarding conference. This could be tailored for individual need.

b) We will also implement any further service changes required as part of the multi-agency Safeguarding Partnership approach as a result of the findings of the NSPCC audit work when they are received.

c) The cabinet member has also agreed the response to the recommendations of the Children and Young People's Scrutiny Committee Spotlight review into peer on peer abuse and these will be implemented as appropriate. There will be several dates as the actions differ.

d) To review what additional information needs to be recorded in MOSAIC for peer on peer abuse cases. This will include continued quality monitoring.

e) To ensure cases of peer on peer abuse are regularly audited to enable us to continually improve and ensure best practice and advice is used by all agencies.

f) Herefordshire will continue to engage with specialist outside-of-council agencies to support this work and further utilise their expertise.

g) Now that an embedded process is in place by which risk assessments/safety plans are shared by schools with the MASH, the next planned step is to quality assure these documents with education and social care colleagues. Detailed feedback will then be provided to the individual school as well as sharing the generic findings from this quality assurance process with all Herefordshire DSLs (designated safeguarding leads).

3 RECOMMENDATIONS

3.1 The 'what could we have done differently?' section above, alongside the recommendations agreed during the spotlight review, leads to the following recommendations:

Attached to each recommendation is a suggested timeline - these are subject to comment by scrutiny committee.

a) Continue to improve the quality of recording on MOSAIC for any cases, including peer on peer cases. This has improved significantly since 2017 but this review found that it could be improved yet further by maintaining the quarterly audit (already in place) on all cases and adding occasional sampling exercises to identify if recording is not adequate. In particular, record keeping should indicate what advice was given and what actions were taken and there is evidence that this is now taking place.

   (Monthly audits starting September 2020 and to be conducted by education safeguarding officer)

b) Issue wider guidance than the national expectations - by looking at all legislation that may impact on such cases. There is a timely opportunity to do this now. The national guidance, Keeping Children Safe in Education, has been updated again in July 2020 and a key appointment to support this work has recently been made in Herefordshire. Whereas schools, in general, have a right to implement their own policies (partly because the process by which any policy is agreed is a key component of any policy), a model exemplar should now be issued given the importance of this issue. Herefordshire Council cannot enforce schools to adopt it however. The context around this issue has moved on considerably since 2017 and what was deemed appropriate then is no longer adequate if we are to learn from our experiences. There is an opportunity now to set an exemplar policy which can be leading edge practice.

   (Policy to be re-issued by Children's and Families Directorate by the end of January 2021 to allow for external consultation)

c) A risk assessment has been shared with all schools (Autumn 2019). This is not the exact one produced in 2017 and things have progressed since then. Schools are ultimately responsible for their own risk assessment processes and multiple forms and guidance are now available. More importantly, we can provide guidance in completion <u>of the process</u> of risk assessments. There is a danger that multiple proformas may confuse, but training in the <u>process</u> of risk assessment and prevention would outweigh this danger. The newly appointed safeguarding officer will lead on this aspect.

   (To be a regular process but to be established by December 2020)

d) Continually review and check that information is passed between educational settings where individuals known to have been either alleged victim or alleged perpetrator and who are moving between settings is shared. To protect confidentiality and sensitivity this process should be supported by the Local

Authority and not left to individual settings to complete. Although there is an existing protocol, the newly appointed safeguarding officer should hold this responsibility as part of the role. For example, an alert system should be established in MOSAIC to identify when individuals are likely to be moving settings.

(To be established by the education safeguarding team by the end of December 2020)

e) Look to establish a planned approach to engaging with families (and children) impacted by peer on peer abuse. This is to include the seeking of their views and from a starting point of belief and with the consent of the families. This would include the schools involved. The level of engagement needs to also take account of equalities legislation and allow for appropriate extra counselling to be offered.

(To be established by December 2020 to allow for consultation)

f) Establish a school support network (using existing groups) to provide help and advice in the event of any cases, but particularly long standing cases. For example, this could include a network of expert Designated Safeguarding Leads (DSLs) to advise and new DSLs, support schools and families.

(To be established virtually by December 2020, by the assistant director, education, development and skills))

g) Propose, via a development with DfE (and Ofsted), a methodology of capturing high quality data to allow authority areas to benchmark the incidence and severity of peer on peer sexual abuse cases. The national system is not transparent enough as yet and Herefordshire, given recent efforts and advice, is well placed to contribute to improving the quality and clarity of data on peer on peer sexual abuse.

(Initial proposal to be shared with DFE and Ofsted by end of October 2020 by the assistant director, education, development and skills)

h) Ensure that all new members of staff appointed to the Directorate are given a wider safeguarding strand in their induction, which should include peer on peer sexual abuse. This should be aimed at prevention and risk assessment rather than historic analysis. It would help make Herefordshire a benchmark for good practice in this regard.

(Initial induction activity to be in place by end of September 2020)

i) That the council consider funding additional resources to support further peer on peer abuse training, in particular to support the educational specialist safeguarding post covering peer on peer abuse work (this post now exists - but

additional resources available for peer on peer abuse training should be considered).

(Resources to be in place as soon as council agree)

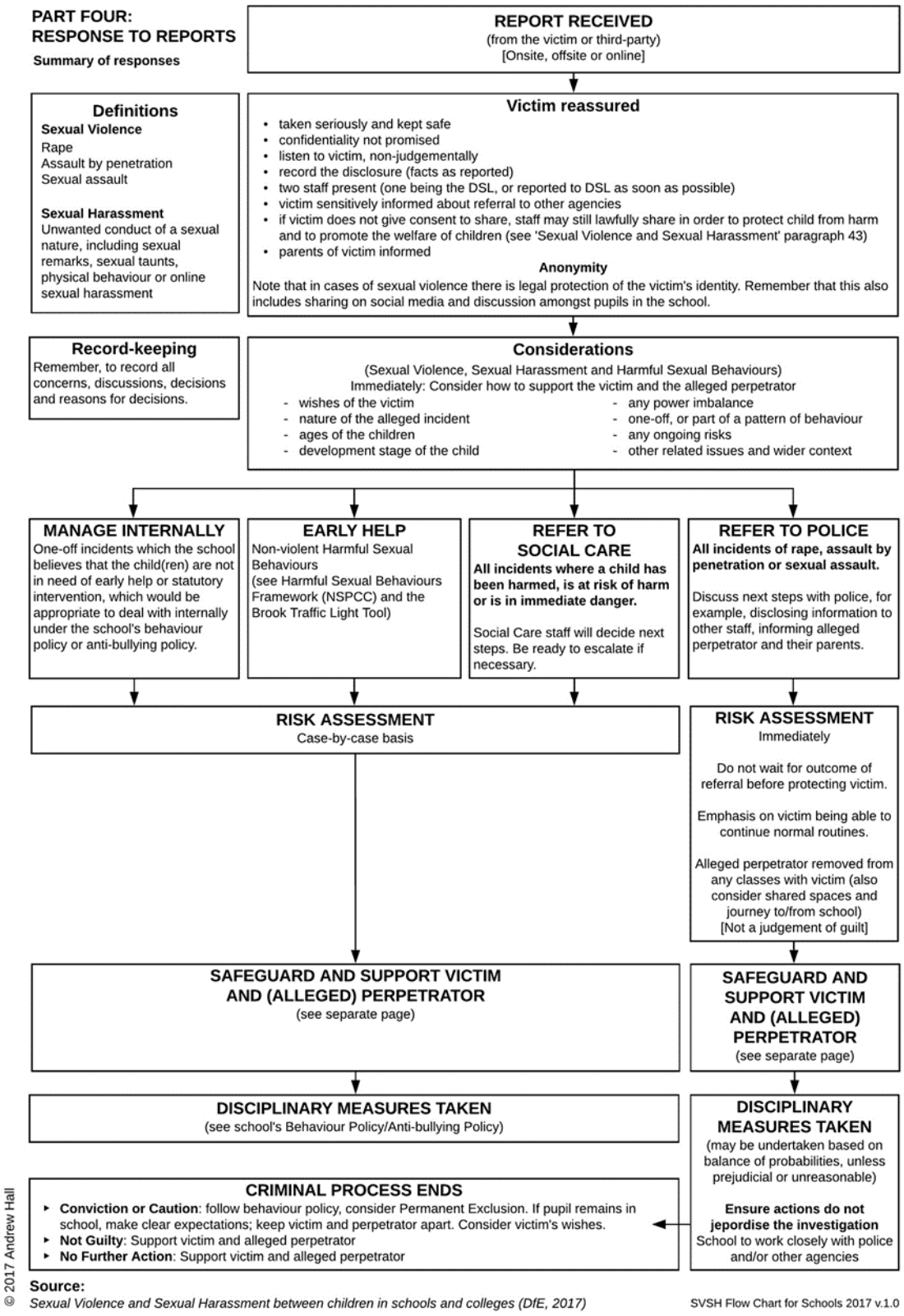
j) That Herefordshire produces an exemplar peer on peer safeguarding guidance and model policy which is issued to all settings. It is acknowledged that whilst all schools deal with Peer on Peer abuse in their safeguarding policy as well as in other policies (such as a school behaviour policy, the anti-bullying policy and the online safety policy - cyberbullying and sexting) schools now need to be more clear and specific about their strategies around wider behaviours relating to sexist and sexual bullying, sexual harassment and sexual violence. In all cases adoption of such a policy is inevitably voluntary (schools will have much in place already) but an exemplar will help with review work. There is the opportunity that given the experiences thus far, Herefordshire can become a centre for excellent practice in this area, in particular by adopting the good work done in this issue, such as by Suffolk and Nottinghamshire Local Authorities. This cannot be easily achieved without the following recommendation however.

(This is in train already - to be issued as soon as wider consultation allows)

k) Finally - Herefordshire Council needs to further acknowledge that the impact of such cases on the families and the children involved (irrespective of any findings) is likely to be profound. An apology has already been given for some of the early work - but we could do more. The council should strongly consider issuing a **process of reconciliation;** offering any family who wishes to use it an opportunity to share their experiences in a safe space with independent and expert support. Although we recognise there is as yet no formal process for such a statement (and as such the reconciliation process would need to be established), the opportunity it would present is the key. If anything positive can come from such experiences then giving a voice to those who have experienced it can be something. It is also a better way of harnessing the experiences within the county to develop more leading edge practice. This cannot be achieved unless the voices of those affected are heard.

For reasons of confidentiality we have sought not to include details that may lead to identification of any individual cases. This is crucial for many reasons. However, we are aware that on reading this, families that have experienced peer on peer abuse may wish to engage with the process of reconciliation. This includes families which we may not have had any disclosure from as yet. We would like to invite all families who may recognise their case – and those who do not, that if they wish to take up the invitation to do so. The process may differ from family to family according to wishes but the invitation is open to all.

(Timeline for consulting, engaging and establishing this process will start following comments from scrutiny)


PART FOUR:
RESPONSE TO REPORTS
Summary of responses
REPORT RECEIVED
(from the victim or third-party)
[Onsite, offsite or online]
Definitions
Sexual Violence
Rape
Assault by penetration
Sexual assault
Sexual Harassment
Unwanted conduct of a sexual nature, including sexual remarks, sexual taunts, physical behaviour or online sexual harassment
Victim reassured
taken seriously and kept safe
confidentiality not promised
listen to victim, non-judgementally
record the disclosure (facts as reported)
two staff present (one being the DSL, or reported to DSL as soon as possible)
victim sensitively informed about referral to other agencies
if victim does not give consent to share, staff may still lawfully share in order to protect child from harm and to promote the welfare of children (see 'Sexual Violence and Sexual Harassment' paragraph 43)
parents of victim informed
Anonymity
Note that in cases of sexual violence there is legal protection of the victim's identity. Remember that this also includes sharing on social media and discussion amongst pupils in the school.
Record-keeping
Remember, to record all concerns, discussions, decisions and reasons for decisions.
Considerations
(Sexual Violence, Sexual Harassment and Harmful Sexual Behaviours)
Immediately: Consider how to support the victim and the alleged perpetrator
wishes of the victim
nature of the alleged incident
ages of the children
development stage of the child
any power imbalance
one-off, or part of a pattern of behaviour
any ongoing risks
other related issues and wider context
MANAGE INTERNALLY
One-off incidents which the school believes that the child(ren) are not in need of early help or statutory intervention, which would be appropriate to deal with internally under the school's behaviour policy or anti-bullying policy.
EARLY HELP
Non-violent Harmful Sexual Behaviours
(see Harmful Sexual Behaviours Framework (NSPCC) and the Brook Traffic Light Tool)
REFER TO SOCIAL CARE
All incidents where a child has been harmed, is at risk of harm or is in immediate danger.
Social Care staff will decide next steps. Be ready to escalate if necessary.
REFER TO POLICE
All incidents of rape, assault by penetration or sexual assault.
Discuss next steps with police, for example, disclosing information to other staff, informing alleged perpetrator and their parents.
RISK ASSESSMENT
Case-by-case basis
RISK ASSESSMENT
Immediately
Do not wait for outcome of referral before protecting victim.
Emphasis on victim being able to continue normal routines.
Alleged perpetrator removed from any classes with victim (also consider shared spaces and journey to/from school)
[Not a judgement of guilt]
SAFEGUARD AND SUPPORT VICTIM AND (ALLEGED) PERPETRATOR
(see separate page)
SAFEGUARD AND SUPPORT VICTIM AND (ALLEGED) PERPETRATOR
(see separate page)
DISCIPLINARY MEASURES TAKEN
(see school's Behaviour Policy/Anti-bullying Policy)
DISCIPLINARY MEASURES TAKEN
(may be undertaken based on balance of probabilities, unless prejudicial or unreasonable)
Ensure actions do not jepordise the investigation
School to work closely with police and/or other agencies
CRIMINAL PROCESS ENDS
Conviction or Caution: follow behaviour policy, consider Permanent Exclusion. If pupil remains in school, make clear expectations; keep victim and perpetrator apart. Consider victim's wishes.
Not Guilty: Support victim and alleged perpetrator
No Further Action: Support victim and alleged perpetrator
Source:
Sexual Violence and Sexual Harassment between children in schools and colleges (DfE, 2017)
SVSH Flow Chart for Schools 2017 v.1.0
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4 Legal Comments

4.1 The council, working with partner organisations and agencies, has specific duties to safeguard and promote the welfare of all children in their area. The Children Acts of 1989 and 2004 set out specific duties: section 17 of the Children Act 1989 places a duty on the council to provide services to children in need in their area. Section 47 of the Children Act 1989 requires councils to undertake enquiries if they believe a child has suffered or is likely to suffer significant harm. The Director of Children and Families and Lead Member for Children and Families in the council are the key points of professional and political accountability, with responsibility for the effective delivery of these functions.

4.2 These duties placed on the council can only be discharged with the full co-operation of other partners, many of whom have individual duties when carrying out their functions under section 11 of the Children Act 2004. Under section 10 of the same Act, the council is under a duty to make arrangements to promote co-operation between itself and organisations and agencies to improve the wellbeing of local children. This co-operation should exist and be effective at all levels of an organisation, from strategic level through to operational delivery.

4.3 With regard to Peer on Peer abuse, Keeping Children Safe in Education (updated in September 2019 and again in September 2020) provides statutory guidance for schools and colleges who must have regard to the guidance when carrying out their duties to safeguard and promote the wellbeing of children.

4.4 In relation to the recommendations Appendix 6 provides a table as to specific statutory duties relevant to each recommendation.

4.5 By implementing recommendations and next steps in the report Legal Services will work with the service to ensure that statutory duties as identified are complied with.

5 Appendices

Appendix 2 - Historic Data Peer on Peer Cases – Exempt Appendix

Appendix 3 - Details of the cases under the review period

Appendix 4 - Create Safer Organisations Report 2017 – Redacted version

Appendix 5 - What is Peer on Peer Abuse - definitions?

Appendix 6 - Legal Basis for Recommendations