



HM Government

# **Working Together: transitional guidance**

**Statutory guidance for Local  
Safeguarding Children Boards, local  
authorities, safeguarding partners, child  
death review partners, and the Child  
Safeguarding Practice Review Panel**

**July 2018**

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# 1. Summary

## 1.1 Purpose of this guidance

This is statutory guidance. Its purpose is to support Local Safeguarding Children Boards (LSCBs), the new safeguarding and child death review partners, and the new Child Safeguarding Practice Review Panel in the transition from LSCBs and serious case reviews (SCRs) to a new system of multi-agency arrangements and local and national child safeguarding practice reviews. This guidance will help them to understand the requirements and to plan and manage their work in the transitional period. They should have regard to it when making their transitional arrangements.

It should be read alongside Working Together to Safeguard Children 2018.

## 1.2 When does this guidance apply?

This guidance applies across England from 29 June 2018. The final expiry date is 29 September 2020.

From 29 June 2018, local authority areas must begin their transition from LSCBs to safeguarding partner and child death review partner arrangements. The transition must be completed by 29 September 2019.

After new safeguarding partner and child death review partner arrangements are set up, LSCBs in the area have a statutory 'grace' period of up to 12 months to complete and publish outstanding SCRs and of up to four months to complete outstanding child death reviews. They should, however, seek to complete these reviews as soon as possible and in the case of outstanding SCRs, no later than six months from the date of the decision to initiate a review. LSCBs must complete all child death reviews by 29 January 2020 and all SCRs by 29 September 2020 at the latest.

This guidance remains applicable in any local area in England until the new arrangements are in place, and during the grace periods where relevant.

## 1.3 What legislation does this guidance refer to?

- The Children Act 2004, including as amended by the Children and Social Work Act 2017
- Associated regulations<sup>1</sup>

## 1.4 Who is this guidance for?

This guidance is for:

- LSCBs
- local authorities (while LSCBs remain in existence)
- safeguarding partners (local authorities, clinical commissioning groups and chief officers of police in a local area)
- child death review partners (local authorities and clinical commissioning groups in a local area)
- the Child Safeguarding Practice Review Panel

## 1.5 Main points

- In section 1, the guidance describes the transitional arrangements which should be followed as local areas move from LSCBs to safeguarding partners and child death review partners
- In section 2, the guidance describes the transitional arrangements which should be followed during the transition from the system of SCRs to the new national and local review arrangement

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<sup>1</sup> [The Children and Social Work Act 2017 \(Commencement No.3\) Regulations 2018](#); [The Children and Social Work Act 2017 \(Commencement No. 4 and Transitional and Saving Provisions\) Regulations 2018](#); [The Child Safeguarding Practice Review and Relevant Agency \(England\) Regulations 2018](#).

## 2. Transition to new local safeguarding arrangements and child death review arrangements

Under the Children Act 2004, as amended by the Children and Social Work Act 2017, LSCBs, set up by local authorities, will be replaced. Under the new legislation, the three safeguarding partners (local authorities, chief officers of police, and clinical commissioning groups) must make arrangements to work together with relevant agencies (as they consider appropriate) to safeguard and protect the welfare of children in the area. The child death review partners (local authorities and clinical commissioning groups) must set up child death review arrangements. From 29 June 2018, the Child Safeguarding Practice Review Panel (“the Panel”) may commission and publish national reviews of serious child safeguarding cases which they consider are complex or of national importance.

From 29 June 2018, local authorities are required, under a new statutory duty, to notify the Panel of incidents where they know or suspect that a child has been abused or neglected and the child has died or been seriously harmed.

See Working Together to Safeguard Children 2018 and further details in section 2 below.

### 2.1 Guidance to LSCBs

#### General

LSCBs must continue to carry out all of their statutory functions, including commissioning SCRs where the criteria are met, until the point at which safeguarding partner arrangements begin to operate in a local area<sup>2</sup>. They must also continue to ensure that the review of each death of a child normally resident in the LSCB area, is undertaken by the established child death overview panel (CDOP), until the point at which new child death review partner arrangements are in place. At the latest the new safeguarding and child death review arrangements must be in place by 29 September 2019<sup>3</sup>.

Before safeguarding partner arrangements begin to operate in a local area, LSCBs should plan how and when to hand over all relevant data and information they hold to the safeguarding partners. In doing so, they should comply with the Data Protection Act 2018 and the General Data Protection Regulation, and provide a clear audit trail on the

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<sup>2</sup> In addition to the guidance set out in this document, therefore, LSCBs should, while they continue to operate, continue to refer to Working Together 2015: chapter 3; chapter 4 (disregarding redundant references to notifiable incidents and the former national panel of independent experts on SCRs); and chapter 5.

<sup>3</sup> LSCBs may, however, continue certain functions beyond this point, in line with the grace periods detailed in this guidance.

handling of all documentation. In particular they should set out any decisions on SCRs which are outstanding at the time of handover.

LSCBs should ensure the retention of pertinent historical records, including (for example) any that might be relevant to the Independent Inquiry into Child Sexual Abuse. They should also arrange to pass on copies of these records to the new safeguarding partners for their area.

## SCRs

Where an SCR has not been completed at the point the new safeguarding partner arrangements begin to operate, for example, if they have only recently been commissioned, the LSCB should seek to complete and publish the SCR within six months of the date of the decision to initiate a review, but has a maximum of **12 months** to do so. The latest date for completion and publication of an SCR is 29 September 2020. In this 12 month grace period the LSCB may not commission any further SCRs or continue with any other former activities. Transitional arrangements covering SCRs are set out in section 2.2.

Before new child death review arrangements begin to operate in a local area, LSCBs should pass copies of all relevant data and information to the child death review partners.

## Child death reviews

Where any child death reviews have not been completed at the point the new child death review arrangements begin to operate, the LSCB has **up to four additional months** to complete those reviews. Where it has not completed a review it must pass the information to the child death review partners. The latest date for completion is 29 January 2020. Any CDOP set up under LSCB arrangements may not undertake any new child death reviews during this four-month period.

If any child death reviews remain incomplete by the end of the four-month period, the LSCB must ensure that all relevant information is provided to the child death review partners.

## 2.2 Guidance to safeguarding partners

Safeguarding partners have **up to 12 months**, from 29 June 2018, to agree their local arrangements and which relevant agencies they consider appropriate should work with them to safeguard and promote the welfare of children in their area.

Safeguarding partners must publish their arrangements, and should notify the Secretary of State for Education when they have done so, by sending the published link to [safeguarding.reform@education.gov.uk](mailto:safeguarding.reform@education.gov.uk). They should also notify the chair of the relevant LSCB(s). They must have published their arrangements by 29 June 2019, but may do so at any time before the end of that period.

Following publication of their arrangements, safeguarding partners have **up to three months** from the date of publication to implement the arrangements. The implementation date should be made clear in the published arrangements. All new local arrangements must have been implemented by 29 September 2019.

If the safeguarding partner arrangements are in place and ready to operate before the child death review partner arrangements for a local area, the safeguarding partners may begin work, without waiting for the child death review partner arrangements to begin.

Once the arrangements have been published and implemented, the LSCB for the local area will cease to exist<sup>4</sup>.

## 2.3 Guidance to child death review partners

From 29 June 2018, child death review partners have **up to 12 months** to agree arrangements for the review of each death of a child normally resident in their area<sup>5</sup>, including arrangements for the analysis of information about deaths reviewed.

Child death review partners should publish their arrangements, and should notify NHS England when they have done so, at [England.cypalignment@nhs.net](mailto:England.cypalignment@nhs.net). At the end of the **12-month period**, or at any time before, child death review partners have **up to three months** to implement the arrangements.

If the child death review partner arrangements are in place and ready to operate before the safeguarding partner arrangements for a local area, the child death review partners may begin child death reviews and their analysis of information from them, without waiting for the safeguarding partner arrangements to begin.

Child death review partners should consider any incomplete child death reviews passed to them by former CDOPs, and take appropriate action. As a result, the child death review partners may identify matters relating to the deaths that are relevant to the welfare of children in the area, or to public health and safety. If so, and they identify that it would be appropriate for anyone to take action (for example, the safeguarding partners), they must inform that person or organisation.

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<sup>4</sup> Subject to the grace periods described in section 1.1 above.

<sup>5</sup> If they consider it appropriate, they may also make arrangements for the review of a death in their area of a child not normally resident there.

## 3. Transition from serious case reviews to national and local reviews

The following sections cover guidance on the transitional arrangements which should operate as the system moves from SCRs to new national and local reviews.

### 3.1 Guidance to local authorities

While the LSCB remains in existence in the local area, the local authority should report to the LSCB any child safeguarding incidents which they are notifying to the Panel<sup>6</sup>. They should do this within **five working days** of becoming aware that the incident has occurred.

### 3.2 Guidance to LSCBs

#### Ongoing duty on LSCBs to commission and publish SCRs in the transition period

LSCBs must continue to make decisions on initiating and publishing SCRs until the point at which safeguarding partner arrangements have been published and are in place in a local area. However, LSCBs should note the provisions set out in the following two sections, including the arrangements for the 'grace period' described below.

#### Links to the Child Safeguarding Practice Review Panel

The Child Safeguarding Practice Review Panel operates from 29 June 2018. The Panel will consider all notifications of serious incidents and may arrange for any case(s) to be reviewed as a national child safeguarding practice review. LSCBs should have regard to any guidance which the Panel publishes. Guidance will include the timescales for rapid reviews and for the Panel's response.

When a serious incident becomes known to the LSCB, the LSCB should promptly undertake a rapid review of the case. The aim is to enable the LSCB to:

- gather the facts about the case, as far as they can be readily established at the time
- discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately

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<sup>6</sup> Local authorities are responsible for notifying the Panel about serious incidents, as set out in section 16C of the Children Act 2004. See paragraphs 12-14 of Chapter 4 of *Working Together to Safeguard Children 2018* for further information and guidance.



- consider the potential for identifying improvements to safeguard and promote the welfare of children
- decide what steps they should take next, including whether to commission an SCR

As soon as the rapid review is complete, the LSCB should send a copy to the Child Safeguarding Practice Review Panel<sup>7</sup>. They should also share with the Panel any thoughts they have had on whether the case may raise issues which are complex or of national importance such that a national review may be appropriate<sup>8</sup>, and on whether they plan to carry out an SCR. They may also do this if, during the course of an SCR, new information comes to light which changes their judgment and suggests a national review may be appropriate.

In many cases there will need to be dialogue between the LSCB and the Panel to support the decision-making process. The LSCB must share further information with the Panel as requested.

If the Panel does decide to undertake a national child safeguarding practice review, the LSCB should take this into account when making a final decision on whether to undertake an SCR of any case covered by a national review.

### ***The Panel and SCRs***

While LSCBs are still operating, the Panel may wish, as part of this consideration, to take a view on whether LSCBs should carry out an SCR. They may also wish to consider LSCBs' proposed approach to publishing SCRs and to the sharing of learning in a local area.

LSCBs should have regard to any advice the Panel may give around the initiation and/or publication of SCRs. LSCBs should let the Panel, the Department for Education (DfE) and Ofsted know of any decisions around SCR initiation and publication, including the name of any reviewer commissioned, as soon as they have made a final decision. LSCBs should also set out for the Panel and the Secretary of State the justification for any decision not to initiate or publish an SCR. They should send copies of all SCRs to the Panel, DfE and Ofsted at least seven working days before publication.

### **Links to safeguarding partners**

#### ***'Grace' period***

Some SCRs may not have been completed and/or published at the point that the new safeguarding partner arrangements begin to operate in all areas covered by the LSCB. Where this is the case, the transitional arrangements allow LSCBs to continue for a

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<sup>7</sup> The Panel may share this with DfE if requested, to enable DfE to carry out its functions.

<sup>8</sup> See also the criteria for national reviews set out at paragraph 22 in Working Together 2018.

'grace period' of **a maximum of 12 additional months** from that point to complete and publish these SCRs.

During the grace period, LSCBs may not commission new SCRs, even if the incident occurred before the start of the grace period, or carry out any other former functions. Information relating to any incidents where decisions on SCRs have not been taken should be passed to the safeguarding partners.

They should also pass on to safeguarding partners any information relating to learning arising from such SCRs (including where these are still in progress), so that the safeguarding partners can consider follow-up actions as appropriate.

If an SCR is not completed or not published by the end of the grace period, the LSCB must pass the complete but unpublished SCR or where it has not been completed, all information relating to the review (which should include learning arising from it), to the safeguarding partners, the Child Safeguarding Practice Review Panel and the DfE.

### **3.3 Guidance to safeguarding partners**

The safeguarding partners must identify serious child safeguarding cases which raise issues of importance in relation to the area and review cases where they consider it appropriate. These are cases where a child has died or been seriously harmed, and abuse or neglect is known or suspected.

In considering such cases, they should take into account any decision previously made by the LSCB regarding whether or not an SCR should be initiated. Particularly (though not exclusively) if further information comes to light about a case which was notified before the date of transition, they may decide to commission a local review, **even if** the former LSCB has previously determined not to initiate an SCR of the same incident.

Safeguarding partners should determine how to make use of information from SCRs which remain incomplete (or complete but unpublished) at the end of the grace period<sup>9</sup>.

Safeguarding partners may conclude, for example, that the information gathered during the course of the incomplete or unpublished SCR gives rise to the need for a local review. They may therefore decide to appoint a reviewer to undertake a local review, if they decide this is appropriate<sup>10</sup>. The reviewer should be given access to the information from the incomplete SCR for use as appropriate.

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<sup>9</sup> Safeguarding partners have no statutory functions relating to SCRs.

<sup>10</sup> This approach may also be needed in any cases where the safeguarding partners believe the SCR needs amendment prior to publication, for example, at the conclusion of a court case

Safeguarding partners are not required to publish completed but unpublished SCRs. However, they may do so, if they agree this is appropriate. In the interests of clarity, they should make clear that the review was commissioned and approved by the former LSCB.

In all cases, safeguarding partners should ensure that their arrangements to work together to identify and respond to the needs of children in the area include provision to consider what improvements to practice can be made, based on information from SCRs. It should be made clear in the arrangements that this provision is applicable whether the SCRs are published, complete but unpublished or still incomplete at the point of transition to the new safeguarding partner arrangements.

### **3.4 Guidance to the Child Safeguarding Practice Review Panel**

The Panel should inform the relevant LSCB promptly following receipt of the rapid review if they consider that:

- a national review is appropriate, setting out the rationale for their decision and next steps
- whether further information is required to support the Panel's decision-making, including whether the LSCB has taken a decision as to whether to commission an SCR

If the Panel decides to undertake a national review they should discuss with the LSCB the potential scope and methodology of the review and how they will engage with them and those involved in the case.

## **Further information**

### **Other relevant departmental advice and statutory guidance**

- Working Together to Safeguard Children 2018
- Working Together to Safeguard Children 2015



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