



HM Government

Revisions to Working Together to Safeguard Children

Government consultation

Launch date 6 January 2015

Respond by 3 February 2015

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Introduction

The purpose of this consultation is to seek views about three substantive changes to the statutory guidance *Working Together to Safeguard Children, 2013 (Working Together)*. These are set out at pages 6-12.

This is not a major review of *Working Together*. The intention is to make only the changes set out here, together with some additional updates and clarifications, in particular amendments to legislation resulting from the Children and Families Act 2014.

Issue date

The consultation was issued on 6 January 2015.

Enquiries

If your enquiry is related to the policy content of the consultation you can contact:

WorkingTogether2015.CONSULTATION@education.gsi.gov.uk

If your enquiry is related to the DfE e-consultation website or the consultation process in general, you can contact the DfE Ministerial and Public Communications Division by email: consultation.unit@education.gsi.gov.uk or by telephone: 0370 000 2288 or via the [DfE Contact us page](#).

Additional copies

Additional copies are available electronically and can be downloaded from [GOV.UK DfE consultations](#).

The response

The results of the consultation and the department's response will be [published on GOV.UK](#) in Spring 2015.

About this consultation

This consultation document seeks views about three proposed changes to the statutory guidance. We are not consulting on the updates and clarifications set out in Annex A. Following this consultation, the government proposes to update and replace the current statutory guidance *Working Together to Safeguard Children* revised and published in 2013.

The three proposed changes being consulted on are:

- the referral of allegations against those who work with children;
- notifiable incidents involving the care of a child; and
- the definition of serious harm for the purposes of serious case reviews.

The current guidance can be viewed by clicking on this link:

<https://www.gov.uk/government/publications/working-together-to-safeguard-children>

This is statutory guidance which aims to help professionals understand what they need to do under the law, and what they can expect from one another, to safeguard children. It focuses on the core legal requirements and it makes clear what individuals and organisations should do to keep children safe. It does not include practice guidance, or detailed guidance about what action professionals should take in response to specific situations. These are matters best left to professional judgement, taking account of the unique circumstances and factors involved in each particular case.

We would like to hear your views on our proposals.

Respond online

To help us analyse the responses please use the online system wherever possible. Visit www.education.gov.uk/consultations to submit your response.

Other ways to respond

If for exceptional reasons, you are unable to use the online system, for example because you use specialist accessibility software that is not compatible with the system, you may download a word document version of the form and email it or post it.

By email

WorkingTogether2015.CONULTATION@education.gsi.gov.uk

By post

Working Together Consultation
Department for Education
Floor 1, Sanctuary Buildings
Great Smith Street
Westminster
London SW1P 3BT

Deadline

The consultation closes on at 5.00pm on 3 February 2015.

The referral of allegations against those who work with children

Background

We are proposing to amend *Working Together* to state that referrals relating to both concerns about a child and allegations against those who work with children should be dealt with in a coordinated manner, via a single point of contact. The rationale behind the change is to simplify referral routes by creating a single entry point. There has been a suggestion that the local authority designated officer (LADO) role causes confusion amongst some professionals about what to refer and to whom. We believe it is for the local authority, with its partners, to determine how it organises its internal systems to investigate allegations against a person and harm to a child. We expect that the impact of this change will be to reduce the risk that allegations against those who work with children are managed in isolation from any action necessary to address welfare concerns relating to the child or children concerned. We are not proposing that the LADO role be disbanded, but rather that it links more closely to the front door of children's social care. The existing LADO role could be retained or divided between a team of officers, beyond the single point of contact. We are also proposing that such an officer or officers should be qualified social workers in order that they have the necessary training and expertise to be able to fulfil this role effectively.

The proposed revised text below (on which we are consulting) is highlighted. It would replace text on pages 48 and 49 of the existing guidance.

Proposed revised text

Section 11 of the Children Act 2004

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

Various other statutory duties apply to other specific organisations working with children and families and are set out in this chapter.

1. Section 11 places a duty on:
 - local authorities and district councils that provide children's and other types of services, including children's and adult social care services,

public health, housing, sport, culture and leisure services, licensing authorities and youth services;

- NHS organisations, including the NHS Commissioning Board and clinical commissioning groups, NHS Trusts and NHS Foundation Trusts;
- the police, including police and crime commissioners and the chief officer of each police force in England and the Mayor's Office for Policing and Crime in London;
- the British Transport Police;
- the Probation Service;
- Governors/Directors of Prisons and Young Offender Institutions;
- Directors of Secure Training Centres; and
- Youth Offending Teams/Services.

2. These organisations should have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children, including:

- a clear line of accountability for the commissioning and/or provision of services designed to safeguard and promote the welfare of children;
- a senior board level lead to take leadership responsibility for the organisation's safeguarding arrangements;
- a culture of listening to children and taking account of their wishes and feelings, both in individual decisions and the development of services;
- arrangements which set out clearly the processes for sharing information, with other professionals and with the Local Safeguarding Children Board (LSCB);
- a designated professional lead (or, for health provider organisations, named professionals) for safeguarding. Their role is to support other professionals in their agencies to recognise the needs of children, including rescue from possible abuse or neglect. Designated professional roles should always be explicitly defined in job descriptions. Professionals should be given sufficient time, funding, supervision and support to fulfil their child welfare and safeguarding responsibilities effectively;
- safe recruitment practices for individuals whom the organisation will permit to work regularly with children, including policies on when to obtain a criminal record check;
- appropriate supervision and support for staff, including undertaking safeguarding training:
 - employers are responsible for ensuring that their staff are competent to carry out their responsibilities for safeguarding and promoting the welfare of children and creating an environment where staff feel able to raise concerns and feel supported in their safeguarding role;

- staff should be given a mandatory induction, which includes familiarisation with child protection responsibilities and procedures to be followed if anyone has any concerns about a child's safety or welfare; and
 - all professionals should have regular reviews of their own practice to ensure they improve over time.
- clear policies in line with those from the LSCB for dealing with allegations against people who work with children. Such policies should make a clear distinction between an allegation, a concern about the quality of care or practice or a complaint. An allegation may relate to a person who works with children who has:
 - behaved in a way that has harmed a child, or may have harmed a child;
 - possibly committed a criminal offence against or related to a child; or
 - behaved towards a child or children in a way that indicates they may pose a risk of harm to children.
3. County level and unitary local authorities should ensure that allegations against people who work with children are not dealt with in isolation. Any action necessary to address corresponding welfare concerns in relation to the child or children involved should be taken without delay. In order that cases are dealt with in a coordinated manner, allegations against those who work with children should be referred to the same point of contact (children's social care) as concerns about a child's welfare. Local authorities should, in addition, have designated a particular officer, or team of officers (either as part of multi-agency arrangements or otherwise), to be involved in the management and oversight of allegations against people that work with children. Any such officer, or team of officers, should be qualified social workers. Arrangements should be put in place to ensure that any allegations about those who work with children are passed to the designated officer, or team of officers, without delay.
 4. Local authorities should put in place arrangements to provide advice and guidance on how to deal with allegations against people who work with children to employers and voluntary organisations. Local authorities should also ensure that there are appropriate arrangements in place to effectively liaise with the police and other agencies to monitor the progress of cases and ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.
 5. Employers and voluntary organisations should ensure that they have clear policies in place setting out the process, including timescales, for investigation and what support and advice will be available to individuals against whom allegations have been made. Any allegation against people who work with children should be reported immediately to a senior manager within the organisation. Children's social care (the single point of contact) should also be informed within one working day of all allegations that come to an employer's attention or that are made directly to the police.

6. If an organisation removes an individual (paid worker or unpaid volunteer) from work such as looking after children (or would have, had the person not left first) because the person poses a risk of harm to children, the organisation must make a referral to the Disclosure and Barring Service. It is an offence to fail to make a referral without good reason.

Questions

1. Do you agree that allegations against people who work with children should be routed through children's social care, so that they are dealt with alongside child welfare concerns in a coordinated manner?
2. Do you agree that the officer or officers managing allegations against those who work with children should be qualified social workers? Please explain your answer.
3. Are there any aspects of the revised text in this area that you think could be made clearer? If so, please explain why and suggest how the text could be improved.

Notifiable incidents and the definition of serious harm

Background

In 2007, the government issued a circular to local authorities setting out how serious incidents involving children should be notified to Ofsted. It has become clear over time that local authorities are unclear both about the requirement to notify and what constitutes a notifiable incident. This has resulted in differences in interpretation between different areas, which has been highlighted in the work being undertaken by the national panel of independent experts on serious case reviews (SCRs). In order to streamline the process and make sure that local authorities are clear about what and when to notify, we propose to clarify the guidance and place it within *Working Together*. This will raise the profile of this guidance, giving it statutory status which will in turn, ensure that local authorities are aware of and understand the need to notify serious incidents to Ofsted and the relevant Local Safeguarding Children Board (LSCB).

We are also proposing to clarify what should be considered by LSCBs as constituting serious harm to a child as a result of abuse or neglect for purposes relating to the initiation of SCRs. This arises from concerns raised by the national panel about LSCBs' failure to initiate SCRs. There are concerns that some LSCBs are failing to make appropriate decisions on what constitutes serious harm, sometimes referring to obsolete versions of *Working Together*, leading to unjustifiable decisions regarding whether SCR criteria are met. The changes to *Working Together* seek to clarify this.

The proposed revised text below (on which we are consulting) is highlighted. It would replace text on page 68 of the existing guidance.

Proposed revised text

Notifiable incidents

1. A notifiable incident is an incident involving the care of a child which meets any of the following criteria:
 - A child has died (including cases of suspected suicide), and abuse or neglect is known or suspected.
 - A child has been seriously harmed and abuse or neglect is known or suspected.

- A looked after child or a child in a regulated setting has died (including cases where abuse or neglect is not known or suspected).¹
2. The local authority should report any incident that meets the above criteria to Ofsted and the relevant LSCB promptly, and within five working days of becoming aware that the incident has occurred.
 3. For the avoidance of doubt, if an incident meets the criteria for a Serious Case Review (see below) then it will also meet the criteria for a notifiable incident (above). There will, though, be notifiable incidents that do not proceed through to Serious Case Review.
 4. Contact details and notification forms for notifying incidents to Ofsted are available on Ofsted's website at https://ofstedonline.ofsted.gov.uk/outreach/Ofsted_Serious_Notification.ofml.

Serious Case Reviews

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either —

(i) the child has died; or

(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

¹ Regulated settings: Childcare on domestic premises; Childcare on non-domestic premises; Home childcarer; Childminder; Children's Homes (including secure children's homes); Adoption Support Agencies; Voluntary Adoption Agencies; Independent Fostering agencies; Residential Family Centres and Holiday Schemes for Disabled Children.

5. “Seriously harmed” in the context of paragraph 12 and regulation 5(2)(b)(ii) above includes, but is not limited to, cases where the child has sustained, as a result of abuse or neglect, any or all of the following:
 - a potentially life-threatening injury;
 - serious impairment at the time of the incident, and/or long-term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

This definition is not exhaustive. In addition, even if a child recovers, this does not mean that serious harm cannot have occurred.

6. Cases which meet one of these criteria (i.e. regulation 5(2)(a) and (b)(i) or 5(2)(a) and (b)(ii) above) **must always** trigger an SCR. In addition, even if one of these criteria are not met an SCR **should always** be carried out when a child dies in custody, in police custody, on remand or following sentencing, in a Young Offender Institution, in a secure training centre or a secure children’s home, or where the child was detained under the Mental Capacity Act 2005. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide.
7. Where a case is being considered under regulation 5(2)(b)(ii), unless it is clear that there are no concerns about inter-agency working, the LSCB **must** commission an SCR. The final decision on whether to conduct the SCR rests with the LSCB Chair. If an SCR is not required because the criteria in regulation 5(2) are not met, the LSCB may still decide to commission an SCR or they may choose to commission an alternative form of case review.
8. LSCBs should consider conducting reviews on cases which do not meet the SCR criteria. They will also want to review instances of good practice and consider how these can be shared and embedded. LSCBs are free to decide how best to conduct these reviews. The LSCB should oversee implementation of actions resulting from these reviews and reflect on progress in its annual report.

Questions

4. Do you agree that the addition to Chapter 4 of guidance on notifiable incidents makes the essential requirements clear - so all organisations know what they are required to do? If not, please explain why and how you think the guidance in this section should be made clearer.
5. Do you agree that the addition to Chapter 4 guidance on the definition of serious harm will support LSCBs in determining whether or not serious harm has occurred? If not, please explain why and how you think the guidance in this section should be made clearer.

Annex A – Minor clarifications and updates

The table below includes other drafting changes we expect to make when we reissue but on which we are not seeking views as part of this consultation. We propose to clarify *Working Together to Safeguard Children 2013* as follows:

Clarification/Update	Reason for change
Statement of safeguarding responsibility	To clarify accountability functions on local authorities as set out in the Children Acts of 1989 and 2004.
Information sharing	Updating to reflect new information sharing guidance.
Schools	Make it clear that this guidance applies in its entirety to all schools. Schools (including independent schools, Academies and free schools) have duties in relation to safeguarding and promoting the welfare of pupils - this is in light of some challenges from local authorities over their role in independent schools.
Child protection conference	Ensure references to the “15 days from the strategy discussion to the core meeting” are consistently referenced throughout <i>Working Together</i> .
Young Carers and Parent Carers	Update the guidance with reference to new duties to assess young carers and parent carers - legislative progress has been made through the Children and Families Act 2014 and the Care Act 2014 to strengthen the rights of all carers. The Children and Families Act 2014 has amended Part 3 of the Children Act 1989 to improve how young carers, parent carers (of disabled children) and their families are identified and supported. This change extends both the right to an assessment to all young carers and parent carers and also introduces a requirement to make an assessment on the appearance of need. The changes to Part 3 are due to come into force from 1 April 2015 but will be briefly outlined in the amendments to be made to <i>Working Together</i> .
Child death reviews	Clarification wording on what constitutes a modifiable death (a modifiable death is defined as where there are factors which may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths); wording which considers the involvement of families in the child death review process; and a paragraph on the disclosure of Child Death Overview Panel information at the request of the Coroner.
Special Educational Needs / Educational Health and Care	Update the guidance with the new SEN provisions.

Clarification/Update	Reason for change
Plans	
Child protection for foreign national children	Changes to reflect the publication of new guidance on <i>Working with foreign authorities on child protection cases and care orders</i> .
Assessment	45 working day timescale to complete assessment – additional wording to support maximum flexibility, particularly in relation to any strengthening around the continuous assessment language and provision of services as soon as need is identified.
Accessing help and services: targeted responses to safeguarding concerns	To specify Female Genital Mutilation, gender-based violence, child sexual exploitation, and radicalisation and other targeted safeguarding concerns, given the recent high profile of these issues and to reflect <i>Keeping Children Safe in Education</i> .
Child Sexual Exploitation in Gangs and Groups (CSEGG)	The Office of the Children’s Commissioner’s final CSEGG report published in November 2013 recommended that the DfE amend its 2009 ‘Safeguarding children and young people from sexual exploitation’ supplementary guidance. The CSEGG report indicated that LSCBs were not complying with our guidance on child sexual exploitation (CSE); and that this guidance was out of date. Due consideration was to be given on any decision to revise the guidance, but in the meantime, it was suggested that opportunities be taken in any further revisions of <i>Working Together 2013</i> to make clear the LSCB role and responsibilities on CSE.
Children returning home from care	Children returning home from care - changes are part of the government response to the Improving Permanence for looked after children consultation proposals which focused on strengthening the statutory framework for children returning home from care. The changes will make explicit the requirements and expectations for continued assessment, planning, support and review for children who return home where this is both planned and unplanned.
Probation	To reflect the structural changes to probation under the Transforming Rehabilitation Programme and the findings of HM Inspectorate of Probation thematic inspection on protecting children.



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