Annex A: KCC Draft Response to the Changes to Statutory Guidance, 'Working Together.'

Question No	Question	KCC Response
Chapter 3: Multi-agency safeguarding arrangements		
1 Leadership	In Working Together 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? If not, please explain why.**	KCC would like to see some guidance issued outlining who should represent the multiplicity of health organisations, including multiple CCGs that might sit within one Local Authority Area, as this would provide a helpful steer for both health colleagues and the other Safeguarding Partners. There may also be benefit in stipulating what level of delegated authority/accountability that health colleague would need to have coming into the new arrangements.
2 Relevant Agencies	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 (GPs) come under NHS England, and housing under the local authority. **Do you**	Yes, KCC agrees with the indicative list. In our experience, having a Lay Member has also been a helpful addition to multi-agency arrangements. It may therefore be useful to include a lay role on the list, as an option for inclusion.

	agree with this indicative list? If not, please explain why and if you believe any agencies should be added or removed.	
3 Schools and educational partners	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? Please explain your answer.**	KCC agrees that all local safeguarding arrangements should contain explicit reference to how the Safeguarding Partners plan to involve, and give a voice to, all local schools and academies. We welcome the fact that, once designated as a relevant agency, schools and colleges are under a statutory duty to work in-line with the arrangements published by the Safeguarding Partners. However, we would like some additional clarity on how to work with schools that do not, for whatever reason, engage fully with the new arrangements or whom are autonomously run and governed, and therefore have little history of engaging with local authorities as a consequence e.g. free schools, academy trusts, etc. What recourse will the Safeguarding Partners have to address such issues? And will the Safeguarding Partners be held accountable for disconnections if evidence is available to show that all appropriate actions have been taken on their behalf in order to re-engage with schools? Under the new Working Together draft guidance, it is stated that a lead practitioner should be provided to support children and families – and that a GP, family support worker, school nurse, teacher, health visitor or SEN coordinator could undertake this role (with decisions about who is in the best position to do so taken on a case-by-case basis). Whilst we agree with the proposal that any agency can take lead responsibilities, having a single point of contact and leadership on safeguarding within schools is crucial – both to ensure consistency for the children involved as well as consistency in the way Safeguarding Partnership's engage with schools.
4 Independent Scrutiny	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	Yes, KCC agrees that the scrutiny of Safeguarding Partner arrangements should be undertaken by an independent person who is entirely separate from the organisation rather than an established Chair. This will be necessary to ensure impartiality and objective reflection.

	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? If not, please explain why.**	
5 Funding	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? If not, please explain why.**	KCC feels the new arrangements will make it easier to obtain equal funding from the Safeguarding Partners; however, it is much less clear whether other agencies will feel the requirement to contribute funding in the same way as has previously been the case under the old arrangements e.g. probation services. As such, the total funding contributions may be less than required and any deficits may have to be made up by the Safeguarding Partners – placing an additional burden on these agencies.
6 Reporting	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? If not, please explain**	Yes, KCC does agree with this approach. However, rather than simply requiring local areas to publish data to assess the effectiveness of the help that is being provided to children and families, including early help, we suggest it would be helpful to stipulate that there needs to be evidence to show how this data is being used as information and intelligence to drive good partnership working. We also think there should be more of a focus on achieving positive outcomes for children, including how these should be best monitored from a national standpoint.

	why.	
7 Threshold Document	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? If not, please explain why.**	KCC agrees with Government that there is no need to stipulate in statute the requirement for Safeguarding Partners to have a threshold document. However, we believe it is important to include the requirement for Partners to publish their criteria for action – in whatever form best suits the needs of the local area – to ensure there is clarity about what services are available and how they should be best utilised at the right time to meet the needs of children and young people. This is particularly important to ensure partners are clear when they need to escalate to statutory protection and safeguarding services. However, this is also needed to ensure agencies to are clear when the needs of the child would be best met at lower levels of intervention – for instance within a universal setting.
Chapter 4: Learning from Serious Cases and New Regulations on Local and National Review		
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? If not, please explain why.**	Yes.
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	Yes.

	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 'Working Together to Safeguard Children' 2018 set out additional circumstances for consideration. **Do you agree with these criteria and circumstances? If not, please explain why.**	
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? If not, please explain why.**	Yes.
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 add requirements regarding the Panel's	Yes.

	supervisory powers. We do not propose to include further details in the regulations relating to procedures for reviews. **Do you agree with these proposals? If not, please explain why.**	
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? If not, please explain why.**	KCC agrees with the guidance's emphasis on making every effort, both before the review and whilst it is in progress, to capture points from the case regarding improvements needed to take corrective action, and to disseminate learning to improve future practice and methodologies. However, we feel that the timescales proposed (it is specified that, depending on the nature and complexity of the case, reports should be completed and published between two and six months from the date of the decision to initiate a review) will be difficult to achieve in practice due, in considerable part, to delays incumbent on the system e.g. in obtaining the results from post mortems. As such, we recommend that the timescales should be extended to between 6-9 months at a maximum.
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? If not, please explain why.**	KCC agrees that to allow for the flexibility necessary to select reviewers with the right experience and availability to match the needs of each case, there should not be a proscribed list of reviewers that local Safeguarding Partners have to call on in order to undertake local reviews.
14	Do you have any comments on the content of the regulations at Annex B which you have not already covered above? **If so, please provide details below.**	
Chapter 5 – Child Death Reviews		

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? If not, please explain why.**	KCC agrees with proposed movement from using the term ‘preventable’ when assessing child death and/or serious harm to the term ‘modifiable factors’ in the majority of cases where children have died as a result of accident or disease. However, we feel this term is less well suited to the comparatively small number of cases where children have died as a result of serious abuse or neglect. In these instances, we feel that ‘modifiable factors’ carries with it the suggestion that an intervention could have occurred to mitigate or prevent the risk of death or serious abuse and neglect from occurring – which is, unfortunately, not always the case. Further, there are a number of wider contributory factors - incidents that will be well beyond the control of practitioners working with families e.g. poverty - which are likely to impact on the circumstances leading to such an incident. These are also not modifiable. We believe that a different phrase – such as ‘reasonable steps’ or ‘achievable interventions’ - may better describe the measures that agencies need to take in the future in order to adapt their own behaviours and approaches to better safeguard children in these instances.
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? If not, please explain why.**	If stakeholders have expressed confusion in relation to these terms, KCC is happy with the DfE’s proposal to adopt a new approach in the designation of child death.
17	The Wood Review recommended that the area covered by child death reviews should	Yes.

	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? If not, please explain why.**	
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? If not, please explain why.**	KCC agrees that this approach would generally be helpful in the majority of circumstances. However, in the small number of instances whereby the circumstances surrounding a child’s death are extremely complex e.g. those cases involving abuse and neglect, we have some reservations. These pivot on the fact the guidance states that families would be able to turn to this ‘key worker’ for all information requests - but this fails to recognise the potential complexities within family dynamics i.e. the requirements of one parent may differ from another. There is also the potential that such information could be used within a criminal trial. For instance, a parent may cite that a drug and alcohol support service did not provide what he/she considered to be enough/the right kind of support following signposting as defence at a criminal trial. We also feel the guidance designation of the lead as someone that ‘usually a healthcare professional’ is quite a broad designation.

19	We propose that every child's death is reviewed at a child death review meeting involving practitioners directly involved in the 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? If not, please explain why.**	KCC agrees that every possible care should be taken when examining a child's death and that this new approach would provide greater scrutiny and oversight in the main. However, there is an inherent risk in that this will also provide for a potentially labour-intensive review of cases that are deemed 'expected' – possibly diverting resources away from cases that are 'unexpected' and which may consequentially warrant more intensive review. If more staff need to be appointed to contend with any increased demand in relation to this change, will additional resourcing be provided to offset this financial burden?
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 CDOP 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? If not, please explain why.**	KCC agrees with taking this approach in the majority of circumstances. However, for those cases that meet the criteria for Case Review Group (as a result of a death arising from serious abuse or harm) this is more problematic. At present, Case Review Group meetings collate all available data and make a decision about whether cases meet the threshold for Serious Case Review; such groups do not go on to undertake investigations. If the boundaries between these two functions become blurred, there is a risk that reviews will become overburdened, that work will be duplicated and that this will lead to an increase in a 'blame culture' between agencies rather than establishing the right environment for reflection and collaborative learning.

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? If not, please explain why.**	Yes.
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? If not, please explain why.**	Yes.
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	Yes.

	custody. **Do you feel we have covered an appropriate range of specific situations? Are the suggested approaches for each of these appropriate and workable? If not, please explain why.**	
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 neighbouring CDOPs and designated doctors for child death liaise and co-ordinate their approach. **Do you agree with this approach? If not, please explain why.**	KCC agrees that themed CDOP meetings may be helpful to focus on complex and challenging issues, to distil trend learning and to ascertain patterns for priority action.
Transitional Arrangements		
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? If not, please explain why.**	Yes.
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 SCRs. **Do you agree with this**	Yes.

	proposal and with the guidance on handling information? If not, please explain why.	
27	Paragraphs 27-31 of the transitional guidance set out how Safeguarding Partners should manage information emerging from SCRs. **Do you agree with these proposals? If not, please explain why.**	KCC does agree with the proposals; however, we would appreciate more detail regarding instances where, following the emergence of new information about a case *before* the date of transition, it is felt appropriate to commission a local review even if the former LSCB has previously determined not to initiate an SCR of the same incident.