Herefordshire
Children Safeguarding Partnership

Child Safeguarding
Practice Review

Thematic learning following allegations of peer-on-peer abuse

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1 Introduction

1.1 This Child Safeguarding Practice Review was commissioned by Herefordshire Safeguarding Children Partnership to explore the multi-agency response to allegations of peer-on-peer abuse.

1.2 The young people involved in the review will be referred to as YP1 and YP2. YP1 made two disclosures to a School Nurse which indicated that the relationship with YP2 had been abusive. It was recognised that there was potential learning from this case in the way that agencies worked together following allegations of peer-on-peer abuse. The National Panel were informed of the decision to undertake a review.

2 Process

2.1 This report has been written with the intention that it will be published, and only contains information required to identify the learning from this case. The review was guided by the terms of reference agreed by the steering group.

2.2 Cath Connor was appointed as the independent reviewer and the review was chaired by Ellen Footman[1]. The review considered agency reports and chronologies. Practitioners and representatives from relevant agencies attended learning events[2] to discuss the case and identify opportunities for practice improvements. The review considered multi-agency practice following disclosures made by YP1 to the School Nurse. The steering group agreed the key learning points resulting from this review. Findings from previous reviews, relevant reports and subsequent improvement plans have informed the recommendations within this review.

2.3 The review author and chair had discussions with YP1 and their parent to obtain their views about the support and intervention provided by agencies. The contributions of YP1 and their parent are included within this report and informed the findings and key learning points, the final report will be shared with them prior to publication.

2.4 Herefordshire Safeguarding Children Partnership recognise the importance of understanding and learning from the experience of all young people involved in allegations of peer-on-peer abuse. This will be addressed as a recommendation.

[1] Cath Connor is independent of Herefordshire Safeguarding Children Partnership and partner agencies. Ellen Footman is the head of Quality and Safeguarding, Designated Nurse for Safeguarding Adults and Children Mental Capacity Act Lead NHS Herefordshire and Worcestershire Clinical Commissioning Group.

[2] This review was completed virtually except for the initial meeting of the review steering group. Arrangements for the involvement of professionals and family members were made in line with guidelines at the time regarding Covid-19.

3 Agency involvement

3.1 The following services / agencies are referred to during the period considered by this review:

- School
- GP
- School Nurses (SN1 and SN2)
- Police
- Children's Social Care (CSC)
- West Mercia Women's Aid (WMWA)
- West Mercia Rape and Sexual Abuse Support Centre (WMRSASC)
- Wye Valley NHS Trust (WVT)

Agency intervention and support

3.2 This section of the report will provide a descriptive overview of agency involvement. Discussion and analysis of multi-agency practice is presented in section 5.

3.3 YP1 met with the School Nurse (SN1) to discuss the relationship with YP2, a pupil at the same school. YP1 informed SN1 that the relationship recently ended, had not been sexual, and disclosed information which indicated that there had been elements of control and abuse. SN1 made a referral to the Multi-Agency Safeguarding Hub (MASH[3]) at Level 4 of the Herefordshire Level of Need Threshold document[4] and the Police. Following enquiries, the Police also made a Level 4 referral to the MASH. The GP was notified of the disclosure of alleged abuse within a relationship with a peer by Health professionals within the MASH.

3.4 Following initial enquiries there was no further involvement by the Police or CSC. School implemented a safety plan which was signed by YP1, YP2 and their parents. SN1 and SN2 provided 1-1 support to YP1 (via the drop in at school) which focussed on healthy relationships and anger management. SN2 referred YP1 to West Mercia Women's Aid with a request for 1-1 support and the CRUSH programme[5]. A couple of weeks after the initial disclosure to SN1, YP1 informed SN2 that they had engaged in a consensual sexual relationship with YP2 and said that they had used contraception.

3.5 SN1 obtained the consent of YP1 and their parent to deliver elements of the CRUSH programme to YP1 in school time. During this work YP1 stated that they had been scared by YP2, and coerced without fully consenting to have a sexual relationship. SN1 made a second Level 4 referral to the MASH and the Police. Following a review of the crime report and risk assessment, the Police also completed a second Level 4 referral to the MASH. Initial enquiries were made and no further action was taken by CSC.

3.6 YP1 confirmed to the Police that they had engaged in a sexual relationship with YP2 on two occasions because they had been scared and believed that YP2 may become angry

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[3] *The MASH is a partnership between the local authority which includes Children's Services, Police, Health, Probation, Education and West Mercia Women's Aid. Primarily it provides a single point of contact to all safeguarding professionals to effectively manage the safety of those considered to be vulnerable. The MASH receives enquires from a variety of sources including participating partner agencies and members of the public. The overarching aim is to protect children and young people considered to be at risk.*

[4] The threshold document in place at the time: https://herefordshiresafeguardingboards.org.uk/media/7908/levels-of-need-leaflet-v5-hfd3549-mar2020.pdf

[5] http://www.westmerciawomensaid.org/services/c-yp-services/crush-overview

or violent if they did not. YP1 said that they had not willingly participated in the sexual relationship. The Police investigated an allegation of rape against YP2 and subsequently found compelling evidence to suggest that the allegation was not founded. The Police shared some evidence with YP1 and their parent and informed school that the investigation had concluded with no further action.

3.7 School continued to implement a safety plan and provided support to both YP1 and YP2 with the ongoing involvement and agreement of their parents. Some months later YP1 informed SN1 that they had withdrawn the allegation because they felt badly after the Police had asked YP1 to consider the impact of the allegation of rape onYP2. YP1 did not tell SN1 that the Police had identified evidence which undermined the allegation. The Police strongly refuted that YP1 had been asked by them to consider the impact of the rape charge on YP2.

3.8 The Police made a referral to the Rape and Sexual Advice Centre and a Children's Independent Sexual Violence Advocate was allocated (ChISVA). YP1 was advised that ongoing support was available from a key worker at school and the school nursing service.

4 Analysis

4.1 Guided by the terms of reference for this review, specific themes were identified following analysis of all the available information:

A. Referrals and decision-making processes
B. Implementation of the child protection procedure: children who abuse others[6]
C. Voice of the child
D. Multi-agency information sharing

4.2 Exploration of each theme enabled rigorous examination of multi-agency practice and identification of opportunities to improve the systems to safeguard children and young people when peer-on-peer abuse has been identified or alleged. Whilst the themes will be discussed separately, it is important to note that each theme had an impact on the others, and learning identified in one area has the potential to influence practice in all.

A Referrals and decision-making processes

4.3 During the period considered by this review SN1 made two referrals within three months to the Police and the MASH following disclosures made by YP1 about their relationship with YP2. The Police also made two referrals to the MASH, following enquiries on receipt of information provided by SN1. The multi-agency response to the referrals is outlined below, followed by an analysis of practice and identification of key learning.

Referral 1

4.4 At the time of the referrals SN1 was a student and received support and supervision from SN2. SN1 informed the review[7] that she asked SN2 to join her in the drop-in[8] when YP1 had shown bruises which they alleged had been made by YP2. SN1 said '*YP1 was very clearly describing an abusive relationship and said that YP2 was horrible to their parent, as well. I believed YP1, there was no reason not to'.*

[6] https://westmidlands.procedures.org.uk/pkoso/regional-safeguarding-guidance/children-who-abuse-others

[7] During a telephone call with the lead reviewer

[8] SN2 was with a pupil in a different room and joined SN1 at the drop in when the initial disclosure was made.

4.5 Following discussions with SN2 and the safeguarding lead at Wye Valley NHS Trust (WVT), SN1 completed a multi-agency referral form (MARF) and made a referral at Level 4 to the MASH and the Police. The referral cited the disclosure by YP1 of significant physical and emotional abuse by YP2.

4.6 A Domestic Abuse Stalking Harassment (DASH) risk assessment was completed by uniformed officers in response to initial concerns of domestic abuse within a relationship, and concluded that the risk to YP1 was medium. Factors which influenced the risk assessment were: the relationship had ended, YP1 and YP2 were living with their parents and school were aware of the issues. Following a review of all the issues and completion of a holistic Child Risk Assessment by the Police Development Officer (DO) within the HAU, the risk was increased to high. The report completed by the Police for this review noted that the factors which informed this decision were that YP1 had reported an extreme form of bullying that had adversely impacted on their health, and school had disclosed that YP1 was having panic attacks and anxiety issues. It was acknowledged that it would have been more appropriate for a Child Risk Assessment to have been completed initially rather than a DASH. This has been addressed by the Police as single agency learning.

4.7 The DO made a referral to the MASH and Health at Level 4 on the Level of Need document. The referral included information about the impact of bullying by YP2 on YP1's emotional wellbeing, historical domestic abuse between parents of YP1, and intelligence that YP1 and another friend of a similar age had been electronically sharing indecent images of themselves with each other[9].

4.8 Records indicate that YP1 and their parent fluctuated in their view about whether to seek a prosecution against YP2. There was also an inconsistency in the understanding of practitioners about whether a prosecution would be sought. The Police report noted that YP1 and their parent were initially unsure about making a formal complaint and asked for YP2 to be given words of advice about their conduct. Following communication between the screening social worker and the Police, the crime report was updated to state that: *YP1 and their parent now supported positive police action and a prosecution.* However, there was no further record or evidence of information sharing between agencies. The education report noted that professionals at school understood the case was not opened by CSC because: *the parent of YP1 was acting protectively by supporting a prosecution. The school are not aware if this decision was looked at again when YP1 and their parent said they did not wish to pursue a prosecution.*

4.9 Police records note that YP2 vehemently denied the allegation during informal talks and was provided with words of advice. The alleged crime was summarised as one word against another and filed as a 'dubious report' with no evidence to support either party.

Referral 2

4.10 The School Nurses continued to offer 1-1 support to YP1. SN1 informed the review that following the initial allegation about YP2 there was a change in friendship groups as some peers believed YP1 and others didn't. The School Nurse/Health Visiting lead for domestic abuse at WVT, supported SN1 to deliver a session which focussed on power and control in relationships during which it emerged that YP1 had felt unable to say no to a sexual relationship with YP2. It was explained to YP1 that their responses when discussing the Teen Power and Control Wheel[10] indicated that they had not freely

[9] Sharing of indecent images was prior to the timeline considered by this review, school were aware and YP1 and their friend were spoken to at the time.

[10] http://www.ncdsv.org/images/Teen%20P&C%20wheel%20NO%20SHADING.pdf

consented to the sexual relationship. SN1 made a second Level 4 referral to the MASH and advised YP1 that the Police and their parent would need to be informed.

4.11 A Police Sergeant completed a Child Risk Assessment which concluded that the risk to YP1 was minimum. It was noted that the relationship had ended, the incident was one year ago and there was lack of clarity regarding consent. Following a review by the DO the level of risk was increased to high. This decision was influenced by the fact that YP1 had alleged that a serious sexual offence had been committed by a pupil at the same school which they were both still attending. The Police made a Level 4 referral to the MASH.

4.12 The referrals were closed by CSC following initial enquiries which focussed on peer-on-peer abuse and it was recorded that: *no further role with regard to the wellbeing of the children was identified*.

4.13 In discussion with the Lead Reviewer and Chair the parent of YP1 said that they were unable to remember much about what had taken place at the time and stated that: *I always said that I didn't want to press charges, they were young and shouldn't get into trouble. YP1 felt pressured when it first started but then it was consensual.*

Key Learning

4.14 The review found that there were opportunities for practice learning with regard to referrals and decision making processes in the following areas, which will be explored separately:

(i) *Processing of referrals to the MASH and communication of decision outcomes*
(ii) *Decision making within the MASH, escalation and professional challenge*
(iii) *Convening a strategy meeting*
(iv) *Referrals to specialist services*

(i) *Processing of referrals to the MASH and communication of decision outcomes*

4.15 The two Level 4 referrals by the Police were not recorded or managed as referrals. The first referral was recorded as a contact record and the second was included on the record as an attachment. This limited the effectiveness of decision making at the MASH, as serious and significant information was not considered.

4.16 Records at the MASH indicated that following the first referral the parent of YP1 had advised that they were being seen by the police and were acting appropriately to safeguard YP1. Record of a telephone call between the MASH social worker and SN1 noted that no outstanding safeguarding concerns were identified. It was unclear what communication took place between the MASH social worker and the Police and it was recorded: *should the police identify safeguarding concerns they will refer back in*. The decision by the screening social worker was that no further action was required, there was evidence of managerial oversight of this decision by the CSC manager at the MASH. There was no record to suggest that the social worker had considered the relevance of additional information within the referral made by the Police prior to making this decision. School completed a safety plan and referred YP1 to the CRUSH programme, from the records, it was evident that decision makers within the MASH perceived school to be taking the lead following the referral.,

4.17 At the learning event professionals stated that at the time, social workers within the MASH considered that YP1 and YP2 were adequately safeguarded by the actions of other agencies, which included the investigation of allegations by the police, and there was no further contribution required by CSC.

4.18 There was significant family history which was not known to professionals. Whilst YP1 was linked to their siblings and half siblings on the system, family history of relevance to safeguarding[11] had not been copied across into their CSC records and was not considered at this time. Given the short timescale to respond to referrals into the MASH it is important that relevant information is easily accessible. There was nothing on YP1's record to indicate concern regarding their welfare prior to the receipt of the initial referral from SN1.

4.19 Practitioners involved in this review stated that at the time of the referrals, the view of key decision makers within the MASH was that peer-on-peer abuse was an issue predominately for schools to manage. CSC noted that there were no additional safeguarding concerns, the parent of YP1 had been spoken to and appeared to be protective, school had a safety plan for YP1 and YP2 and School Nurses were providing support to YP1. Professionals involved in this review noted that the support provided was limited and inadequate to effectively safeguard YP1, YP2 and their peers. There was lack of consideration of the needs and safety of YP1 YP2 and their peers outside of the school environment. All relevant agencies should take part in safety planning meetings regarding peer-on-peer abuse; the agencies may differ, depending on the context and young people concerned.

4.20 Agencies had a limited understanding of the family environment for both YP1 and YP2 and it was not known whether there were factors which may have enabled peer-on-peer abuse to persist. There was limited understanding amongst professionals about the culture of both families, specifically whether coercion and controlling behaviour was normalised. In addition, parental attitudes to premature sexual activity were not explored. Omission to complete Child and Family assessments for YP1 and YP2 was a missed opportunity to explore key issues regarding: risks, vulnerabilities, healthy relationships, premature sexual activity, contraception and sexual health and the impact of the allegation on YP2. It was acknowledged within the report completed by CSC for this review that the referrals should have prompted wider consideration of the risks and vulnerabilities that YP1 and YP2 were exposed to and it would have been appropriate to complete a Child and Family assessment for both. An assessment would have explored the needs and vulnerabilities of YP1 and YP2 and the capacity of the parents to safeguard YP1 and YP2 effectively.

4.21 In addition, there were intermittent technical difficulties at this time which impacted on secure email communication between Police, Health and CSC. Also, at the time of the second referral, Health professionals within the MASH had implemented a triage system to assist GP surgeries[12]. There was no record of the second referral being received or triaged by Health professionals within the MASH. Emails from this time have been deleted and it is not possible to state with certainty whether the referral was received by Health professionals or whether it had been forwarded to the GP. Health professionals involved in this review were confident that had they reviewed a referral with disclosure of peer-on-peer abuse it would have been shared with the GP. It is possible that technical issues prevented the email being shared with Health although this cannot be concluded with certainty. Currently all police referrals to the MASH are shared with Health and forwarded to the GP with no health triage.

4.22 It was a significant omission that information contained in the police referrals was not considered by the screening social worker. This limited the effectiveness of decision making at the MASH. A recent review of practice at the MASH has clarified the actions

[11] Including historical domestic abuse and parental mental health

[12] In response to feedback of possible overload at some GP surgeries regarding the volume of information received via police referrals at all levels.

required on receipt of a concern about a child, or a referral at any level. A new process map was implemented in October 2019 which includes managerial oversight at the earliest opportunity. The improved process should ensure that all referrals to the MASH are managed at the appropriate level and prevent the repetition of practice shortcomings identified by this review.

4.23 Agencies were not always notified about the outcome of referrals to the MASH. SN1 was informed that the case was closed when they phoned for an update following the first referral and this was followed by a letter. There was no formal response from CSC to the School Nursing service to advise of the outcome following the second referral. As the referrals from the Police were not processed appropriately the Police did not receive a formal outcome notification on either occasion.

4.24 Since this review the process to inform referrers about decisions made at the MASH has been revised. From October 2020 all referrers receive an outcome letter within 48 hours to inform of the decision made at the MASH and how this was reached. It is important that agencies have a timely notification of the outcome following a referral to the MASH in order to provide an opportunity for practitioners to escalate any ongoing concerns and resolve professional disagreements.

4.25 This review has found that shortcomings in the system to process and record referrals had a significant impact on decision making at the MASH. It is possible that had appropriate consideration been given to information contained within the referrals by SN1 and the Police, the provision of multi-agency support may have been more appropriate. Changes have been made to systems and processes within the MASH, and those of relevance to learning from this review are detailed above. The impact of the changes is monitored by the MASH multi-agency audit group and a monthly report is provided to the MASH Partnership Forum.

Learning Point 1

It is important that the process of decision making at the MASH is collaborative and multi-agency, and that:

- **there is a clear process to record referrals, decisions made and actions required, to ensure that information is not lost when more than one agency make a referral.**
- **referring agencies receive a timely and clear response from the MASH to inform them of the outcome decisions[13] following receipt of all referrals as this will enable practitioners to consider escalation if there are ongoing concerns.**
- **there are effective and secure systems of communication between partner agencies to support an efficient referral process.**

Learning Point 2

Family history of relevance to safeguarding (e.g. domestic abuse, parental mental health) should be included on the CSC records of all children within the family, to facilitate holistic consideration of issues which may impact on the wellbeing of children and young people.

[13] With a clear rationale for the decision

Learning Point 3

When there are concerns about peer-on-peer abuse, consideration is given to the completion of Child and Family Assessments for both the alleged victim, and the young person alleged to have caused harm to provide:

- **holistic consideration of all issues.**
- **analysis of the risks and vulnerabilities of both the victim and young person alleged to have caused harm.**
- **an action plan involving relevant partner agencies to address the needs of all children involved.**
- **an opportunity to listen to the voice of both the victim and young person alleged to have caused harm and understand their lived experience.**

(ii) Decision making within the MASH, escalation and professional challenge

4.26 There was lack of multi-agency collaboration in decision making at the MASH following the referrals made by SN1. Professionals involved in this review advised that this was a systemic issue within the MASH and of relevance beyond this review.

4.27 Professionals from Health, Police and Education shared a view that CSC were perceived to be the experts in safeguarding and take the lead in decision making. It appeared, from information provided to this review, that agencies were not always considered as equal partners at the MASH. There were no checks completed with other professionals / agencies within the MASH during the period considered by this review. The decisions following both referrals were made by CSC and there was no record that other agencies had been tasked to provide information. A thematic audit at the MASH in June 2020[14] also identified limitations in the completion of checks with partner agencies.

4.28 Practitioners spoke about a culture at the MASH in which the views of one professional / agency were not taken as seriously as others and said that this can be experienced as tokenistic and deskilling. Professionals acknowledged that it takes confidence to challenge a decision if a referral results in no further action. Since August 2020 the Education MASH officers have been managed by a newly appointed safeguarding lead for education. There is now increased capacity to review decisions that are made within the MASH, and support practitioners to challenge and escalate when appropriate.

4.29 The improved processes and procedures at the MASH make provision for checks to be undertaken in a timely and proportionate way and clarifies the roles and responsibilities of all MASH partners. In addition, an Early Help Hub has been established within the MASH[15] to take referrals at Level 3 and below. All Level 4 referrals are screened by a Duty Social Worker. It is essential that these changes in practice are embedded and sustained, to ensure that decision making at the MASH is consistently robust and informs the provision of appropriate support and intervention to vulnerable children and families.

4.30 Following learning from this and other reviews the Police have reflected on the challenges to explore and resolve professional differences within the MASH. It was noted that escalation is a formal process and Practitioners stated that there are less opportunities for informal discussion between colleagues / agencies when not co-located.

[14] MASH thematic audit report July 2020 – Persons posing a risk to children (PPRC)
[15] launched on 21.9.20

4.31 The NHS Trust report noted that the School Nurses probably had less concerns about there being no involvement by Children's Social Care because they were aware that the Police were undertaking enquiries, and therefore action to safeguard the children was underway. At the learning event practitioners from school and the School Nursing service stated that, in future the escalation procedure would be implemented if there was lack of clarity about, or disagreement with decisions made at the MASH following referrals made at Level 4. The following actions have been taken by WVT and the Police in response to learning from this review:

- *When a MASH referral made at Level 4 is deemed not to require social care intervention, the referrer must contact the WVT Safeguarding Children Team to seek advice*[16]*.*
- *With immediate effect, all Level 4 Police referrals that receive an NFA decision by Children's Social Care will be brought to the attention of a Supervisor for further discussion with Children's Social Care and consideration of implementing the Professional Differences Policy if necessary*[17]*.*

4.32 Historically there have been challenges for colleagues other than CSC and the Police to contribute as equal partners in the MASH. A reluctance of practitioners to challenge decisions has been identified in previous reviews. It is important that practitioners receive support to resolve disagreements about decisions with reference to Herefordshire Professional Differences Policy. Whilst there have been some progress in recent years, this review has found that further improvements are required to develop collaborative multi-agency practice that will inform decision making within the MASH, and foster a culture where escalation and professional challenge is accepted as good practice.

Learning Point 4

When a referral made at Level 4 is deemed not to require social care intervention;

- **professionals should discuss such cases with a Safeguarding Lead and**
- **challenge decisions when there is professional disagreement using the Professional Differences Policy.**

(iii) Convening a strategy meeting

4.33 The Referrals to the MASH were made at Level 4 on the threshold of need guidance document and there was no strategy meeting or discussion. This was a significant omission particularly with regard to the second referrals from SN1 and the Police which alleged that YP1 had felt forced to have a sexual relationship. It was acknowledged by all the professionals involved in the review that a Strategy Meeting should have been convened to consider the issues. At the learning event it was noted that that the incident was being investigated by the Police and YP1 and YP2 had not been interviewed, which may have influenced decision making regarding the Strategy Meeting. Professionals agreed however, that Police activity should not have impacted on the progression to a Strategy Discussion.

4.34 The 2020 Triennial analysis of SCR's[18] outlines the importance of Strategy Discussions for framing decision making between partner agencies and determining the roles of key

[16] Information from the WV NHS Trust report
[17] Information provided during the review
[18] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869586/TRIENNIAL_SCR_REPORT_2014_to_2017.pdf

statutory agencies and states: *Too frequently, examples are described where strategy discussions failed to involve all the key agencies – namely the police, children's social care, any relevant health agencies and other significant professionals involved with the family (p91).*

4.35 Regional child protection procedures in place at the time of the referrals include multi-agency policy guidance for children who abuse others which states:

> *In all cases where a referral is made to Children's Services in relation to a child who has been or is a victim of abuse and the suspected abuser is a child or young person, the Police and Children's Social Care must convene a Strategy Discussion / Meeting within the Section 47 enquiry time-scales. The Police will also decide whether a criminal offence is alleged.*
>
> *A separate Strategy Discussion / Meeting must be convened in relation to the suspected abuser. The Strategy Discussion / Meeting must consider the needs of the child, as well as any other children who may be at risk from that individual[19].*

4.36 During the time considered by this review Working Together 2015[20] was the relevant statutory guidance which stated:

> *Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm there should be a strategy discussion involving local authority children's social care (including the fostering service, if the child is looked after), the police, health and other bodies such as the referring agency (p36).*

4.37 Working Together 2015 also noted that the local authority social worker, their manager, health professional and a police representative should, as a minimum be involved in the Strategy Discussion. In addition to sharing available information a Strategy Discussion should have: agreed the conduct and timing of any criminal investigation, decided whether Section 47 enquiries should be undertaken and agreed the support required by YP1 and YP2. The responsibility and actions of each agency would have been detailed within the record of the strategy discussion.

4.38 Professionals involved in this review agreed that there should have been two strategy meetings / discussions following the referrals made by SN1, one for YP1 and the second to focus on YP2. Support for both pupils was addressed by the provision of key workers at school. Following the second referral protection of their peers was addressed by the arrest of YP2 by the Police. Throughout the period considered by this review communication between agencies was limited due to the absence of a strategy meeting. It was acknowledged that there should have been joint Section 47 enquiries[21] between the Police and CSC involving school, School Nursing and other partner agencies as appropriate. The absence of collaboration resulted in the arrest of YP2 and a single agency investigation by the Police.

4.39 Professionals stated that during the time considered by this review, strategy meetings were led by CSC and decisions about whether to convene a strategy discussion were routinely not made in collaboration with partners. Health professionals advised that they were not always included in strategy discussions unless there was clear evidence of neglect or health issues. Following learning from this review Police now include a proposal when appropriate, to have a Strategy Meeting as an action within Level 4

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[19] https://westmidlands.procedures.org.uk/pkoso/regional-safeguarding-guidance/children-who-abuse-others

[20] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf

[21] section 47 of the Children Act 1989 puts a duty on the local authority to undertake enquiries if they believe a child has suffered or is likely to suffer significant harm.

referrals to the MASH. Improved processes at the MASH include strategy meetings and current practice would require separate Strategy Meetings to be held for the alleged victim and young person alleged to have caused harm, and there would be consideration of a Child and Family Assessment for both. In addition, if a health representative was not in attendance the Strategy Meeting would not be considered quorate.

4.40 The report prepared by the Police for this review highlighted that there was no support provided to YP2 who had been accused of two crimes which included a serious allegation for which they had been released under investigation. YP2 categorically denied both the allegations and there was no multi-agency support provided to support them at what was a very challenging and traumatic time[22]. Had a strategy meeting taken place, arrangements could have been made for CSC and the Police to work together to ensure that the YP2 received appropriate support during the Police investigation.

4.41 The response of agencies to the disclosures by YP1 lacked coordination due to lack of multi-agency discussion and joint planning. There was no multi-agency consideration with CSC regarding the needs and vulnerability of YP1 and YP2 and whether actions were required to safeguard other pupils. This response did not follow procedure and guidance following disclosure of peer-on-peer abuse and did not adequately address safeguarding concerns that were known at the time.

4.42 The 2020 Triennial analysis noted that:

> *As one of the three key 'safeguarding partners', the police play a crucial role in multi-agency working to protect children from harm. At times however, in these reviews, police investigations appeared to run in parallel with other agencies' efforts to protect children, rather than being seen as an integral part of the process (p93).*

4.43 Agencies appeared to have been reassured by the fact that the Police were conducting enquiries and there was a false and inappropriate assurance that the Police investigation would provide an appropriate response to safeguard and protect YP1. There was limited evidence of critical reflection by practitioners, or managerial oversight, which may have identified the need for increased coordination and communication between partners.

4.44 In this case, the Police investigation and safety plans implemented by the school were the key activities considered by agencies to protect YP1. There was lack of coordination and no integrated multi-agency plan to protect and support both young people and their peers. Omission to convene a Strategy Meeting was a significant factor which limited the opportunity for information sharing during the time period considered by this review and impacted on the ability of agencies to collaborate effectively.

Learning Point 5

When there are concerns that a child has suffered significant harm as a result of peer-on-peer abuse it is important that:

- **key safeguarding partners are involved in strategy discussions, share responsibility for joint decision making and there is agreement and clear accountability for subsequent single and multi- agency activity, which includes criminal investigations to address concerns.**
- **a coordinated multi-agency plan is agreed at a Strategy Meeting(s) to focus on the needs and vulnerabilities of both the victim and young**

[22] Information provided by the Police

person alleged to have caused harm and address any risks to the children involved and their peers.

(iv) Referrals to specialist services

4.45 There was a delay in making some referrals and lack of capacity within agencies which impacted on the support provided to YP1. In addition, agencies mainly communicated with YP1 via their parent who often refused services on YP1's behalf. At the learning event, practitioners said that it was a challenge to speak with YP1 as their phone was often not working and the parent was often provided as the key contact rather than YP1. It was not known if YP1 fully understood the breadth of support that was available and this was not explored with them. It would have been good practice to discuss specialist services directly with YP1 and make a referral with their consent rather than only liaising with the parent.

4.46 There appears to have been a misunderstanding[23] between the School Nursing service and the Police which resulted in a two-month delay in making a referral to the Rape and Sexual Abuse Support Centre and allocation of a ChISVA[24]. It is important that practitioners clarify and document which agency is taking responsibility for making a referral, to prevent misunderstanding and delay.

4.47 At the learning event it was noted that that the ChISVA could have provided specific expertise around wellbeing and understanding of positive relationships and either worked directly with YP1 or provided support to the School Nurses. The School Nurses had anticipated that the ChISVA would take over from the School Nursing service to provide specialist expertise and support, however, by the time the ChISVA was allocated YP1 had declined the service.

4.48 The local policy guidance[25] on children who abuse others highlights support available for victims and states:

> *Staff should be aware of local support services, particularly the Children & Young People's Independent Sexual Violence Advocacy services (ChISVA). The role of the CHISVA is to provide practical and emotional support to children who have experienced rape, sexual abuse or sexual exploitation at any time. They will complete a risk and needs assessment with the victim and develop a support plan. It is common for this plan to include liaising with the school and offering support sessions during school time and on school premises…….*
>
> *Within some areas, the police will make an automatic referral to the ChISVA service however, referral routes are open to all services.*
>
> *Many services will provide additional support for family members and are able to provide input and safeguarding recommendations into multi-agency assessment conferences.*

4.49 A referral for 1-1 support and the CRUSH programme was made by SN2 to West Mercia Women's Aid shortly after YP1 had disclosed that they had been subject to coercion and control in the relationship with YP2. At this time there were lack of resources and limited capacity within WMWA, and there was no direct contact with YP1 to discuss the referral. The CRUSH programme was heavily oversubscribed and there was a six-month delay between the referral and contact with the parent of YP1, who subsequently advised WMWA that the service was not required as YP1 was no longer in an abusive

[23] Each agency thought that the other was making the referral
[24] Children & Young People's Independent Sexual Violence Advisor
[25] https://westmidlands.procedures.org.uk/pkoso/regional-safeguarding-guidance/children-who-abuse-others

relationship. The referral to WMWA drifted as there was only one worker at the time, there is now a team who keep in touch and provide virtual support when there is a delay between a referral and provision of direct support. Support was provided to YP1 and as noted at paragraph 3.5, elements of the CRUSH programme were delivered at school by the school nurses.

Learning Point 6

It is important that practitioners are aware of the referral procedures for specialist agencies to support young people involved in peer-on-peer abuse, and that there is sufficient capacity within these agencies to provide timely and proportionate support and intervention to all young people involved in the alleged abuse.

Learning Point 7

Specialist services should always seek to work directly with young people following a referral in order to: clarify the role of the service, explain the support that is available, and identify with the young person the support required.

B Implementation of the child protection procedure: children who abuse others

4.50 The Annual Report of Her Majesty's Chief Inspector of Education, Children's Services and Skills 2018/19[26] states that;

> *Peer-on-peer abuse that involves sexual assault and violence almost always needs a coordinated response from health, education, police and social care agencies. Children who develop harmful sexual behaviour have often experienced abuse and neglect themselves. As well as supporting and protecting the victim, and taking appropriate punitive and safeguarding action, professionals need to consider whether the perpetrator could be a victim of abuse too (p13).*

4.51 Policies and procedures of relevance to the issues raised in this review all highlight the importance of multi-agency cooperation and the provision of a joint response from relevant agencies. The procedure for Children Who Abuse Others notes that:

> *An allegation of rape and/or sexual abuse has wider repercussions and the impacts upon friends, peer groups, siblings and parents of the children involved should be taken into consideration when planning the multi-agency response.*

4.52 Whilst there were some examples of good practice, specifically within the school setting, there were inevitable limitations in the impact of work undertaken with YP1 and YP2, due to the lack of multi-agency coordination, limited information sharing and absence of a jointly agreed action plan. There was no multi-agency consideration given to the impact on friends, peer groups, siblings and parents of the children involved.

4.53 Practitioners acknowledged that historically in Herefordshire, peer-on-peer abuse has been perceived as an issue to be managed specifically by schools. This review has highlighted decision making within the MASH which supported this view. Whilst the school involved in this review responded very well, a recent Spotlight Review which explored the response to peer-on-peer abuse in Herefordshire found that practice across schools has been variable. It is important to note that National Guidance has only been available since May 2018. The guidance highlights that peer-on-peer abuse is a complex issue which requires a coordinated multi-agency response. At the learning event

[26] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859422/Annual_Report_of_Her_Majesty_s_Chief_Inspector_of_Education__Children_s_Services_and_Skills_201819.pdf

professionals acknowledged that it was inappropriate and inadequate to expect schools to manage peer-on-peer abuse in isolation. Work to improve the multi-agency response and monitor the impact of improved practice is ongoing and progress to date is available at appendix (i).

4.54 Work to address peer-on-peer abuse is complex and challenging and no one agency has all the relevant information. Relationships between young people fluctuate and are not static. The procedure in place at the time to address sexual activity in children and young people (including under-age sexual activity) and peer-on-peer abuse stated:

> *The boundary between what is abusive and what is part of normal childhood or youthful experimentation can be blurred. The ability of professionals to determine whether a child's sexual behaviour is developmental, inappropriate or abusive will hinge around the related concepts of true consent, power imbalance and exploitation*[27]*.*

4.55 Closure of the referrals to the MASH without holistic consideration of the issues by all safeguarding partners meant that there was limited discussion between professionals to develop an understanding of the concepts of true consent, power imbalance and exploitation in the context of the disclosures made by YP1. Information provided by YP1 became the focus of a criminal investigation in which YP1 said they felt, "*confused, out of their depth and struggled to explain themselves".*

4.56 Statutory guidance for schools and colleges (2019) notes that:

> *A not guilty verdict or a decision not to progress with their case will likely be traumatic for the victim. The fact that an allegation cannot be substantiated does not necessarily mean that it was unfounded.*

This view was shared by some of the practitioners at the learning event, specifically the School Nurses. It would not be possible or appropriate for this review to comment in detail on the factual accuracy of the disclosures made by YP1. Limited communication between Police and Health regarding professional perspectives of the disclosures and outcome of subsequent investigations meant that different views were not explored and the support needs of YP1 and YP2 were not effectively met.

4.57 The work undertaken by school to support both pupils following the allegations made by YP1 was acknowledged as a positive example of good practice by all professionals involved in this review. It was evident from information provided to this review that there was a whole school approach to embed positive relationships and address peer-on-peer abuse. Consideration was given to the most appropriate individuals in school to act as key workers for both pupils, and significant efforts were made to ensure that parents and pupils were fully involved with the development of safety plans and in agreement with all support provided by the school.

4.58 Mother stated that: *school handled the situation really well and did everything in their power to keep YP1 and YP2 safe.*

See Learning Points 3, 5 and 6

C Voice of the child

4.59 There were opportunities for YP1 to get their voice heard by the key workers at school and the School Nursing service. In addition, the Police responded to YP1's voice and acted upon the disclosures they made. Agency records and contributions by

[27] https://westmidlands.procedures.org.uk/pkplh/regional-safeguarding-guidance/sexual-activity-in-children-and-young-people-including-under-age-sexual-activity-and-peer-on-peer-abuse/#s710

practitioners to this review illustrated the significant efforts that were made to provide YP1 with a safe space in which they could discuss concerns with a trusted professional. However, given the lack of information sharing between agencies, practitioners did not have a shared understanding of YP1's wishes and feelings.

4.60 It would have been appropriate for the School Nurses to explore with YP1 why they were initially adamant that there had been no sexual relationship when they made the first disclosure to SN1 and a couple of weeks later they informed SN2 that the sexual relationship had been consensual and contraception had been used (Paragraph 3.3-3.5). Exploration of YP1's changed account could have been done sensitively and it would have helped to understand why YP1 felt able to share additional information about the sexual relationship at that time. This may have been because they felt that they had been believed by the professionals and trusted them to disclose further information. Similarly, when the work with the power and control wheel was completed it was not clear if YP1's earlier disclosure to SN2 about having a consensual sexual relationship with YP2 was discussed when YP1 responded to questions which indicated that they had felt unable to say no to a sexual relationship.

4.61 YP1 attended the GP with a suspected UTI following the referrals to the MASH, and their parent was present throughout the consultation with an advanced nurse practitioner (ANP). YP1 was asked if they were sexually active and said no. YP1 told the lead reviewer that this was true at the time and suggested that professionals should be more direct when asking young people questions. It would have been more appropriate to have asked YP1 if they had ever been sexually active. It is not possible to have confidence however, that YP1 would have disclosed previous relationships. It is important to note that the ANP was not aware that YP1 had alleged that they had felt forced to have a sexual relationship with YP2 and there was no record that this information had been shared with the GP.

4.62 Both YP1 and their parent said that there would not have been a problem if the parent had been asked to leave to enable the nurse to speak with YP1 in private. YP1 would have presented as Gillick competent and this would have enabled the possibility of a more detailed and frank discussion regarding sexual health and contraceptive advice. It was noted in the agency report prepared for this review that the GP surgery recognised that it was an omission that YP1 was not given the opportunity to be seen alone during the consultation and this has been addressed as single agency learning.

4.63 There was an opportunity for YP1 to engage with a range of services that would have provided further opportunities for professionals to understand their lived experience. The key worker at school and the School Nurses were well placed to explore YP1's lack of engagement with services however they were not aware at the time that services had been declined by the parent on behalf of YP1. Had the School Nursing service and/or the Key Worker at school been aware of this, a plan to support and assist them to access services could have been implemented. This was a missed opportunity. At this time the School Nurses were managing a large number of cases and there was limited time and opportunity for critical reflection regarding practice which may have identified the need to obtain information from other agencies.

4.64 Agencies had limited understanding of the lived experience of both YP1 and YP2. The provision of support and intervention was in direct response to the disclosures made by YP1. Practitioners lacked understanding of the factors which influenced the risk and resilience of both young people and their needs and vulnerabilities were not fully known to agencies. Completion of a Child and Family assessment as detailed in Learning Point 3 will address these practise shortcomings, specifically with regard to listening to the

voice of all young people involved in peer-on peer abuse in order to inform the provision of relevant, proportionate and appropriate support and intervention.

Learning Point 9

It is important that professionals who have existing relationships with young people are informed when referrals are made to specialist services so that they can support and encourage the young person to engage.

D Multi-agency information sharing

4.65 Lack of multi-agency coordination and discussion meant that there was limited opportunity for agencies to discuss the impact of the police investigation on YP1 and YP2. It was acknowledged by the Police during this review that it would have been appropriate to make a third referral to CSC following closure of the investigation into the allegation of rape, as the vulnerabilities of both young people were known to the Police. At this time there were significant concerns specifically regarding the welfare of YP1 and it was an omission that this information was not shared with partner agencies. It is important to note that at this time the supervising officer was involved in other serious investigations. Ongoing training has been implemented for Police supervising officers to refer to CSC when additional safeguarding concerns are identified.

4.66 YP1 informed SN1 that the police had asked them to withdraw the allegation of rape due to the impact on YP2. The explanation provided by YP1 was accepted and clarification was not sought from the Police, possibly due to lack of experience and/or confidence to challenge another agency. Consequently SN1 continued to support YP1 whilst unaware of information held by the police which resulted in closure of the investigation. It was a missed opportunity that School Nurses did not liaise with the Police to obtain further clarity as this would have provided an opportunity to share information regarding evidence which informed decision making to close the case and enabled the School Nurses to provide support to YP1 in an informed and targeted way. In addition, the police were aware that the School Nurses were working with YP1 at the time and it would have been good practice for the Police to share some of the information obtained with the School Nursing service.

4.67 WMWA contacted the Police for an update on the investigation prior to speaking with the parent of YP1 and were informed that the investigation had closed. School received a phone call from the Police to advise that the investigation had concluded with no charge and no further action. As a key partner working in the school, the School Nurse should have been updated with this information as they were providing direct support to YP1. At the learning event professionals acknowledged the challenge of sharing information that emerges during a police investigation when there has not been a joint strategy meeting to establish lines of communication. Learning point 5 will support improved information sharing and communication between agencies.

4.68 The GP received a notification from health colleagues within the MASH following the initial referral which advised that YP1 had been in a relationship with a peer and experienced control and abuse. Health professionals at the MASH were not aware of the second referral made by SN1 and the GP did not receive a notification. Therefore, information that YP1 had made an allegation that they had been forced to have a sexual relationship was not included in the records of the GP. This was significant as when YP1 was diagnosed with a suspected UTI by the nurse practitioner there was a missed opportunity to explore the disclosure that they had been forced to have a sexual relationship. These shortcomings in systems and processes will be addressed by practice improvements at the MASH, as detailed in this review and Learning Point 1.

4.69 There were clear limitations in the information sharing process between practitioners and agencies. In addition, there was little evidence of critical reflection within and between agencies and the importance of triangulating information provided by YP1, their parent or other professionals was not identified. Professionals involved in this review spoke about a lack of professional curiosity. This review has identified systemic and cultural factors that may have acted as potential barriers to invoking curiosity and inhibited the capacity of professional's to be curious within their practice. Burton V and Revell L (2018)[28] argued that for a practitioner to exercise curiosity they require confidence that tension and uncertainty will be managed within reflective practice and supervisory processes. Whilst it is appropriate that professionals take responsibility for their own practice it is important to note that there were organisational factors which impacted on the ability of practitioners at the time to demonstrate curiosity. Opportunities for critical reflection and rigorous supervision were limited during the timeline considered by this review.

Learning Point 10

It is necessary that practitioners are supported through the provision of supervision and robust managerial oversight to critically reflect on their practice and identify action that may be required to improve single and/or multi-agency intervention to safeguard children and young people

5 Good Practice

- The support provided by school to YP1 and YP2, in particular from the school's pastoral support officer, was acknowledged by all involved in this review to be an excellent example of good practice.
- The response to YP1's disclosures and the rapid implementation of the risk management plan by school meant that both pupils were able to return to school safely and continue with their studies.
- The School Nurses provided a flexible and responsive service to YP1 with a consistent professional in whom YP1 could confide.

6 Organisational Context

6.1 During the period considered by this review, Children's Social Care in Herefordshire experienced a period of significant challenge. Shortcomings in practice were identified in the Ofsted Report of 2018 which assessed that the overall effectiveness of children's social care services required improvement[29]. Whilst challenges remain, a reference to peer-on-peer abuse in a letter from Ofsted, following a focussed visit in January 2020, is of specific relevance to this review:

> *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*

[28] Burton, V., & Revell, L. (2018). Professional curiosity in child protection: Thinking the unthinkable in a Neo-Liberal World. The British journal of social work, 48(6), 1508-1523.
[29] https://files.ofsted.gov.uk/v1/file/50006281

practice reviews, including through a recent multi-agency spotlight review on peer-on-peer abuse[30].

6.2 The multi-agency spotlight review on peer-on-peer abuse and a review into the handling of peer-on-peer sexual abuse cases referred to the Multi-Agency Safeguarding Hub (MASH) between January 2017 and November 2019, resulted in a range of recommendations to improve the response to peer-on peer-abuse.

6.3 The following actions in response to these recommendations are of direct relevance to the findings of this review:

- Continue to improve the quality of recording for peer-on peer cases.
- Monthly audits of the multi-agency response to peer-on-peer abuse starting September 2020 to be conducted by the newly appointed education safeguarding officer.
- Peer-on-peer abuse policy to be re-issued by the Children's and Families Directorate by the end of January 2021.
- Establish a planned approach to engaging with families (and children) impacted by peer-on-peer abuse.
- 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.
- Improvements in information sharing between school settings and partner agencies.

6.4 Improvement of practice regarding peer-on-peer abuse is a current priority within Herefordshire. A contextual safeguarding team has been formed from August 2020 with specific expertise and knowledge to inform a multi-agency response to concerns regarding peer-on-peer abuse. A contextual safeguarding approach is now taken to consider how wider systems enable or prevent abuse from being perpetrated. Robust monitoring will be required to evidence that these changes have had a positive impact on practice.

6.5 Strategic focus on the development of a contextual safeguarding approach has the potential to significantly strengthen the multi-agency response to peer-on-peer abuse. Improvements to systems and processes will be consistent with current work, supported by the NSPCC to improve the multi-agency approach to address harmful sexual behaviour (HSB)[31].

6.6 Key learning identified within this review mirrors the findings from previous reviews within Herefordshire. A workshop[32] for senior leaders from agencies involved in safeguarding was held in February 2020 to identify themes and resulting actions to address the learning from previous reviews.

6.7 Improvement priorities for the Herefordshire Safeguarding Children Partnership were agreed and those of direct relevance to this review include:

- Development of clear referral pathways and a shared understanding and agreement among partner agencies regarding the application of thresholds of all levels of need.

[30] https://files.ofsted.gov.uk/v1/file/50143405

[31] In July 2019 the Herefordshire Safeguarding Children Board (as it was known then) commissioned the NSPCC to support the Partnership to carry out a HSB self-assessment regarding the multi-agency approach to tackling HSB in Herefordshire. An action plan with recommendations is due to be agreed in December 2020.

[32] Hosted by the Herefordshire Safeguarding Partners Board and Quality and Effectiveness Group

- To develop functions of the MASH with specific regard to the improvement of managerial oversight, effective information sharing, collaborative decision making and collective responsibility.

Also, relevant to findings in this review, it was agreed that the Herefordshire Safeguarding Children Partnership should seek assurance on the application of thresholds and implementation of the Escalation and Professional Differences Policy.

7 Conclusion

7.1 This review has explored the support and intervention provided by practitioners following serious allegations made by one young person against another which included being forced to engage in a sexual relationship. The omission to establish an effective multi-agency response on receipt of two referrals at the MASH impacted on the response of practitioners in all agencies. This review has established that the provision of support and intervention to the young people and their peers fell short of expected practice.

7.2 Opportunities for single agency learning have been identified by all agencies involved in the review, some of which have been reflected in this report. Multi-agency learning has focussed on systems and processes with regard to: referrals, strategy meetings assessments, information sharing and inter agency challenge.

7.3 There were practice shortcomings in the implementation of the child protection procedure; *children who abuse others,* and plans to improve and develop the multi-agency response to peer-on-peer abuse were underway before this review started. Recommendations and actions from this review will seek to complement the work in progress and avoid duplication.

7.4 From information provided by practitioners to this review it was evident that changes are required to working practices within the MASH in order to foster a culture in which the contribution of all partners is sought and valued. It will be important to focus on the development of professional relationships whilst implementing the learning from this review.

7.5 Herefordshire Safeguarding Children Partnership are committed to implement the required actions to ensure that should similar circumstances present in future a robust multi-agency response will be provided.

8 Learning Points and Recommendation

Learning points identified during this review have been grouped under the following themes:

(i) Procedures within the Mash and multi-agency collaboration
(ii) Peer-on-peer abuse
(iii) Supervision, escalation and challenge
(iv) Working with young people who may be sexually active
(v) Referrals to specialist services

(i) Procedures within the Mash and multi-agency collaboration

Learning Point 1

It is important that the process of decision making at the MASH is collaborative and multi-agency, and that:

- there is a clear process to record referrals, decisions made and actions required, to ensure that information is not lost when more than one agency make a referral.
- referring agencies receive a timely and clear response from the MASH to inform them of the outcome decisions[33] following receipt of all referrals as this will enable practitioners to consider escalation if there are ongoing concerns.
- there are effective and secure systems of communication between partner agencies to support an efficient referral process.

Learning Point 2

Family history of relevance to safeguarding (e.g. domestic abuse, parental mental health) should be included on the CSC records of all children within the family, to facilitate holistic consideration of issues which may impact on the wellbeing of children and young people**.**

Learning Point 5

When there are concerns that a child has suffered significant harm as a result of peer-on-peer abuse it is important that:

- key safeguarding partners are involved in strategy discussions, share responsibility for joint decision making and there is agreement and clear accountability for single and multi- agency activity to address concerns.
- a coordinated multi-agency plan is agreed at a strategy meeting(s) to focus on the needs and vulnerabilities of both the victim and young person alleged to have caused harm and address any risks to the children involved and their peers.

(ii) Peer-on-peer abuse

Learning Point 3

When there are concerns about peer-on-peer abuse, consideration is given to completion of a Child and Family Assessment(s) for both the alleged victim and young person alleged to have caused harm to provide:

- holistic consideration of all issues.
- analysis of the risks and vulnerabilities of both the victim and young person alleged to have caused harm an action plan involving relevant partner agencies to address the needs of all children involved.
- an opportunity to listen to the voice of both the victim and young person alleged to have caused harm and understand their lived experience.

See Learning Points 5 and 6

(iii) Supervision, escalation and challenge

Learning Point 4

When a referral made at Level 4 is deemed not to require social care intervention;

- Professionals should discuss such cases with a Safeguarding Lead and,

[33] With a clear rationale for the decision

- challenge decisions when there is professional disagreement using the Professional Differences Policy

Learning Point 10

It is necessary that practitioners are supported through the provision of supervision and robust managerial oversight to critically reflect on their practice and to identify actions that may be required to improve single and/or multi-agency intervention to safeguard children and young people.

(iv) Working with young people who may be sexually active

Learning Point 8

When speaking with young people about their sexual health/activity it is important that professional's:

- communicate clearly and ask direct questions
- provide an opportunity for young people to be seen alone without a parent or carer.

(v) Referrals to specialist services

Learning Point 6

It is important that practitioners are aware of the referral procedures for specialist agencies to support young people involved in peer-on-peer abuse, and that there is sufficient capacity within these agencies to provide timely and proportionate support and intervention to all young people involved in the alleged abuse.

Learning Point 7

Specialist services should always seek to work directly with young people following a referral in order to: clarify the role of the service, explain the support that is available, and identify with the young person the support required.

Learning Point 9

It is important that professionals who have existing relationships with young people are informed when referrals are made to specialist services so that they can support and encourage the young person to engage.

Recommendation and proposed actions

Improvement plans to progress recommendations from recent reviews are currently being implemented and some changes have already taken place. It is appropriate and proportionate that this review supports the progress that has been made, strengthens efforts to further improve practice and avoids duplication. Therefore there are two recommendations:

Recommendation 1

The safeguarding partnership seeks assurance that learning points identified by this review are addressed by the implementation of action plans in response to: (i) learning from previous safeguarding reviews and (ii) to improve the multi-agency response to peer-on-peer abuse. There should be a specific focus on the areas listed below, and further actions agreed should gaps be identified.

- Recording and processing of referrals to the MASH
- Development of a culture within the MASH to foster collaborative decision making and effective partnership working
- Multi-agency response to peer-on-peer abuse
- Promotion of working practice where professional challenge is fostered and welcomed.
- Effective use of Escalation and Professional Differences Policy
- Clarity among partners about process to convene a strategy meeting
- Development of critical reflection and managerial oversight when working with young people who have alleged peer-on-peer abuse
- Provision of support to all young people involved in peer-on-peer abuse including young person alleged to have caused harm
- All professionals provide an opportunity to see young people alone without parent and carers and ask clear and direct questions when exploring sexual activity
- Professionals work creatively to communicate directly with young people rather than through a parent or carer

Recommendation 2

The safeguarding partnership seeks assurance that the views and experience of young people involved in peer-on-peer abuse and their parents/carers inform practice improvements.