



HM Government

# **Changes to statutory guidance: Working Together to Safeguard Children; and new regulations**

**Government consultation response**

**February 2018**

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## Introduction

The Government is committed to doing all that it can to protect every child and young person from abuse and neglect, and we remain clear that the needs of children should always be at the centre of the child protection system. Children are best protected when frontline practitioners are clear about what is required of them individually, and how they need to work together in partnership with others to promote the best interests of children and their families. *Working Together to Safeguard Children* is the statutory guidance which helps all agencies to know what the law says they, and others, must do in order to provide a coordinated approach to safeguarding and promoting the welfare of children.

We are committed to improving the outcomes for our most vulnerable children through a sustained, long-term reform of the child protection system - the aim is to make sure we have an excellent practice system, in which children and families receive targeted and effective support when they need it.

### **The Wood Review**

Alan Wood's review of the role and functions of Local Safeguarding Children Boards (LSCBs), published in May 2016, found widespread agreement that the current system of local multi-agency child safeguarding arrangements needed to change. He proposed a new model that would ensure collective accountability across local authorities, the police and health. He also recommended a new system of local and national reviews, to replace serious case reviews; and new arrangements for child death reviews.

The review's key recommendations are now included in the Children and Social Work Act 2017.

Significant changes to local multi-agency arrangements have recently been established through the Children and Social Work 2017. The Act creates new duties for police, health and the local authority to make arrangements locally to safeguard and promote the welfare of children in their area. Following the passage of the Act in April 2017, the Government has worked to revise the statutory guidance *Working Together to Safeguard Children*, and draft the regulations required to commence the legislation. The public consultation on these draft documents ran from 25 October 2017 to 31 December 2017. During this period, the Government also held a series of nine regional consultation events across England.

The consultation sought sector input on the proposed changes to *Working Together to Safeguard Children*, as well as the draft regulations. It attracted 703 responses from a wide variety of interested stakeholders, including representatives from local authorities, health sector bodies, police, youth justice, voluntary and community organisations, social

care professionals, safeguarding boards and educational establishments. Nearly 450 delegates attended the regional events and shared their views in person.

This document summarises the results of the consultation, and sets out the Government's response. A list of the organisations which responded to the online consultation (and did not ask for their response to remain confidential) is available at Annex A.

We are pleased that over seven hundred organisations and individuals responded to the consultation; and grateful for the care, attention and detail that people gave in their responses. We have reflected carefully on all the feedback received, and will continue to work in partnership with interested parties to develop the guidance in the coming months.

## Overview of consultation findings

The key themes addressed by respondents to the consultation are summarised below. The findings in respect of each question, and the accompanying Government response, are available in the following section (*Consultation Responses*).

### General Comments

**The guidance document:** The response to the draft guidance has been generally positive; with most proposals accepted by a significant majority of respondents. We are grateful to everyone who took the time to share their views.

**The role of schools:** Throughout the consultation, a significant number of respondents (including many schools) reflected the view that 'education' should be included as the fourth safeguarding partner. We have noted these comments, and will seek to give greater emphasis to the role of schools in the published guidance. However, in addressing this point it is important to note that primary legislation (the Children and Social Work Act 2017) defines and empowers the safeguarding partners. The provisions of the Act were developed and approved through Parliamentary process, and statutory guidance is not able to amend the structures set out in law.

**Other points:** In addition to the specific questions included in the consultation document, a number of other important points were raised over the course of the consultation - for example, removing references to 'managers' in the section detailing social workers' decision-making processes, and the potential impact this change would have on shared accountability in frontline practice. General comments were also made on the overall emphasis given to the voice of the child and children's rights. We will be taking account of these points during the revision process.

### Safeguarding Partners

**Safeguarding Partners:** Many respondents felt that the guidance would benefit from greater emphasis on an appropriate level of seniority and expertise for safeguarding partner representatives. We therefore intend to revisit the drafting of Chapter 3 to ensure that the guidance sets out clearly the appropriate levels of seniority for those representing their agencies. In addition, certain specific functions for safeguarding partners to undertake (for example, multi-agency training) were recommended as necessary for inclusion in statutory guidance. We will look again at the core functions of safeguarding partners as we review the guidance. Finally, in view of feedback from the sector, we now propose to specify that safeguarding partners should issue a threshold document.

**Relevant agencies:** The consultation demonstrated some confusion around the nature of relevant agencies, including their legal status in respect of local arrangements, opportunities for dispute resolution and contributions to funding. We will review the statutory guidance to ensure that the responsibilities of relevant agencies are explained as clearly as possible, including their duty to engage with published arrangements. We will also extend the expectation that safeguarding partners make ‘*explicit reference to how the safeguarding partners plan to involve, and give a voice to, all local schools and academies...*’ in their plans, to include early years settings as well as educational establishments. Finally, in response to specific feedback from respondents, the statutory instrument will be revised to include entries for sports organisations and religious organisations. This will help to address concerns that the draft guidance did not sufficiently reflect the importance of these organisations in safeguarding children.

**Independent scrutiny:** There was a broad consensus from respondents that the guidance should contain more detail regarding the independent scrutiny of safeguarding arrangements; as well as any potential interaction the independent scrutiny may have with the national inspectorates for each safeguarding partner. The general purpose of independent scrutiny should be to provide an objective evaluation of effectiveness, and provide feedback which can support continuous improvement – we will examine the suggestion to set out in greater detail the specific functions of independent scrutiny. We will also work with the relevant inspectorates – Ofsted, the Care Quality Commission (CQC) and HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) – to clarify specific responsibilities for each element of the regulatory environment.

## Reviews and the national Panel

**Timescales for action when child safeguarding cases first notified:** Many respondents said that the five-day timescale for an initial investigation was too short. We propose to clarify in guidance (a) what this investigation should – and should not – seek to achieve, and (b) that five days is a guideline, intended to inform decisions on next steps.

**Relationship between the Panel and the safeguarding partners:** Respondents stressed the need for collaborative working, and we agree this should be made clearer. We will talk to the new Panel chair about this and about practical timing issues, and will reflect the outcomes in the revised guidance.

**Reviewers:** Respondents generally agreed that we should not publish a statutory list of reviewers for local reviews, but many (including local government organisations) thought that a central list for optional use would raise standards and be helpful. We therefore propose to explore this suggestion further.

**Funding for reviews:** Responses to the consultation also indicated a lack of clarity around funding for reviews. We explain below that central government intends to fund the Panel and national reviewers' contractual costs, but locally-incurred costs of reviews will need to be funded locally.

## Child Death Reviews

**Statutory guidance:** Chapter 5 of *Working Together* sets out the legislative framework for the review of child deaths and guidance on how to meet the statutory requirements. Alongside this, the Child Death Review Statutory Guidance sets out in detail the processes to be followed to meet the statutory requirements. There were a large number of requests from respondents to edit Chapter 5, and remove any overlap with the Child Death Review Statutory Guidance. There were also requests to shorten the Child Death Review Statutory Guidance and adjust the tone of the document, as some respondents felt it was too 'medical' for the intended audience. We therefore propose to edit both Chapter 5 and the Child Death Review Statutory Guidance to ensure the guidance is well suited to the demands of multi-agency working.

**Extension of geographical footprints:** Respondents were generally supportive of our proposals, but felt the suggestion that child death review partners should review 80-120 child deaths each year was challenging. Many argued for a lower guideline, in particular to take account of practical challenges in some rural areas. Respondents did not support an upper limit for the amount of reviews per year. We therefore propose to amend this to an expectation that child death review partners should typically review at least 60 child deaths each year.

## Transitional Guidance

**Grace periods:** Respondents generally suggested that the proposed 'grace period' of two months for child death overview panels to complete any outstanding child death reviews was not long enough. We therefore propose to extend the period to four months.

**Information handling:** General comments in respect of this section suggested that the transitional guidance is a valuable opportunity to underline the critical importance of an effective handover of information between existing and incoming structures. We will work to ensure that the final publication includes an appropriate level of guidance on this issue.

## Consultation Responses

A total of 703 organisations and individuals submitted written responses to the consultation, either through the online hub or directly in writing to the Department for Education's dedicated mailbox.

As the consultation covered a wide range of reforms linked to different areas of sector expertise, not every respondent submitted an answer to all 27 questions. The amount of responses analysed below therefore varies from question to question; and in all cases the amount is lower than the total number of respondents.

### Question 1

*As set out in paragraphs 4-7 of Chapter 3 of the draft 'Working Together to Safeguard Children' 2018 it will be the responsibility of the safeguarding partners' representatives to determine how they work together in respect of their arrangements. All three partners have equal and joint responsibility for local safeguarding arrangements, and each safeguarding partner will appoint their own representative. We do not propose to set out in statutory guidance who these representatives should be, as it is a matter for safeguarding partners. Do you agree with this approach?*

	Total	Percent
Yes	376	62.5%
No	226	37.5%

### Consultation findings

Of the 602 respondents that answered Question 1, 62.5% agreed with the proposed approach. Of those disagreeing with the lack of prescription, many (including the National Education Union and the Office of the Children's Commissioner) suggested that the draft guidance could be amended to provide some indicative parameters around the issue of representatives, for example by specifying acceptable levels of delegation or expertise.

A high proportion of respondents to this question used the opportunity to submit comments on safeguarding partnerships in general, particularly: the complexity of the health landscape; the need for guidance to clarify dispute resolution processes; and the importance of certain specific functions that all safeguarding partnerships should be required to undertake (multi-agency training and frontline audits). These issues were also consistently raised by attendees at the 'Working Together' consultation events.



## Government response

We welcome the agreement of the majority of consultees that local safeguarding partners should be given the flexibility to select their own representatives. We will consider the comments on the seniority or specific roles of safeguarding partners, and detail around safeguarding partner functions, as the document is revised. We will also consider further the content of the guidance relating to effective dispute resolution. In particular, we will clarify that the appropriate representatives for safeguarding partners are the local authority chief executive, clinical commissioning group (CCG) accountable officer, and chief officer of police. In general terms, we intend to proceed with the proposal that statutory guidance should allow safeguarding partners a sufficient degree of flexibility.

## Question 2

*Safeguarding partners can choose specific agencies which they believe to be relevant to the work of safeguarding and promoting the welfare of children in their area. The 'Local Safeguarding Partner (Relevant Agencies) (England) Regulations' details the specific agencies which safeguarding partners can choose from. It is important to note that certain key agencies are not listed, as their functions are commissioned or otherwise overseen by one or more of the safeguarding partners - for example, general practitioners come under NHS England, and housing under the local authority. Do you agree with this indicative list?*

	Total	Percent
Yes	370	61.6%
No	231	38.4%

## Consultation findings

Of the 601 respondents that answered Question 2, 61.6% agreed with the indicative list. Many of the comments received in relation to this question reflected a lack of clarity around the parameters or function of the list - particularly the exclusion of commissioned services where the commissioning body has already been included as a relevant agency. Those who disagreed with the indicative list felt the concept of relevant agencies could be interpreted as suggesting a 'two-tier' system of safeguarding. Some respondents were cautious about the capacity of a defined list to be sufficiently comprehensive, and the potential which the new system represented for increased variation across local areas. A number of stakeholders, including the Association of School & College Leaders (ASCL) and the British Association of Social Workers (BASW), requested that sports organisations receive effective representation; while others advocated for the specific inclusion of religious organisations.

## Government response

We welcome the general agreement expressed in relation to the draft relevant agencies regulations. While we have taken into account suggested amendments where appropriate, some of the agencies which respondents proposed for addition have not been included due to existing coverage within the list. For example - GPs, dentists and mental health service providers are already represented variously through the inclusion of CCGs, NHS England, NHS Trusts and Foundation Trusts. It is important to note that the list of relevant agencies is intentionally focused at a strategic, agency-based level. It is not intended to be an exhaustive list of all bodies and individuals which come into contact with children.

We will revisit the supporting guidance to make sure the roles and responsibilities of relevant agencies are explained as clearly as possible. This includes the fact that safeguarding partners can engage and work with a wide spectrum of stakeholders. Feedback received on general clarifications to the list will be considered before a final version of the statutory instrument is laid before Parliament. We intend to extend the list to include entries covering sports organisations and religious organisations. This reflects the concerns expressed that the draft guidance did not reflect the importance of these organisations in safeguarding children.

## Question 3

*All schools (including maintained schools, special schools, independent schools, academies and free schools) have key duties in relation to safeguarding children and promoting their welfare. As set out in paragraphs 18-19 of Chapter 3 of the draft 'Working Together to Safeguard Children' 2018 we expect all local safeguarding arrangements to contain explicit reference to how the safeguarding partners plan to involve, and give a voice to, all local schools and academies in their work. Do you agree that this expectation should be stipulated in statutory guidance?*

	Total	Percent
Yes	569	94.8%
No	31	5.2%

## Consultation findings

Of the 600 respondents that answered Question 3, 94.8% agreed with the proposed approach. Many, including the Association of Directors of Children's Services (ADCS) and the NSPCC, highlighted the crucial importance of the need for strong relationships between schools and the safeguarding partners. Those that disagreed tended to do so on the basis that the expectation should be widened, to encompass other important

safeguarding settings. Through the events held across England in recent months, as well as through this consultation, we have heard that the involvement and voice of early years settings and colleges should be included in this specific expectation.

The NPCC stressed that guidance should reflect the *reciprocal* responsibility of schools to understand their role in local arrangements, and engage with the safeguarding partners accordingly.

## Government response

The Government is clear that schools and other educational establishments play a crucial role in safeguarding, and the strong consensus in response to this consultation question demonstrates widespread agreement that their involvement will be vital in ensuring the effectiveness of local arrangements. In view of the clear consensus demonstrated by respondents regarding the role of schools and other educational settings in multi-agency working, we intend to proceed with the proposal to reference this expectation in guidance; and will clarify the guidance further to stress the importance of all relevant education establishments and early years settings. We will continue to consider the wider points raised by respondents around the role of schools, and the need for effective relationships and reciprocal engagement between schools and the safeguarding partners. We will work to ensure that all relevant statutory guidance (including *Keeping Children Safe in Education*) clearly explains the roles and responsibilities of educational establishments in respect of local safeguarding arrangements.

## Question 4

*The safeguarding partners must include arrangements for scrutiny by an independent person of the effectiveness of safeguarding arrangements, and how best to implement a robust system of independent scrutiny will be a local decision. Paragraph 20 of Chapter 3 of the draft 'Working Together to Safeguard Children' 2018 states that safeguarding partners should involve a person or persons who are independent, for example by virtue of being from outside the local area or having no prior involvement with local agencies. Do you agree with this?*

	Total	Percent
Yes	504	84.7%
No	91	15.3%

## Consultation findings

Of the 595 respondents that answered Question 4, 84.7% agreed with the approach. Among those that disagreed, many advocated for a national structure or system of oversight of the independent scrutiny for local areas.

A significant number of respondents – including the ADCS, NSPCC, the Office of the Children’s Commissioner, the Royal College of Paediatrics and Child Health (RCPCH) and the Association of Independent LSCB Chairs (AILC) also suggested that the guidance should specify the core functions and expectations of the person or agency providing independent scrutiny.

Discussions throughout the consultation events also indicated a widespread desire to better understand the relationship between the independent scrutiny and the safeguarding partners’ national inspectorates.

## Government response

We welcome the strong consensus evident from the responses to this consultation question. We intend to proceed with the proposal to afford safeguarding partners the flexibility to establish suitable independent scrutiny of their arrangements, but will consider what high-level guidance can be provided to help ensure consistent and effective outcomes nationally. We will also revisit the guidance to describe the purpose of the scrutiny in more detail. We will continue to consider the additional comments received in relation to this question, and will work with the inspectorates to produce clear guidance on their role in the scrutiny of safeguarding arrangements.

## Question 5

*Paragraph 24 of Chapter 3 of the draft 'Working Together to Safeguard Children' 2018 makes it clear that safeguarding partners should agree the level of funding secured from each partner and relevant agency, to support the new safeguarding arrangements. Decisions on funding are for local determination, but contributions should be equitable and proportionate to meet local needs. Do you agree that this is the right approach?*

	Total	Percent
Yes	363	62.3%
No	220	37.7%

## Consultation findings

Of the 583 respondents that answered Question 5, 62.3% agreed with the approach. A number of responses suggested a level of uncertainty around whether the relevant

agencies could or should contribute to the arrangements. Many of those that disagreed, including the Association of School and College Leaders (ASCL) and the RCPCH, called for the provision of a funding formula. Others called for guidance to specify equal contributions from the safeguarding partners.

## Government response

We welcome the general agreement for this approach, reflecting an understanding of the need for flexibility across local areas. We therefore intend to proceed with the proposal to include this statement in guidance. While the primary legislation is clear that relevant agencies can contribute to the local safeguarding arrangements, we will ensure this is also clearly set out in statutory guidance. We recognise that funding is a challenging issue for all safeguarding services, and it will be important for local safeguarding partners to work effectively with their relevant agencies to reach an agreement that is proportionate and equitable. The effectiveness of local arrangements will be dependent on professional local relationships and clear partnership conversations, including around the issue of resourcing.

## Question 6

*Safeguarding partners must publish a report at least once in every 12 months, setting out what they (and their relevant agencies) have done as a result of the arrangements, and how effective the arrangements have been. These reports will be a key element of local accountability and self-assessment. At paragraph 29 of Chapter 3 of the draft 'Working Together to Safeguard Children' 2018 we have set out a non-exhaustive list of parameters for these reports in guidance, to ensure a nationally consistent set of useful and high quality publications. Do you agree with this approach?*

	Total	Percent
Yes	528	89.3%
No	63	10.7%

## Consultation findings

Of the 591 respondents that answered Question 6, 89.3% agreed with the approach. Many, including Ofsted, stressed the need for reports to provide detailed, evidence-based self-assessments and analysis of safeguarding performance. Those that disagreed and left additional comments tended to cite the variable quality and impact of reports produced under the existing system.

## Government response

We welcome the clear consensus evident from the responses. We therefore intend to proceed with the proposal to include this in guidance. We will consider the responses provided to ensure that guidance supports the preparation and publication of reports that provide sufficiently robust data in a meaningful context.

## Question 7

*The safeguarding partners should consider carefully how multi-agency safeguarding arrangements will work in their area. This includes determining how best to ensure that clear criteria for taking action are made available to relevant agencies and others in a transparent, accessible and well-understood way. Currently, Local Safeguarding Children Boards are required to produce a threshold document. We are not proposing to specify in statutory guidance how, and in what format, the safeguarding partners should make their criteria for action available. Do you agree with this approach?*

	Total	Percent
Yes	289	49.2%
No	298	50.8%

## Consultation findings

Of the 587 respondents that answered Question 7, 49.2% agreed with the approach. A significant number of respondents who disagreed raised wider points of debate around the practice issues related to threshold documents, some of which fell outside of the scope of this consultation. Those expressing disagreement with the approach included a number of representatives from local government; with Devon, Buckinghamshire, Hampshire and Cumbria County Councils among those respondents supporting the retention of threshold documents in statutory guidance. Many respondents cited the value of consistent terminology and a common language as a key factor in their position.

## Government response

Responses to this consultation question reflect an evenly balanced split of opinion on the issue of making criteria for action available in the specific format of threshold documents. Given the strong views expressed by several of the sector's representative bodies (ASCL, BASW, the Office of the Children's Commissioner, National Association of Head Teachers (NAHT), NSPCC, RCPCH and Ofsted), we intend to revise the statutory guidance to recommend the development and publication of threshold documents as a key responsibility for safeguarding partners.

## Question 8

*Paragraphs 15-17 of Chapter 4 of the draft 'Working Together to Safeguard Children' 2018 set out the actions the safeguarding partners should take on receipt of a notification of a child safeguarding incident, and the relationship between the safeguarding partners and Panel from then on. Do you agree with the procedure as set out?*

	Total	Percent
Yes	346	60.2%
No	229	39.8%

### Consultation findings

Of the 575 respondents that answered Question 8, 60.2% agreed with the procedure set out regarding the notification of child safeguarding incidents. However, not all those who answered 'yes' agreed with every aspect, and many who answered 'no' only had issues with the timescale for the concise investigative exercise. Respondents – in particular CCGs and NHS Trusts – felt that five days would not give the safeguarding partners enough time to complete a meaningful investigation, and was therefore unrealistic and unachievable. This view was also expressed consistently at the consultation events, where only a few considered it realistic. Some also suggested that the guidance did not make the purpose of this initial exercise sufficiently clear. There were a few additional comments regarding the terminology, both at the consultation events and in the written responses.

A number of respondents also highlighted concerns about the working relationship between the national Panel and safeguarding partners – in particularly the lack of timescales for the Panel to respond to safeguarding partners following their concise investigation with a decision on whether to commission a national review. Others questioned how the Panel would deal with notifications and the frequency of their deliberations, and whether this was likely to create delays in decision-making which might prevent the safeguarding partners from progressing with a local review.

Several respondents suggested that adding a process map or flowchart to this section of the guidance might be helpful.

### Government response

Most people agree with the need for quick action to be taken on receipt of a notification and understand the benefit in seeking quick learning, so we intend to retain this principle. However, we recognise the concerns around the five-day timescale. The purpose of this initial exercise is to clarify quickly the seriousness of the case, form a rapid overview of the main issues when a child has died or has been seriously harmed, and establish the

potential for learning. If it does reveal any points of immediate learning they should be shared appropriately, but this exercise is not about reaching conclusions, or writing up detailed chronologies of involvement. We will ensure the guidance clarifies the purpose of this initial exercise and builds in an understanding that there is flexibility in the system; and that the five-day timescale is intended to inform a decision on next steps.

Similarly, we agree that the guidance needs better to reflect the collaborative working relationship between the Panel and safeguarding partners generally, including on the sharing of emerging lessons. We will work with the chair of the Panel to agree a way forward on this and on timescales more generally, which will be reflected in the final version of the guidance. We will also consider whether a visual chart might be useful to explain workflows.

## Question 9

*The Act makes clear that the Panel and safeguarding partners respectively have responsibility to determine whether a review is appropriate, on the basis of whether the review may identify improvements that should be made to safeguard and promote the welfare of children. Regulations may require the Panel and safeguarding partners to take certain matters into account when taking the decision on cases to review, and guidance may support this. Regulation 4 sets out national review criteria which the Panel would be required to take into account when deciding whether to commission a national review. Regulation 18 sets out local review criteria which safeguarding partners would be required to take into account when deciding whether to commission a local review. Paragraphs 20 and 37 of Chapter 4 of the draft 'Working Together to Safeguard Children' 2018 set out additional circumstances for consideration. Do you agree with these criteria and circumstances?*

	Total	Percent
Yes	436	77.2%
No	129	22.8%

## Consultation findings

Of the 565 respondents that answered Question 9, 77.2% of respondents agreed with the criteria and circumstances for national and local reviews as set out in the regulations and guidance. There were mixed views on the scope of the criteria, with some respondents feeling that it was too broad – potentially resulting in an increase in reviews at local level. Others welcomed the increased scope, in some cases offering additional criteria they felt should also be included. A number of respondents felt that the criteria for national and local reviews were too similar, although a similar number felt that this similarity was appropriate.



There were requests for further clarification and definition around some of the terminology in the regulations. This included requests for the definition of 'institutional settings' to be widened to cover other types of residential provision. Others said that various aspects of the guidance should be expanded.

There was a broad welcome, including from Cafcass and the AILC, for the discretion safeguarding partners will have in deciding whether to carry out a review and the focus on learning. However, a number of respondents (including the Social Care Institute for Excellence (SCIE) and the national panel of independent experts on serious case reviews) suggested that the process of reaching a decision on whether to initiate a review should be transparent and subject to independent scrutiny, in order to ensure accountability to the child/children and family concerned with the case. This independent oversight was seen as particularly important in cases where the safeguarding partners had found difficulty in reaching a consensus; and in cases where the safeguarding partners themselves were likely to be the focus of a review.

A common request from both LSCBs and CCGs was for greater clarity regarding the interaction between local reviews and other simultaneous review processes (for example, domestic homicide reviews or mental health homicide reviews).

Ofsted and the Local Government Association (LGA), amongst others, welcomed the statement that that reviews should be focused on identifying improvements in services for children, and not holding individuals or organisations to account.

## **Government response**

We welcome the general agreement with the criteria and circumstances as set out in the regulations and guidance, and therefore plan to retain them broadly as drafted. We are also pleased that the increased flexibility given to local areas in determining which cases to review has been welcomed. We will ensure this flexibility is clear in the guidance, as some respondents found the new provisions confusing. We recognise, however, that there may need to be greater clarity around some of the terminology used, and will review this in light of the consultation responses. In particular, we propose to broaden the definition of 'institutional settings' to cover all settings with residential provision for children, and include this alongside other institutional settings in the guidance, rather than the regulations. This will also have the benefit of simplifying the criteria in the regulations. We also plan to clarify in the guidance that the independent scrutiny role applies to the effectiveness of the arrangements for serious child safeguarding cases, and that the safeguarding partners therefore need to ensure that this is in place. We will also consider whether we can strengthen the guidance on how simultaneous reviews should interact.

## Question 10

*Paragraphs 23-24 and 41-42 of Chapter 4 of the draft 'Working Together to Safeguard Children' 2018 set out the factors which the safeguarding partners and the Panel respectively should consider when commissioning reviewers for local and national reviews. Do you agree with these factors?*

	Total	Percent
Yes	499	87.9%
No	69	12.1%

### Consultation findings

Of the 568 respondents that answered Question 10, 87.9% of respondents agreed with the factors set out in paragraphs 23-24 and 41-42. Many of the issues set out below were also raised at consultation events by various stakeholders.

There was strong support from respondents, including Ofsted and the NSPCC, for the guidance to state the importance of reviewers being sufficiently independent to ensure that their reviews remain impartial. A significant number of respondents felt that there should be a centralised quality assurance process in place for reviewers. Some also felt that there should be agreed national standards and accreditation for the role. The majority of respondents agreed with the factors to be considered when commissioning reviewers for local and national reviews. A significant number of responses felt that additional factors should be considered when commissioning reviewers, including: reviewer experience and skill in engaging with multi-agency practitioners; knowledge and understanding of special educational needs (SEN) and disabled children's safeguarding issues; and experience or knowledge of implementing change and improvement.

A number of respondents raised concerns regarding the funding of national reviews, and whether local area contributions would be required. Respondents, including the LGA and NSPCC, raised concerns regarding the need for an adequate supply of reviewers in the reviewer pool to meet demand for both local and national reviewers.

A number of respondents pointed out the inconsistencies between the removal of reviewers for local and national reviews, believing that the stronger wording covering national reviewers should apply equally to local reviewers.

### Government response

We note the points raised regarding the independence of reviewers. We believe that the guidance as drafted already makes clear the need to consider whether the reviewer has

any conflicts of interest which could restrict their ability to identify improvements, but propose to add further clarification to the effect that reviewers should be impartial.

We have considered carefully suggestions for a system of quality assurance for reviewers, or national standards and accreditation. We will consider this in the longer term, but intend that the factors set out will provide those commissioning reviews (the safeguarding partners or the Panel) with an adequate framework which allows for local and national flexibility.

It will always be for those commissioning reviews to satisfy themselves that the reviewers they select possess the required knowledge, experience and skills to conduct reviews which comply with the guidance and are proportionate.

We will reflect further on ways in which the factors to be considered by those commissioning reviews might be amplified. We will, however, need to ensure that any such factors would be applicable to all reviews.

We note the points raised regarding funding of reviews. Local reviews must be funded locally, as must any costs associated with national reviewer activity in a local area – for example, the time required by staff to contribute to reviews. The Government’s intention is that the contractual costs of national reviewers, however, will be funded centrally, as will the costs of operating the Panel. Regulations will set out further clarification of the system of appointment and removal of reviewers for national and local reviewers.

We have considered concerns regarding the need for an adequate supply of reviewers. We are pleased that many respondents thought that a list of reviewer qualities would be beneficial and we will monitor the impact of this, as well as the wider changes regarding national reviewers, on the system. We note the points made about the removal of reviewers, and will review the guidance in light of these comments.

## Question 11

*Paragraphs 25-28 and 43-46 of Chapter 4 of the draft 'Working Together to Safeguard Children' 2018 set out the procedures which the safeguarding partners and the Panel respectively should follow when supervising local and national reviews. Regulations 12-14 of the 'National and Local Child Safeguarding Practice Review (England) Regulations' add requirements regarding the Panel’s supervisory powers. We do not propose to include further details in the regulations relating to procedures for reviews. Do you agree with these proposals?*

	Total	Percent
Yes	483	86.1%
No	78	13.9%

## Consultation findings

Of the 561 respondents that answered Question 11, 86.1% of respondents agreed with the proposals. A number of respondents welcomed the reference in guidance to the systems methodology. However, Cafcass and others thought that the guidance as drafted limited reviewers to one model of methodology, and offered the suggestion that referring to principles of the systems methodology would provide more flexibility.

The BASW have pointed out that paragraphs 25 and 43 seemed inconsistent in the requests made on the methodology of local reviews and national reviews.

A few respondents, including attendees at the consultation events, highlighted the work undertaken by the NSPCC and SCIE on 'quality markers' for high quality reviews. In particular, it was suggested that additional guidance could be provided around the effective scoping of reviews, to ensure they focus on the appropriate areas of learning.

There were also requests, including from the National Police Chiefs Council (NPCC), for direction on how local or national reviews should integrate with other ongoing investigations - for example, criminal proceedings and domestic homicide reviews.

## Government response

We welcome the clear consensus that indicates general agreement with the procedures as set out.

We recognise that guidance around methodology could be clearer, in order to allow local areas to be able to employ a range of methodologies that are consistent with the principles of the systems methodology. We will review the drafting of this section accordingly. We will also revisit paragraphs 25 and 43 on local and national reviews respectively, in light of their inconsistency.

We agree that careful scoping before a review is a key part of generating clear recommendations for improvement, and will consider whether additional guidance in the area would be helpful.

The interaction between reviews and other proceedings is already noted in the draft guidance, but we will consider whether more can be added which would be helpful in all circumstances.

## Question 12

*Paragraphs 30-33 and 48-52 of Chapter 4 of the draft 'Working Together to Safeguard Children' 2018 set out the expectations for the final report which the safeguarding partners and the Panel respectively should follow. These paragraphs also cover*

*timescales for publication and arrangements for submitting final reports. Do you agree with these expectations and timescales?*

	<b>Total</b>	<b>Percent</b>
Yes	427	76.5%
No	131	23.5%

## **Consultation findings**

Of the 558 respondents that answered Question 12, 76.5% of respondents agreed with the proposals and timescales.

Many respondents acknowledged the importance of maintaining the momentum of learning reviews, and not allowing them to ‘drift’. During the consultation events it was apparent that there was some confusion about the relationship we anticipate between local safeguarding partners and the new national Panel. A significant number of respondents point to the fact that cases are often complex and linked to criminal investigations or coroner’s inquests. ADCS, SCIE and the NPCC were among those who said that the timetable for reviews was more challenging than suggested. A significant number therefore called for greater flexibility around these deadlines to reflect local circumstances. Cafcass suggest that where reports are not to be published due to ongoing criminal justice inquiries, the guidance could suggest that in these circumstances, a short summary of learning and actions taken could be published within six months. Health partners were generally divided in opinion, although NHS England were among those who took the view that the timescales were unlikely to be achievable for complex cases.

The NSPCC and the Office of the Children’s Commissioner called for guidance to make clear that local reports should be published and accessible. On a point of detail, a number of respondents, including Ofsted, point out that there is no reference to sending final reports to Ofsted as well as the Secretary of State and the national Panel. The NPCC, Association of Lawyers for Children and others would like to see the guidance cover when and how reports are shared with family members and professionals involved in individual cases prior to publication.

Some respondents noted a lack of clarity in the draft regulations regarding the timescales for submitting reports to the Panel and the Secretary of State. The NPCC stressed that relevant central government departments should also monitor national review recommendations and publish outcomes.

## **Government response**

We welcome the clear support for ensuring the need for emerging lessons to be identified and shared promptly.

Once the Panel is in place, it will clearly need to come to quick decisions on the processes it puts in place when working with local areas. These processes will be reflected in the revised *Working Together* guidance. It is clear that the relationship between the new Panel and local safeguarding partners will need to be based on clear communication and (as noted in the response to Question 8 above) once the Panel receives notification of an incident from a local area, a process of dialogue will be required. In this way, any decision to commission a national review will not lead to delays in local action which may be required, or duplication of work aimed at securing immediate learning.

Although we acknowledge that the timescales for the publication of reports may be challenging, we intend to proceed with this proposal. The draft guidance provides safeguarding partners with some flexibility, and recognises that exceptional circumstances can have an impact and may lead to delay in publication. We are also of the view that the draft guidance makes clear the strong presumption that all reports are published. It already states that where a report is not to be published, the Panel and local areas must publish any information about improvements that should be made following the review that they consider appropriate (with a presumption that in most cases the full report should be published). Making sure lessons learned locally are shared more widely, and have the opportunity to inform policy development and practice in other areas (as well as nationally) will be a priority for the new national Panel. This is why the new What Works Centre for Children's Social Care will be represented on the Panel.

We are clarifying the regulations regarding timescales for submitting final reports. We also agree that Ofsted, HMICFRS and CQC are key players in making sure the learning contained in reports leads to improved outcomes; and that their work with local areas, including inspections, may require them to look at how recommendations from Panel reports are being implemented locally. We will therefore be speaking with the inspectorates about when and how local and national reports are shared with them. We also accept the helpful suggestions made around managing the impact of local and national reports on children, families and others involved in individual cases, and will ensure this is better reflected in the guidance. We also accept that arrangements will need to be put in place to ensure that the national Panel monitors responses and progress in implementing national-level recommended improvements – whether those improvements are for local services or central government departments.

## Question 13

*The Act allows the Secretary of State to make regulations to set up a list of reviewers, from which safeguarding partners could be required to select reviewers for local reviews. To maintain maximum flexibility in the system, we do not propose to set up such a statutory list at this time. Do you agree with this approach?*

	Total	Percent
Yes	397	70.4%
No	167	29.6%

## Consultation findings

Of the 564 respondents that answered Question 13, 70.4% agreed with the proposal not to set up a statutory list (in regulations) of local reviewers at this time.

However, many of those who commented, including Action for Children, ADCS, LGA and the British Association for the Study and Prevention of Child Abuse and Neglect (BASPCAN), expressed a strong preference for a non-statutory but approved or accredited list of reviewers to be made available, citing the common difficulty in identifying and engaging good reviewers. The NPCC also noted the benefit in a move towards an approved cadre of reviewers, while acknowledging the challenges. Several mentioned the need for reviewers to be trained and their work evaluated, and for guidance on how to identify and engage good reviewers.

Ofsted and SCIE both suggest building on the serious case review quality markers developed recently by the NSPCC and SCIE to establish standards of good practice in reviewing.

## Government response

We welcome the general agreement with the decision not to establish a statutory list of local reviewers at this time, but note the strong interest in the concept of a central list. The Panel will be setting up a pool of reviewers which will be publicly available, but we intend to consider in more detail the potential benefits of a non-statutory local list. We will discuss this further with key interested parties.

## Question 14

*Do you have any comments on the content of the 'National and Local Child Safeguarding Practice Review (England) Regulations which you have not already covered above?*

	Total	Percent
Yes	160	28.6%
No	400	71.4%

## Consultation findings

Of the 560 respondents that answered Question 14, 71.4% had no further comments. Of those that did, the majority referred to issues which had already been covered in responses to Questions 8 – 13, including: the timescales for completing the concise investigative exercise and the relationship between the Child Safeguarding Review Panel and local safeguarding partners (Question 8); the criteria for national and local child safeguarding practice reviews (Question 9); and expectations of final reports (Question 12) and reviewers (Question 13).

## Government response

We will ensure that responses to this question are taken into account in the revised guidance alongside those made in response to the preceding questions.

## Question 15

*In reviewing the circumstances around the death of a child, the overarching aim is to prevent future child deaths. We have heard from stakeholders that the term “preventable” has posed a hindrance to learning. Instead of asking about preventability, we propose that the child death review process should consider and identify “modifiable factors”. That is, contributory factors to a death, that could be modified to reduce the risk of future child deaths. Do you agree with this approach?*

	Total	Percent
Yes	537	89.4%
No	64	10.6%

## Consultation findings

Of the 601 respondents that answered Question 15, 89.4% agreed with the proposal. A number of comments suggested that some reference to ‘preventability’ or ‘contributory factors’ should remain; while others agreed that the word ‘preventable’ can paralyse discussions. Panels felt that they cannot judge whether the death of a particular child could have been prevented – but they are able to identify if there were ‘modifiable factors’ which could prevent a future death in similar circumstances. A significant amount of comments also asked for more clarity on the definition of modifiable factors.

## Government response

We welcome the clear consensus in responses received that a focus on modifiable factors is a helpful approach. We therefore intend to proceed with this proposal. We agree that more work is needed to ensure consistent definition of modifiable factors



across the country; however, we do not believe that it is possible to define these through this guidance.

## Question 16

*We have heard from stakeholders that the distinction between ‘expected’ and ‘unexpected’ child deaths can lead to confusion (partly because it may depend from whose viewpoint the question is being considered). We propose a new approach, which allows each individual death to be responded to appropriately, rather than determining whether or not a death meets certain criteria for investigation.*

*This is about working differently, and changing the initial stages of the process. It does not imply an additional burden. Do you agree with this approach?*

	Total	Percent
Yes	485	82.5%
No	103	17.5%

## Consultation findings

Of the 588 respondents who answered Question 16, 82.5% agreed with the proposed approach. Many of the comments provided by respondents requested more clarity around the proposal. Answers generally reflected that the term “unexpected” is widely understood, and that if removed, more clarity would be required on when a joint agency response is required. A significant number asked specifically for more clarity on the triggers for a joint agency response. Some, including the NPCC, asked for more explicit reference to the Kennedy Guidelines. A number of comments asked for more clarity on the proposed role of ‘designated doctor for child deaths’ in relation to this question, as this is a change from the previous role of ‘designated paediatrician for unexpected deaths in childhood’.

## Government response

We welcome the clear consensus in responses received that this is a helpful approach, and therefore intend to proceed with this proposal. However, we also recognise that more clarity is needed on the new process. We will amend the draft guidance to clarify the circumstances and causes that trigger a joint agency response. We will ensure more emphasis and an explicit reference to *Sudden unexpected death in infancy and childhood: multi-agency guidelines for care and investigation (2016)* – to clarify that we intend this to remain the detailed operational guidelines for undertaking a joint agency response. We will clarify the definition and expectations for the role of ‘designated doctor for child deaths’. In keeping with other designated professional roles, this role will be responsible for oversight of the child death review process, and would not necessarily

have the specific operational responsibilities that were set out for the designated paediatrician for unexpected deaths in childhood in *Working Together 2015*.

## Question 17

*The Wood Review recommended that the area covered by child death reviews should cover ‘a population size that gives a sufficient number of deaths to be analysed for patterns, themes and trends of death’. The new legislation gives the child death review partners flexibility to agree that two or more local authority areas may work together as a single area. We are proposing that the geographical ‘footprint’ of the arrangements should be locally agreed, based on patient flows across existing networks of NHS care.*

*Child death review partners should come together to develop clear plans outlining the administrative and logistical processes for their new arrangements. Child death review ‘footprints’ should typically cover a child population such that they review 80-120 child deaths each year Do you agree with these proposals?*

	Total	Percent
Yes	469	80.3%
No	115	19.7%

## Consultation findings

Of the 584 respondents who answered Question 17, 80.3% agreed with the proposals on geographical footprints. There was general agreement from respondents that child death overview panels (CDOPs) reviewing very small numbers does not lead to effective analysis. The National Network of Designated Healthcare Professionals for Safeguarding Children commented that, while there is no statistical difference between reviewing 20 or 80 cases a year, there are good arguments for larger caseloads to professionalise the process – ensuring that panels and administrators get sufficient exposure to a range of cases. Many argued for a lower limit (i.e. below 80), in particular to take account of practical challenges in some rural areas. At consultation events, a minimum of around 60 was generally agreed by stakeholders to be about right. There was not significant support for an upper limit of cases. For example, some child death review partners may choose to have a single CDOP administration team across a region, supporting a number of sub-regional panels. This would be in line with the findings of the Wood Review.

## Government response

There was a great deal of consideration on the issue of child death review partner area size during the consultation process. As set out in legislation, the minimum area size is that of a single local authority. However, in line with feedback, we will amend the proposal that child death review footprints should review 80-120 child deaths each year.

Footprints should be locally agreed, aligned to existing networks of NHS care and should take account of agency and organisational boundaries. The expectation is that child death review footprints should cover a child population such that they typically review at least 60 child deaths each year.

## Question 18

*We propose that families should be assigned a “key worker” to act as a single point of contact who they can turn to for information on the child death review process, and who can signpost them to sources of support. This is already best practice and should not imply an additional burden. More information on the role of the key worker is available in chapter 6.5.1 of the Child Death Review Statutory Guidance. Do you agree with this proposal?*

	Total	Percent
Yes	554	93.3%
No	40	6.7%

## Consultation findings

Of the 594 respondents who answered Question 18, 93.3% agreed with the proposal for families to be assigned a ‘key worker’. A number of comments expressed concern around resources, or suggested that protected time would be needed for the role. However, many others gave examples of organisations who were already taking this approach. Others suggested that an outline of competencies should be produced, and/or training provided. Some respondents were concerned that it may not always be appropriate for the key worker to be from the hospital where the child died. Finally, several suggested that a different term should be used for the role.

## Government response

Wide support for the key worker role was expressed through the consultation. We will share examples from the many NHS organisations who already assign a key worker to bereaved parents, and will clarify competencies for the role. We also recognise the concerns around language. However, there was no consensus around an alternative term, and therefore we propose to retain the term ‘key worker’. We will clarify how this role should interact with policy Family Liaison Officers and Coroner’s Officers.

## Question 19

*We propose that every child’s death is reviewed at a child death review meeting involving practitioners directly involved in the child’s care, prior to being discussed anonymously by the Child Death Overview Panel (CDOP). The nature of this meeting will vary according*

*to the circumstances of the child's death and the practitioners involved. It would (for example) take the form of a final case discussion following a Joint Agency Response to a sudden unexpected death in infancy; or a hospital-based mortality meeting following a death on a neonatal unit. The purpose of the child death review meeting is to ensure local learning and reflection. In contrast, the purpose of the CDOP is to provide independent scrutiny of each case, ensuring this is from a multi-agency perspective. Do you agree with this proposal?*

	<b>Total</b>	<b>Percent</b>
Yes	492	84.5%
No	90	15.5%

## **Consultation findings**

Of the 582 respondents who answered Question 19, 84.5% agreed with the proposal. Many comments requested greater clarity on the proposal, and reflected concern that an additional meeting was being proposed. Others said that this approach represents a major change to the aims, format and attendance of some hospital mortality and morbidity meetings. The British Association of Perinatal Medicine asked for specific clarification on how this meeting will fit in with the Perinatal Mortality Review Tool.

## **Government response**

We welcome the support shown for the proposal that all child deaths should be discussed at a local meeting, not just those deaths where there is a joint agency response. We recognise that more clarity is needed around the aims and nature of these meetings. We will amend the guidance to emphasise that the child death review meeting should be flexible and proportionate, and focused on local learning. It is important that all deaths are reviewed, but, particularly where the death is anticipated (as in a child with a life-limiting condition, an extremely premature baby with multiple complications, or a baby with complex congenital anomalies), the review may be quite brief; and perhaps focused on the end of life and bereavement care for the family. We will clarify how the Review Tool should be used in perinatal mortality meetings.

## **Question 20**

*Practitioners involved in the care of the child who died should be invited to attend the child death review meeting. If they cannot attend, they should submit a report, for which a Form B may be used. We propose that Child Death Overview Panel administrators work closely with child death review partners to gather and collate these reports. Please see Chapter 4 of the Child Death Review Statutory Guidance for more information on this process. Do you agree with this proposal?*

	Total	Percent
Yes	506	86.8%
No	77	13.2%

## Consultation findings

Of the 583 respondents that answered Question 20, 86.8% agreed with this proposal. Many comments expressed confusion around how this meeting fits in with the CDOP, and whether there is the potential for duplication. Many comments expressed concern regarding the practical challenges of other practitioners (i.e. from other organisations and agencies) attending all hospital child death review meetings. A significant number expressed concern about time and resources; and others suggested that each organisation involved in the case should be represented.

## Government response

As with Question 19 (above), we welcome the consensus that it is important that there is a local review, for learning and reflection, of every child's death. However, we will amend the guidance to clarify the difference between the purpose of this meeting and that of the CDOP. We will also clarify expectations regarding inviting other practitioners to attend hospital child death review meetings. A list was included in the draft guidance of practitioners to be invited. We will amend this to clarify that the list details practitioners who might be invited, depending on circumstances. We will also clarify that this is a gold standard to aim for, which may not be possible in all cases. Some areas reported that their CDOP administration teams worked with the chairs of child death review meetings to gather Form Bs. We do not propose to make this a requirement, as the practicality will vary between areas.

## Question 21

*A revised Form C is proposed at Appendix 5 of the Child Death Review Statutory Guidance. We have heard from stakeholders that two of the form's domains - 'family and environment' and 'parenting capacity' - are not helpful distinctions. We propose changing these domains to 'Social environment including family and parenting capacity', and 'Physical environment', respectively. Do you agree with this proposal?*

	Total	Percent
Yes	525	89.7%
No	60	10.3%

## Consultation findings

Of the 585 respondents who answered Question 21, 89.7% agreed with the proposal to amend the specified domains. Many who agreed with the change acknowledged that the current domains cause confusion. Others who suggested that the existing domains should continue did so on the basis that they match the Common Assessment Framework. A number of comments suggested that other factors should be included in the revised Form C; and others suggested that it would be good to ensure a consistent output from the revised Form C.

## Government response

On balance, we believe that it is helpful to change the domains. The current domains cause significant confusion around whether an issue relates to the 'social environment' or to 'parenting', which leads to non-standard reporting. The physical environment is recognised as an important factor in a wide range of health conditions, and may be a contributor to many causes of mortality. At present it is poorly recorded by CDOPs. It is important that factors in relation to the physical environment are recorded in a standardised manner.

## Question 22

*We have heard from stakeholders that in many cases reports from child death review meetings (particularly hospital mortality meetings) are not routinely sent to CDOPs. We propose that all child death review meetings should routinely send a report to the CDOP, to inform its independent review of the case. This approach is intended to strengthen the link between the local review and the CDOP process, while also allowing for the right balance between local reflection and independent scrutiny of practice. Do you agree with this proposal?*

	Total	Percent
Yes	577	98%
No	12	2%

## Consultation findings

Of the 589 respondents who answered Question 22, 98% agreed that child death review meetings should routinely send a report to the CDOP. There was significant support for this proposal, and a desire for the reports to be in a consistent format.

## Government response

We welcome the clear support for this proposal. We will revise the child death review reporting forms to ensure that child death review meetings send a standard output to CDOPs.

## Question 23

*Chapter 7 of the Child Death Review Statutory Guidance outlines expectations in a number of specific circumstances, including: deaths of UK-resident children overseas; deaths of children with learning disabilities; deaths of children in adult healthcare settings; suicide and self-harm; deaths in inpatient mental health settings and deaths in custody. Do you feel we have covered an appropriate range of specific situations?*

	Total	Percent
Yes	443	83.9%
No	85	16.1%

## Consultation findings

Of the 528 respondents who answered Question 23, 83.9% agreed that Chapter 7 as drafted covered an appropriate range of situations. Many comments pointed out specific errors in Chapter 7.1 on deaths overseas. A significant number suggested adding a section on children who die in residential settings (including residential homes, secure facilities, hospices, boarding schools and foster care).

## Government response

The aim of Chapter 7 is to cover circumstances where additional statutory processes apply, and require coordination with the child death review process. No additional circumstances of that nature were suggested. For looked-after children, we will amend the guidance to clarify which child death review partners are responsible for ensuring review when a looked-after child is placed in another area. In the section of guidance on child death review partners reviewing the deaths of non-resident children, we will further clarify the main groups of children that this would apply to. We will correct the errors in Chapter 7.1, particularly around coronial process for children who die overseas.

## Question 24

*We have heard from stakeholders that some types of deaths (e.g. suicides) may best be reviewed at a themed CDOP meeting. This may apply when deaths from a particular cause are of small number and/or require specialist expertise to inform the discussion. In*

*these circumstances, we propose that neighboring CDOPs and designated doctors for child death liaise and co-ordinate their approach. Do you agree with this approach?*

	<b>Total</b>	<b>Percent</b>
Yes	520	90.3%
No	56	9.7%

## **Consultation findings**

Of the 576 respondents who answered Question 24, 90.3% agreed with the specified approach. Many commented that themed panels are useful, and already taking place (for example, on neonatal deaths). It was pointed out that neonatal panels are different from most of the panels proposed, as they are for a large, rather than small, number of deaths. A number of comments expressed concerns that themed panels may introduce a significant delay between the death and the CDOP review. It was suggested that themes should be decided by local need, with the designated doctor for child death. There were requests to include the police in suggested suicide themed panel membership.

## **Government response**

A majority of respondents agreed that themed panels are, or could be, helpful. However, local flexibility is needed for these to develop in ways that work in different circumstances across the country. We will clarify that the panels suggested in the guidance are intended as examples only.

## **Question 25**

*Paragraphs 14-15 of the transitional guidance explain the proposal that child death overview panels have a ‘grace period’ of up to two months following the start of the child death review partner arrangements in their area in which to complete any outstanding child death reviews. Do you agree with this proposal?*

	<b>Total</b>	<b>Percent</b>
Yes	391	69.8%
No	169	30.2%

## **Consultation findings**

Of the 560 respondents that answered Question 25, 69.8% agreed with the proposal for a ‘grace period’ of two months for completing any outstanding child death reviews. The majority of respondents answering ‘No’ (including the National Network of Designated Professionals for Safeguarding Children and the RCPCH) said the period was too short,



given the complexity of some cases and the time it takes to obtain information from other agencies.

A 'grace period' will be provided for legally as part of transition arrangements. We need therefore to be able to establish a clear date on which the grace period begins and ends. We appreciate that not all child death reviews will have been completed within this fixed period as there will be situations where the CDOP is unable to complete its work because of external factors. We will make it clear in guidance that the child death review partners that include the original CDOP area will be responsible for ensuring that reviews are completed and the learning disseminated.

## Government response

We welcome the clear consensus evident from the responses received that a 'grace period' would be helpful. We have also noted the strong feelings from several respondents that two months is too short. We therefore intend to proceed with this proposal, with a longer 'grace period' of four months.

The question of flexibility is more difficult to achieve. In order to allow for the 'grace period' to operate legally, it needs to be set up as part of the statutory transition arrangements. We need therefore to be able to establish a clear date on which the grace period begins and ends for the arrangement to be effective legally. We appreciate that not all child death reviews will have been completed within this fixed period as there will be situations where the CDOP is unable to conclude its work because of external factors. We will make it clear in guidance that the child death review partners that include the original CDOP area will be responsible for ensuring that reviews are completed and the learning disseminated.

## Question 26

*Paragraphs 23-25 of the transitional guidance explain the proposal that Local Safeguarding Children Boards should have a 'grace period' of up to 12 months following the start of the safeguarding partner arrangements in their area in which to complete and publish outstanding serious case reviews. Do you agree with this proposal and with the guidance on handling information?*

	Total	Percent
Yes	479	85.5%
No	81	14.5%

## Consultation findings

Of the 560 respondents that answered Question 26, 85.5% agreed with the proposal for a 'grace period' of 12 months for completing and publishing SCRs. This included the AILC and 86 LSCBs; only five LSCBs expressed dissenting views. Nearly two-fifths of those respondents answering 'No' – particularly schools – said the period was too long, several saying that the maximum period should be six months given, in particular, the risk of loss of learning. Some of those answering 'Yes' (including Cafcass) stressed the point that 12 months was acceptable but was the maximum acceptable length of time for the grace period. Around 45 other respondents who commented (both those answering Yes and No) said, on the other hand, that there should be more flexibility in the arrangements because of delays in publication due (for example) to criminal proceedings which are outside the control of the LSCB. A number of respondents stressed the need for emerging learning to be shared promptly.

## Government response

We welcome the clear consensus evident from the responses received that a 'grace period' is a helpful approach and the strong view overall that this period should be set at 12 months. We therefore intend to proceed with this proposal.

As mentioned in the response to Question 25 (above), we need to be able to provide clarity regarding the end of the LSCB's role in SCRs, and so must establish a clear end point for any 'grace period'. We appreciate that not all outstanding SCRs will be able to be completed and published within this fixed period, as there will be situations where the LSCB is unable to conclude its work on an SCR because of external factors. We agree that the prompt sharing of emerging learning is vital. We also acknowledge the importance of keeping families informed of developments. We will seek to reflect all these points carefully in the guidance, including making sure that it is clear that in some cases, the role of the LSCB on an SCR will need to cease and the safeguarding partners will instead need to consider what the next steps should be.

## Question 27

*Paragraphs 27-31 of the transitional guidance set out how safeguarding partners should manage information emerging from serious case reviews. Do you agree with these proposals?*

	Total	Percent
Yes	509	92.7%
No	40	7.3%

## **Consultation findings**

Of the 549 respondents that answered Question 27, 92.7% agreed that safeguarding partners should take into consideration information emerging from serious case reviews. A significant number of respondents felt that safeguarding partners should be responsible for making use of information from SCRs which are incomplete or complete but unpublished at the end of the 12 month grace period. Many respondents agreed that safeguarding partners could determine that the information gathered during the course of incomplete or unpublished SCRs may provide a need for local reviews. Others felt that safeguarding partners should be required to publish complete but unpublished SCRs. A number of respondents also felt that the guidance required greater detail to cover all possible instances of transitional situations.

## **Government response**

We welcome the clear consensus evident from the responses received that safeguarding partners should take into consideration information emerging from serious case reviews. We therefore intend to proceed with this proposal. We appreciate that there may be a number of outstanding complete unpublished SCRs, even after the 'grace period', but in such circumstances the safeguarding partners will need to consider the next steps.

We agree the guidance needs to promote good approaches to information-sharing in the transition period to enable better learning, and will consider how the guidance can better achieve this.

## Next steps

The Government will review the guidance and statutory instruments in accordance with the findings of this consultation.

As the regulations are subject to the affirmative Parliamentary procedure, the statutory instruments will be debated and voted on by both Houses of Parliament in the Spring.

Following commencement of the relevant provisions of the Children and Social Work Act 2017, an updated version of '*Working Together to Safeguard Children*' will be published, and the new safeguarding arrangements will come into effect.

Local areas will have twelve months from the date of commencement to develop and publish their arrangements, and a further three months to implement them in full.

## Annex A: List of organisations that responded to the consultation

- Action for Children
- Albany Junior School
- All Saints Primary School
- Association for Young People's Health
- Association of Directors of Children's Services (ADCS)
- Association of Directors of Public Health
- Association of Independent LSCB Chairs (AILC)
- Association of Lawyers for Children
- Association of School and College Leaders (ASCL)
- Avon and Somerset Constabulary
- Barking Havering and Redbridge University Hospitals Trust
- Barnsley Hospital NHS Foundation Trust
- Barnsley Metropolitan Borough Council
- Barts Health NHS Trust
- BASPCAN
- Bath and North East Somerset Council
- Bath and North East Somerset LSCB
- Bedford Borough LSCB
- Belsay Daycare
- Berkshire West CCGs
- Bexley LSCB
- Bignold Primary School
- Birmingham Children's Trust
- Birmingham City Council
- Birmingham Community Healthcare NHS Foundation Trust
- Birmingham LSCB
- Birmingham Women and Children's Hospital

- Bitterne Park School
- Black Country Partnership NHS Foundation Trust
- Blackburn with Darwen CCG
- Blackburn with Darwen LSCB
- Blackpool LSCB
- Blackpool Teaching Hospitals NHS Foundation Trust
- Blatchington Mill School
- Bliss
- Boarding Schools' Association
- Bolton CCG
- Bolton LSCB
- Bournemouth and Poole/Dorset LSCB
- Bracknell Forest LSCB
- Bradford LSCB
- Braintree District Council
- Brent Council, Brent CCG, Brent Police
- Brent LSCB
- Bridgewater Community Healthcare NHS Foundation Trust
- Bright Start Child Care
- Brighton and Sussex University Hospitals NHS Trust
- Bristol CCG
- Bristol Royal Children's Hospital
- Bristol LSCB
- Bristol, Gloucestershire, Somerset & Wiltshire Community Rehabilitation Company
- British Association of Community Child Health
- British Association of Perinatal Medicine
- British Association of Social Workers
- British Dental Association
- British Equestrian Federation
- British Society of Paediatric Dentistry
- British Transport Police

- Buckinghamshire County Council
- Buckinghamshire LSCB
- Bury LSCB
- Cafcass (Children & Family Court Advisory & Support Service)
- Calderdale and Kirklees CDOP
- Calderdale Metropolitan Borough Council
- Cambridgeshire & Peterborough LSCBs
- Cambridgeshire County Council
- Camden LSCB
- Canford School
- Canterbury Christ Church University
- Care Quality Commission
- Central Bedfordshire Council Children's Services
- Central Bedfordshire LSCB
- Central London Community Healthcare NHS Trust
- Centre of Excellence for Information Sharing
- Centre of Expertise on Child Sexual Abuse
- CenterPoint
- Bradford Child Death Overview Panel
- Chapelford Village Primary School
- Charlton Kings Infants' School
- Chaucer College
- Chellaston Academy
- Cheshire East LSCB
- Children England
- Children's Commissioner of England
- Children's Rights Alliance for England
- Chorley South Ribble, Greater Preston, West Lancashire CCGs
- Churchill Community College
- City & Hackney CCG
- City and Hackney LSCB

- City of Wolverhampton Council
- City of York LSCB
- Claines CE Primary
- CLIC Sargent
- Cockermouth School
- Colchester Borough Council
- Compass Academy Trust
- Conway Schools
- Cornwall Council
- County Durham and Darlington NHS Foundation Trust
- Coventry and Rugby & Warwickshire North CCGs
- Coventry LSCB
- Croydon CCG
- Croydon LSCB
- Cumbria County Council
- Cumbria LSCB
- Darlington LSCB
- Derby City and Derbyshire County CDOP
- Derby City Council
- Derby LSCB
- Derbyshire Children's Hospital
- Derbyshire County Council
- Derbyshire Healthcare NHS Foundation Trust
- Derbyshire LSCB
- Devon Children and Families Partnership
- Devon County Council
- Disabled Children's Partnership Campaign
- Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
- Doncaster CCG
- Doncaster Council
- Dorset, Devon & Cornwall Community Rehabilitation Company



- Dorset County Council
- Dr Challoners Grammar School
- Dudley LSCB
- Durham County Council
- Durham LSCB
- Ealing LSCB
- East & North Hertfordshire CCG
- East Lancashire Hospitals NHS Trust
- East Lancs CCG
- East London NHS Foundation Trust
- East of England Ambulance Service
- East Riding of Yorkshire Council
- East Sussex County Council
- East Sussex LSCB
- ECPAT UK
- Edwalton Primary School
- Enfield LSCB
- Epsom and St. Helier University Hospitals NHS Trust
- Erewash CCG
- Essex County Council
- Essex LSCB
- Essex, Southend & Thurrock Strategic CDOP
- Evelina London Childrens Hospital
- Fairlands Primary School
- Family Rights Group
- Federation of Greenways Schools
- Findern Primary School
- Fisherfield Childcare
- Focus Swaffham Campus
- Freedom and Autonomy for Schools National Association
- Gateshead Council

- Gateshead LSCB
- Gayton Junior School
- Girlguiding
- Glebefields Primary School
- Gloucestershire County Council
- Gloucestershire LSCB
- Godmanchester Community Education Trust
- Godolphin and Latymer School
- Grange Primary School
- Great Yarmouth and Waveney CCG
- Greater Manchester CDOP
- Greater Manchester Mental Health Services NHS Foundation Trust
- Greenwich LSCB
- Great Yarmouth and Waveney CCG
- Great Ormond Street Hospital NHS Foundation Trust
- Guildford and Waverley CCG
- Guy's and St Thomas' NHS Trust
- Hackney Learning Trust
- Halcyon London International School
- Halton LSCB
- Hampshire County Council
- Hampshire LSCB
- Hanbury Primary School
- Hardwick CCG
- Haringey LSCB
- Harrow CCG
- Harrow LSCB
- Havering School Improvement Services
- Healthy London Partnership
- Heart of England NHS Foundation Trust
- Herefordshire Council

- Herefordshire Safeguarding Boards
- Hertfordshire County Council
- Hertfordshire LSCB
- Herts Valleys CCG
- Highgate Primary School Board of Governors
- Hillingdon CCG
- Hillingdon LSCB
- Hillside School
- HM Prison and Probation Service
- Holy Trinity CE Primary Academy
- Homerton University Hospital NHS Foundation Trust
- Hospital and Home Education Learning Centre
- Hounslow CCG
- Hounslow LSCB
- Howard League for Penal Reform
- Howard of Effingham School
- Hull LSCB
- Hydesville Tower School
- I CAN
- Independent Chair North of Tyne CDOP
- Independent Chair of Barnsley LSCB
- Independent Chair of Medway LSCB
- Independent Chair York, Salford, Leicestershire and Rutland Safeguarding Children Boards
- Independent Schools Council
- Independent Schools Inspectorate
- Institute of Health Visiting
- Isle of Wight LSCB
- Islington LSCB
- James Allen's Girls' School
- Jewell Academy

- John Taylor High School
- Jubilee Academy Mossley
- Kendall CE Primary School
- Kent County Council
- Kent Police
- Kernow, Torbay and Devon CCGs
- Kings College London
- Kingston and Richmond LSCB
- Knowsley LSCB
- Lancashire Care NHS Foundation Trust
- Lancashire LSCB
- Landau Forte College
- Leeds City Council
- Leicester City Council
- Leicestershire & Rutland LSCB
- Leicestershire County Council
- Lewisham LSCB
- Lincolnshire LSCB
- Liverpool LSCB
- Local Government Association (LGA)
- London Borough of Bromley
- London Borough of Haringey
- London Borough of Merton
- London Borough of Redbridge
- London Borough of Sutton
- London Borough of Tower Hamlets
- Lordenshaw Consultancy Limited
- Luton CCG
- Luton LSCB
- Manchester City Council
- Manchester Safeguarding Boards

- Manchester University NHS Foundation Trust
- Marner Primary School
- Meadowbrook College
- Medina House School
- Medway Council
- Medway LSCB
- Mercia Primary Academy Trust
- Merseyside CDOP
- Merseyside Police
- Metropolitan Police
- Mid Essex CCG
- Morecambe Bay CCG
- Myerscough College
- Nagalro
- National Association of Head Teachers
- National Association of Independent Schools and Non-Maintained Special Schools
- National Children's Bureau (including Council for Disabled Children)
- National College for Teaching and Leadership
- National Day Nurseries Association
- National Education Union
- National Fostering Agency Group
- National Governance Association
- National Independent Reviewing Officer Managers Partnership
- National Institute for Health and Care Excellence (NICE)
- National LADO Network (NLN)
- National Network of Designated Professionals for Safeguarding Children (NNDHP)
- National Network of Parent Carer Forums
- National Police Chiefs Council
- National Probation Service
- New Horizons Learning Centre
- Newcastle College

- Newcastle Gateshead CCG
- NHS Bury CCG
- NHS Central London CCG
- NHS Corby CCG
- NHS Nene CCG
- NHS Dorset CCG
- NHS Ealing CCG
- NHS Eastern Cheshire CCG
- NHS South Cheshire CCG
- NHS Vale Royal CCG
- NHS West Cheshire CCG
- NHS England
- NHS Hammersmith and Fulham CCG
- NHS Newham CCG
- NHS North Cumbria CCG
- NHS Swindon CCG
- NHS Tower Hamlets CCG
- NHS West London CCG
- NHSE South Central
- Norfolk and Norwich University Hospital Foundation Trust
- Norfolk and Suffolk NHS Foundation Trust
- Norfolk Community Health and Care NHS Trust
- Norfolk County Council
- Norfolk LSCB
- North Bristol NHS Trust
- North East Lincolnshire LSCB
- North Lincolnshire CCG
- North Lincolnshire Council
- North Lincolnshire LSCB
- North Tyneside LSCB
- North Yorkshire and York Safeguarding Children Health Professionals Network

- North Yorkshire County Council
- Northampton General Hospital
- Northamptonshire County Council
- North Derbyshire CCG
- Northern, Eastern & Western Devon CCG
- Northumberland Tyne & Wear NHS Foundation Trust
- Nottingham City Council
- Nottingham University Hospitals NHS Trust
- Nottinghamshire LSCB
- NPS Cambs
- NSPCC
- Oak Bank School
- Oasis Academy Nunsthorpe
- Ofsted
- Old Hill Primary School
- Oldham LSCB
- Options Higford
- Orchard Academy
- Ormiston Academies Trust
- Outburst After School Club
- Outwood Academy Brumby
- Oxford Health NHS Foundation Trust
- Oxfordshire CCG
- Oxfordshire County Council
- Oxfordshire LSCB
- Oxleas NHS Foundation Trust
- Pan Cheshire CDOP
- Peace Children's Centre
- Pearson Education
- Peterborough City Council
- Pipeline Youth Initiative

- Platt Bridge Community School
- Plymouth City Council
- Pool Hayes Academy
- Poole Hospital NHS Foundation Trust
- Portsmouth College
- Portsmouth Hospital Trust
- Positive Resolutions Plus
- Pre-school Learning Alliance
- Purple Futures Community Rehabilitation Company
- QegUK
- Queensbury Tykes Pre-school
- Rainbow Trust
- Rainbows Hospice for Children and Young People
- Ravenscliffe High School and Sports College
- Reading LSCB
- Redbridge CCG
- Redbridge LSCB
- Redcar and Cleveland LSCB
- Research in Practice
- Richmond LSCB
- Rochdale Borough LSCB
- Rokesly Infant School
- Rotherham Borough Council
- Rotherham Doncaster and South Humber NHS Foundation Trust
- Rotherham Health and Wellbeing Board
- Rotherham LSCB
- Royal Borough of Windsor and Maidenhead
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Paediatrics and Child Health
- Royal College of Speech and Language Therapists (RCSLT)



- Royal Yachting Association
- SafeLives
- Sailors Childrens Society
- Salford Council
- Salford Royal Foundation NHS Trust
- Salford LSCB
- Sands
- Sandwell and West Birmingham CCG
- Sandwell LADO
- School - Tudor Grange Academy Worcester
- Sheffield Teaching Hospitals
- Shenfield High School
- Shropshire Community Health NHS Trust
- Shropshire LSCB
- Sir Frank Whittle Studio School
- Sirona Care & Health
- Slough LSCB
- Solent NHS Trust
- Solihull LSCB
- Someries Infant School
- Somerset CCG
- Somerset County Council
- South Sefton and Southport & Formby CCG
- South Tees CCG
- South West Education Group
- South West LADO Group
- South West Yorkshire Partnership NHS Foundation Trust
- South Yorkshire Police
- Southern Derbyshire CCG
- Southampton City CCG
- Southampton City College

- Southend Borough Council
- Southwark Inclusive Learning Service
- Spectrum Educational Advice and Support
- Springbank Primary School
- St Andrews School
- St Anne's Catholic School
- St Catherine's School
- St Helens LSCB
- St John's CE Primary School
- St Mary Magdalen's Primary School
- St Paul and St Timothy's Catholic Infant School
- St Paul's School
- St. Martin's Church
- Staffordshire LADO
- Staffordshire LSCB
- Stoke-on-Trent City Council
- Stoke-on-Trent LSCB
- Stokes Wood Primary School
- Stowe School
- Suffolk County Council
- Summerhill Primary School
- Surrey County Council
- Surrey Police
- Surrey LSCB
- Sutton CCG
- Sutton Valence School
- Swindon and Wiltshire CDOP
- Swindon College
- Swindon LSCB
- Tameside Council
- Tees CDOP

- Telford & Wrekin Council
- Telford & Wrekin LSCB
- The Albion Foundation
- The Amber Trust
- The British Psychological Society
- The Children's Society
- The Education Village Academy Trust
- The Enthusiasm Trust
- The Lighthouse School
- The Littlehampton Academy
- The Lullaby Trust
- The National Deaf Children's Society
- The Newcastle upon Tyne Hospitals NHS Foundation Trust
- The Orchard Primary School
- The Rowan Centre
- The Wren School
- Tiggy Winkles Day Nursery
- Tilbury Pioneer Academy
- Toad Hall Pre-School
- Tor Bridge High
- Torbay LSCB
- Tower Bridge Primary School
- Tower Hamlets CDOP
- Tower Hamlets LSCB
- Tower Hamlets LSCB
- Trafford CCG
- Trafford LSCB
- Tri-Borough LSCB
- Truro Diocese
- Twyford School
- University of Bedfordshire

- University of Brighton
- University of Middlesex
- Virgin Care (Bath and North East Somerset)
- Virtual School Sensory Support
- Voice the Union
- Wakefield & District LSCB
- Walsall Children's Services
- Walsall Healthcare NHS Trust
- Waltham Forest LSCB
- Walthamstow Coroners Court
- Wandsworth Children Service
- Wandsworth LSCB
- Warwickshire Police
- Warwickshire Police & West Mercia Police
- Warwickshire LSCB
- Wellington Medical Centre
- West Berkshire LSCB
- West Hampshire CCG
- West Hertfordshire Hospitals NHS Trust
- West London Mental Health NHS Trust
- West Midlands Police
- West of England CDOP
- Wigan LSCB
- Willows Montessori Nursery
- Wiltshire County Council
- Wiltshire LSCB
- Wixams Academy
- Wokingham LSCB
- Wolverhampton LSCB
- Wood Green Academy
- Worcestershire County Council

- Worcestershire LSCB
- Working Together with Parents Network
- Wrightington, Wigan and Leigh NHS Foundation Trust
- Wymondham College
- 4Governors Ltd



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