



Department  
for Education

# **Working together to safeguard children**

**Government consultation response**

**March 2015**

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## Introduction

The Government recently consulted on three proposed changes to *Working Together to Safeguard Children 2013 (Working Together)* statutory guidance. The changes aim to improve practice by enhancing the way that local authorities, Local Safeguarding Children Boards (LSCBs) and others make decisions, leading to greater awareness and improved outcomes for children. The consultation ran from 6 January 2015 to 3 February 2015 and received 308 responses. A breakdown of who responded is at Annex A.

The consultation sought views on three proposed changes:

- **The referral of allegations against those who work with children.**

We proposed 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 via a single point of contact. The rationale behind the change was to simplify referral routes, thereby reducing the risk that allegations are managed in isolation from any action necessary to address child welfare concerns. There had also been a suggestion that the local authority designated officer (LADO) role causes confusion amongst some professionals about what to refer and to whom.

- **Notifiable incidents involving care of a child**

In 2007, the government issued a circular to local authorities setting out how serious incidents involving children should be notified to Ofsted. It had become evident over time that local authorities were unclear both about the requirement to notify and what constituted a notifiable incident. This had resulted in differences in interpretation between different areas. We proposed to clarify the guidance and place it within *Working Together*, enabling the circular to be withdrawn.

- **Clarification of the term ‘seriously harmed’**

We proposed to clarify what LSCBs should take into account when considering what constitutes serious harm to a child in the context of serious case reviews (SCRs). There were concerns – flagged by the national panel - that some LSCBs were failing to make appropriate decisions on what constituted serious harm, sometimes referring to obsolete versions of *Working Together*, which sometimes led to unjustifiable or inconsistent decisions on whether SCR criteria were met.

The consultation document also provided a table of minor clarifications and updates which were expected to be made when the statutory guidance was reissued, but on which views were not sought as part of the consultation. The changes we have made are set out in Annex B.

# Summary of responses received and the government's response

## Main findings from the consultation

The Government is grateful to the organisations and individuals who responded to the consultation.

On the first two questions in the consultation, responses were mixed. The responses to question 1, on the single point of contact, were fairly evenly split, but gave a clear sense that there should be a balance between coordination and local discretion. On question 2, about the management of allegations by qualified social workers, there was a clear majority view against the proposal as it stood. Question 3 (asking for textual suggestions) elicited a range of helpful comments.

On questions 4 and 5, the majority of respondents welcomed the proposed changes in principle. Responses on question 4 were particularly strongly in favour of the inclusion of advice on notifiable incidents. On question 5, a clear majority was in favour of the inclusion of some wording to support decisions on the question of 'serious harm', though there were comments on points of detail.

We have reflected carefully on the feedback received.

- We have amended the proposed wording to emphasise that referrals relating to concerns about a child and allegations against those who work with children should be dealt with in a coordinated manner, without specifying that they should be referred via the same single point of contact. This allows room for local discretion.
- We have amended the proposed wording to state that staff involved in the management and oversight of allegations against those who work with children should be sufficiently experienced or qualified, and that new appointments should be qualified social workers (unless they have previous experience in this role). This means that experienced designated officers can continue in their roles.
- We have set out more clearly the requirements on local authorities to notify serious incidents involving children, following some specific comments.
- We have made some clarifications on the question of 'long-term impairment' in the definition of 'seriously harmed', again following some specific comments.

## Question analysis

### The referral of allegations against those who work with children

This section covers consultation questions 1 to 3.

#### Question 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?**

	Total	Percent
Yes	139	46%
No	128	43%
Not sure	34	11%

There were 301 responses to this question.

The proposal received a fairly even number of responses between those in favour or against.

Responses included:

- a coordinated approach is important;
- the child protection system is in a good position to manage allegations against staff;
- confusion by some respondents about what exactly was being proposed, with many believing that the role and current arrangements would be moved entirely - from the LADO - to social care, leading to concerns from respondents about the capacity of children’s social care to deal with the ‘additional’ work;
- a significant number of respondents commented on the value they attached to their relationship with the LADO and voiced concerns about children’s social care;
- concerns from some respondents that the independence and specialist role and skills set of the LADO would be lost or diluted if routed through children’s social care; and that some cases might ‘fall through the cracks’; and
- a significant number of responses felt that the single point of access would remove confusion, improve insight, provide more consistent responses, place the child at the centre of the process and improve the support they receive, make referrals easier, and help ensure that all referrals are coordinated and handled in a timely manner.

## Government response

In response to the concerns raised, we have decided to change the text that we consulted on. We have therefore removed the proposed expectation that allegations against those who work with children should be routed through children's social care, and instead stated that allegations and referrals relating to concerns about a child should be dealt with in a coordinated manner. We believe that this strikes the right balance between emphasising the importance of a coordinated approach – which consultees felt was important – and allowing room for local discretion.

## Question 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.**

	Total	Percent
No	150	50%
Yes	103	35%
Not sure	45	15%

There were 298 responses to this question.

The proposal that the officer or officers managing allegations against those who work with children should be qualified social workers was rejected by a significant majority (150 of 298 respondents), and a number of those in favour caveated their responses.

Responses included:

- such an approach would be consistent and credible;
- this would ensure that the role is child-focused;
- social workers would bring particular skills around assessment of risk and thresholds, relevant child protection legislation and knowledge of early help and care pathways;
- concerns that social workers will not have the skills possessed by those currently fulfilling the LADO role;
- the option that a 'team' approach would allow for only some team members to be required to have qualified social worker status;
- concerns raised that replacing experienced LADOs might result in a poorer quality service, with many agencies commenting that they are satisfied with the service provided by existing LADOs who are not qualified but bring specialist knowledge from a range of backgrounds; and

- a number of responses, whilst in support of the proposal, raised concerns about the role needing a specific skills set and experience, e.g. handling misconduct and disciplinary issues which a social worker might not necessarily possess on the basis of the qualification alone; and that a senior manager should undertake the role.

## Government response

Respondents to the consultation were clearly against the proposal that all those managing allegations against those who work with children should be qualified social workers. The crux of the concerns raised by respondents centred on the possible loss of experienced members of staff who are currently fulfilling this role to a high standard, resulting in a poorer service.

While the department's view, and the view of the Chief Social Worker for Children and Families, remains that social workers should manage allegations against those who work with children, we have listened to the concerns raised through the consultation. In response to the consultation feedback, we have added a new expectation that those managing allegations should be sufficiently qualified and experienced. This will mean that high quality, experienced designated officers, who are not necessarily social work qualified, can continue to fulfil this role. We have, however, said that new appointments to such roles should be qualified social workers, unless they have previous experience as such. We believe that this will bring some strong benefits, as highlighted by some consultation respondents, and particularly within the context of the new accredited roles being introduced to children's social care.

## Question 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.**

	Total	Percent
Yes	140	55%
No	94	37%
Not sure	21	8%

There were 255 responses to this question.

A majority of respondents felt that the revised text in this area could be made clearer and some provided suggestions on how the text could be improved. This included comments made in respect of the points on which changes have been made, as described above.

## Notifiable incidents involving the care of a child

### Question 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.

	Total	Percent
Yes	178	71%
No	49	19%
Maybe	24	10%

There were 251 responses to this question.

Responses included:

- the text is clear and the arrangements robust;
- it is helpful to acknowledge that not all notifiable incidents to Ofsted will become serious case reviews;
- some confusion about the definition of serious harm;
- a few respondents felt that the notification criteria should continue to include wider issues such as concerns about professional practice, implications for Government policy or media interest cases;
- some respondents felt that the notification system was complex and raised concerns about the risk of duplication between notification arrangements;
- some respondents suggested that greater detail should be provided on the different types of abuse and neglect; and
- concerns were expressed that the guidance might be interpreted that all notifiable incidents are believed to lead to SCRs.

### Government response

The majority of respondents found the guidance on notifiable incidents made the essential requirements and the arrangements for notification clear. However, responses indicated the need for some further clarification. As a result, we have amended the layout of the bullet points slightly. We have also made a minor change to clarify that the local authority should inform all LSCBs that have an interest in the case.



On the question of confusion about the definition of serious harm, the response to question five now provides a definition which will help support local authority decision-making when determining whether to notify an incident.

We have considered carefully suggestions to extend the notification criteria to include wider issues about professional practice, government policy or media interest. We do not believe that doing so would simplify the notification process for local authorities and would result in incidents being notified which were of limited significance to LSCBs, Ofsted and the Department for Education. Key cases which raise issues of professional practice are very likely to be notified under other criteria.

On the question of how the notification system relates to other systems, we do not propose to seek to make wider changes at this stage. Additionally, we believe the requirement to report incidents within five working days is reasonable and that such notifications should be made using only information known to agencies at that time.

We note the suggestion that *Working Together* should provide greater detail on the types of abuse and neglect. The glossary in Appendix A of *Working Together* will continue to provide descriptions of abuse and neglect and should support local authorities to determine whether an incident warrants notification.

We considered concerns that the guidance might be interpreted that all notifiable incidents will lead to an SCR. The proposed wording already made clear that there will be notifiable incidents that do not proceed through to SCR. We do, however, believe that lessons can be learned from many incidents, including near misses, and it will remain for LSCBs to commission appropriate reviews.

## The definition of serious harm

### Question 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.**

	Total	Percent
Yes	165	65%
No	56	22%
Maybe	33	13%

There were 254 responses to this question.

Responses included:

- a view that clearer guidance about what constitutes serious harm will make it more likely that cases that reach the threshold receive the correct level of scrutiny by LSCBs;
- a welcome for the inclusion of mental and emotional health in the definition;
- 17 respondents (7%) thought the definition was too vague or subjective. The use of the word 'potentially' was thought to be particularly open-ended;
- 24 respondents (9% of those responding to this question) had particular concerns about the reference to 'long-term impairment'. Most felt that it was too difficult to be sure at the time of an incident whether long-term impairment would arise;
- 12 respondents (5%) said that the definition should refer to serious sexual assaults or should otherwise clarify the position regarding sexual abuse in the context of SCRs;
- 17 respondents (7%) thought that the definition would result in an increase in SCRs and had resource implications;
- eight respondents (3%) said that the guidance on SCRs should clarify that there is a causal link between the death or serious injury of a child, and the abuse or neglect; and
- fewer than five respondents commented on the following: that the guidance should clarify more strongly the learning from SCRs, the impact of emotional abuse, and issues relating to suicide.

## Government response

### Issues relating to the definition of serious harm

The majority of respondents thought that the definition was, in principle, helpful. Inevitably, any definition cannot be comprehensive. The wording proposed is not intended to cover all scenarios and it remains for LSCBs to determine whether or not the criteria are met. The national panel of independent experts on serious case reviews will also continue to offer advice on this and related issues, and Ofsted consider these issues when reviewing LSCBs.

On the question of long-term impairment we agree that the proposed wording could be clearer, and have made some minor changes.

We have considered carefully the question of adding a specific reference to sexual harm/abuse. However, we believe that the wording we are adding does in fact appropriately cover harm arising from sexual abuse.

On the question of resource implications, we accept that the additional wording may possibly result in more SCRs, subject to LSCBs' decisions. However, we believe that

such an outcome would not be unreasonable, if better and more open learning from incidents results.

We note the suggestion that *Working Together* should state that there is a causal link between the child's death or injury, and abuse or neglect, as stated in 2006 and 2010. We do not propose to revert to earlier wording on this. It remains for LSCBs to decide whether it is appropriate to undertake an SCR, and the SCR panel is in place to review those decisions.

## Annex A: Consultation responses

The Government received written consultation responses from:

<b>Respondent</b>	<b>Number of responses</b>
Local Safeguarding Children Board	70
The health sector	104
Other	49
Local authority	39
Voluntary and community sector	27
School	26
Consultant/adviser	10
Parent/carer	9
Social worker	8
Non-departmental body/association	7
Police	5
University/FE provider	3
Barrister/solicitor/law group	2
Child/young person	1
Trade union	1

## Annex B: Clarifications and updates

The table below includes other drafting changes we have made on which we did not seek views as part of the consultation. We have clarified *Working Together to Safeguard Children 2015* as follows:

Policy Area	Clarification/Update
Statement of safeguarding responsibility	A statement of the accountability of local authorities as set out in the Children Acts of 1989 and 2004, and of the safeguarding duties of other agencies.
Schools	Clarification that the guidance applies in its entirety to all schools, including independent schools, academies and free schools, who all have duties in relation to safeguarding and promoting the welfare of pupils, consistent with <i>Keeping Children Safe in Education</i> .
Child protection conference	Ensure references to the “15 working days from the strategy discussion to the child protection conference” are consistently referenced throughout <i>Working Together</i> .
Young Carers and Parent Carers	Updates to include the new duties to assess young carers and parent carers, as introduced in the Children and Families Act 2014 and the Care Act 2014.
Child death reviews	Revised wording on what constitutes a modifiable death and wording which considers the involvement of families in the child death review process.
Special Educational Needs / Educational Health and Care Plans	Updated the guidance with the new SEN provisions following the Children and Families Act 2014.
Child protection for foreign national children	Included changes to reflect the publication of new guidance on <i>Working with foreign authorities on child protection cases and care orders</i> (published July 2014).
Assessment	Added additional wording to support maximum flexibility in relation to the 45 working day timescale to complete assessment.
Information sharing	Updated to refer to new information sharing advice.
Children returning home from care	Made 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	Reflected the structural changes to probation under the Transforming Rehabilitation Programme and the findings of HM Inspectorate of Probation thematic inspection on protecting children.

Policy Area	Clarification/Update
Health	Made appropriate updates to reflect NHS changes.
Secure Children's Homes	Set out the role of the Prisons and Probation Ombudsman in investigating a death in a Secure Children's Home in line with amendments to Children's Homes (England) Regulations which are due to come into force on 1 April 2015.
LSCB Annual Report	Set out some new expectations on LSCB annual reports, to reflect government decisions relating to Child Sexual Exploitation.
Whistleblowing	Set out new expectation that all organisations that have safeguarding responsibilities must have internal whistleblowing policies in place, which are integrated into training and codes of conduct.
Channel panels	Reflected duties set out in the Counter-Terrorism and Security Act 2015 regarding Channel panels, due to come into force on 12 April 2015.



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