BASW England draft response to DfE consultation on changes to statutory guidance: Working Together to Safeguard Children and Child Death Review and new regulations

22 December 2017

Introduction

What is your name?

Nushra Mansuri (Professional Officer, BASW England)

What is your organisation?

BASW (British Association of Social Workers)

BASW is the UK's professional association for social work, led by and accountable to a growing membership of over 21,000 social workers. Our members work in direct social work practice, management, research and academic positions in diverse social work settings across the UK. BASW members share a collective commitment to the professional Code of Ethics, core social work values and principles that will secure the best possible outcomes for children and young people, adults, families and communities.

What is your email address?

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Yes		**No**	**X**

Reason for confidentiality

What is your name?

Nushra Mansuri – I have compiled this response on behalf of BASW England and principally our Children and Families Practice, Policy and Education Group.

1. Revisions to Chapter Three: Multi-agency safeguarding arrangements; and new regulations on relevant agencies

Question 1: Leadership

As set out in paragraph 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?

Yes		**No**	**X**

If no, please explain why.

Fundamentally, as stated in the consultation document, a lot of the proposed changes have arisen as a result of the Government commissioning Alan Woods in December 2015 to undertake a a comprehensive review of the role and functions of Local Safeguarding Children Boards (LSCBs) within the context of local strategic multi-agency working and serious case reviews. This review was never formally put out to the sector for consultation although there was a questionnaire and a number of events. Subsequently, many of Alan Wood's recommendations were drafted into the Children and Social Work Bill 2016 which again restricted opportunities for meaningful consultation with the sector on what are clearly very important changes. Our members have expressed concerns about this which are captured in some of our responses.

Firstly, these changes are being proposed at a time when resources are already severely over-stretched not just in local authorities but across the public sector including health and police services. In respect of children's services, the Local Government Association has predicted a further £2bn in central government funding cuts over the next three years. In reality, BASW England is concerned that the huge austerity cuts experienced by all 3 partner agencies will ultimately, underpin what the new safeguarding arrangements look like rather than what will works best for children. Whilst in principle, we welcome greater flexibility, there are huge risk in the proposals in light of the impact of austerity.

BASW England members are not convinced that the DfE have produced an evidence base that demonstrates that these changes will make the current system safer for children. Furthermore, some of the most recent judgements on LSCBs demonstrate improvement in their performance including a number which have been judged as good and outstanding (Children's social care data in England 2017: main findings 31 August

Question 1: Leadership

2017 Ofsted) - the inspection reports evidence how LSCBs have contributed to ensuring the safeguarding of children . In addition, LSCBs around the country have driven a wider range of initiatives concerning vulnerability tackling complex issues such as CSE, forced marriage, modern slavery, trafficking, radicalisation, increased understanding of the impact of domestic abuse on children and young people, FGM, faith-based abuse, so-called 'honour' violence, etc. BASW England is concerned that such activities will diminish in the context of scarce resources and fewer requirements.

Finally, it is important to reflect on why LSCBs were originally established: Following the inquiry into the death of Maria Colwell in 1974, Area Child Protection Committees (ACPCs) were established in England and Wales as a result of a serious lack of coordination among services responsible for child welfare. In January 2003, Lord Laming published his report into the death of Victoria Climbie which recommended that those coordinated partnerships be put on a stronger and statutory footing to provide greater strength to those ways of working. This culminated in the Green Paper Every Child Matters (2003) proposing the establishment of statutory LSCBs to replace ACPCs and the Children Act 2004 enshrining in statute the requirement for every top tier local authority in England to establish a LSCB.

Whilst BASW England has always held the view that LSCBs should be improved, we did not call for their abolition and we consider this to be a regressive, negative and radical change at a time when the system is facing such severe challenge as previously described. This proposal is untested and untried and our members are not convinced it is progressive.

Question 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 come under NHS England, and housing under the local authority.

Do you agree with this indicative list?

Yes		**No**	**X**

If no, please explain why.

Question 2: Relevant Agencies

BASW England members are concerned that the mixed economy of provision has led to a number of 'for profit' organisations providing services in the sector. It is really important that other motives do not in any way unduly influence the duty of the partners to safeguard and promote the welfare of children. Care must be exercised in this area by the safeguarding partners to ensure that this does not happen.

Professor Eileen Munro made articulated her views on this in 2014 arguing that establishing a market in child protection would create perverse incentives for private companies to either take more children into care or leave too many languishing with dangerous families. She asserted that "It's the state's responsibility to protect people from maltreatment. It should not be delegated to a profit-making organisation" and went on to say that there was a danger that outsourcing to companies with no experience in delivering child protection would undermine existing local partnership arrangements, pointing out that "A private sector company with an eye on the money will not pull its weight in the 'working together between agencies' aspect. That rests on goodwill."

Should any agencies be added or removed?

The fire service is not included on the indicative list when they are often involved in safeguarding cases sadly, including fatalities were arson is involved. We strongly suggest that they they are added to the list as a relevant agency.

We understand from our colleagues in health that not all the clinical and professional expertise across health is represented in these proposals i.e. acute and primary health; the voice of the acute hospital could be lost as well as the role of designated safeguarding leads. This needs to be looked at. There are concerns that NHS England will set priorities for health that may not result in staff owning 'working together'. Examples of poor practice have been shared with us indicating that Working Together is not being made a high enough priority.

All school types need to be included. There should be as emphasis on faith schools in terms of accountability and the work of ICSA. We would like to see the category of sports groups broadened out and are not sure if the proposed title is the best way to encapsulate this category.

Other agencies that need to be included are out of hours services and Channel (part o Prevent strategy)

Finally, our members would like to see agencies currently represented at LSCBs retained given that they have a wealth of knowledge and experience and also can

Question 2: Relevant Agencies

provide continuity. As above, each agency that wishes to be involved in the local safeguarding partnership needs to have valid and ethical reasons for wanting to be involved.

Question 3: Schools and other 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?

Yes	**X**	**No**	

Please explain your answer

BASW England supports this but feels that the statutory guidance needs to go even further and make education an equal partner to local authorities, the police and CCGs given that it is difficult to imagine how any effective safeguarding arrangements could work without actively involving schools. The last sentence in Paragraph 19 seems unnecessarily hesitant - schools have general legal duties to safeguard and promote the welfare of students attending them. They cannot meet these duties unless they work in line with local interagency arrangements, these should include specific duties. Any school or college that is designated as a relevant agency has a duty to contribute to the strategies and plans made by the safeguarding partners to ensure that they are relevant and appropriate to the range of schools and colleges in the area.

Our members are also concerned that schools are not always well represented due to work overload and shortages of teachers and suggest that a cluster of schools might wish to appoint a representative. However, the government agenda to produce 100% academisation of schools is also a challenge in terms of engagement within an increasingly fragmented system and are finding a lot of variation. Some academies appear to have good links with safeguarding agencies whilst others do not as they see themselves as very separate and independent from the wider system which is proving to be problematic and needs to be urgently addressed by the DfE.

Question 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 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?

Yes	**x**	**No**	

If no, please explain why.

BASW England supports the need for a robust system of independent scrutiny and would like the following important amendment *'...a person or persons,* ***or agency,*** *who are independent...'*

The current arrangement of Independent Chairs publishing an Annual Report has resulted in very weak evaluative practices e.g. lacking rigour akin to social science methods. This amendment may encourage national childcare charities, academic institutions, consultancies, etc. to develop safeguarding systems evaluation models.

Clarification is also needed here as to whether 'independent scrutiny' includes Ofsted (or other) inspection reports - if so, in a given period, no other independent scrutiny would be of any value.

BASW England members have raised concerns about the expectation that the three partners named in the draft guidance (the LA, Police and CCG) will work together cooperatively in the interest of children, in situations where a loal authority has been judged inadequate or requiring improvement or where the Police or CCG/health have had inspections that highlight concerns about the way children are safeguarded; in such circumstances, it is very important that there is external scrutiny and challenge once it is no longer a requirement for local authorities to have an independent LSCB chair or LSCB whereby an independent person holds the wider system and agencies to account.

Some of our members felt that the person needed to be independent but not necessarily from outside the local area as they also needed to possess a good understanding of local practices etc whilst being able to bring challenge to the relevant agencies. Finally, it is also important to bear in mind that peer scrutiny can be effective in supporting continuous improvement, but it may be difficult to convince the

Question 4: Independent Scrutiny

public of the independence of scrutiny that is commissioned and presumably funded by the safeguarding partners.

Concerns were raised in the consultation events about a lack of independent scrutiny by Ofsted leading to strategic drift and generally, a lack of robust scrutiny contained in inspection processes.

Question 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?

Yes		**No**	**X**

If no, please explain why.

"The Wood Review identified variance in levels of funding as a problem across the LSCB system" - Consultation Document, Page 9. Asking safeguarding partners to make their own decisions about funding with no guidance other than that it should be "equitable and proportionate" will do nothing to address this issue. A framework to calculate appropriate funding should be specified.

The consultation documents do not appear to contain any financial impact assessments. These proposals must be properly costed and resourced if they are going to succeed. As we have already stated in this response, a number of our concerns stem from austerity and rapidly shrinking budgets.

BASW England would like to see a bold, prescriptive statement about funding allocation; we understand that in London, the Met and the CCGs contribute to LSCBs, but Las make the largest financial contribution. These changes are going to have significant budget and cost implications. Our members are concerned that LAs will end up making the greatest financial contribution by default which raises lots of issues

Question 5: Funding

including risks to safeguarding partnerships – particularly, at a time of such considerable cuts to local authority budgets. Geographical boundaries are a further complication in these arrangements as the individual agencies do not necessarily have co-terminus boundaries. There are also situations where local authorities are merging and we are not sure of the implications of that in relation to these new safeguarding structures and how this will impact on effective partnerships. Whilst greater flexibility may appear to be attractive, BASW England is concerned that the success of arrangements may become to dependent on strong individual leadership as opposed to a robust systems approach.

Question 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?

Yes		**No**	**X**

If no, please explain why.

NO - Not in it's current form, as this needs to be clear about the relationship with Independent Scrutiny. Should the Independent Scrutineer publish the annual report to ensure independence? Current Annual Reports are usually signed off by Chief Executives to whom Safeguarding Chairs are accountable, thus are not wholly independent.

If this report is to be published by the safeguarding partnership rather than the Independent Scrutineer, the purpose and primary audience(s) (not just the content) need to be explicitly stated. Is this report aiming to raise awareness to a wide audience, to provide accountability in the public sphere, or to provide evaluative information as part of a business planning process for the safeguarding workforce/leadership, etc.

Question 6: Reporting

Paragraphs 28 and 29 set out the outline. There is some repetition between the paragraphs, which makes it slightly confusing. It would be better to put the statements about content into a single paragraph.

Question 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?

Yes		**No**	**X**

If no, please explain why.

This is another example where the statutory guidance is too fluid and needs to be more prescriptive. All LSCB's currently have threshold documents, and presumably will continue to maintain them in the period immediately following these changes. Many of our members are in favour of the current threshold documents being retained as they feel that they work well. It is important to remember that they were amongst other things a focus in the Government response (March 2013) to Lord Carlile's report on the Edlington case.

In the long term it would be helpful if the guidance included some statement of the minimum expectation in interpreting Section 16E(2) - "arrangements for the safeguarding partners to work together to identify and respond to the needs of children in the area." This has particular relevance in the context of the independent scrutiny to be commissioned by the safeguarding partners. Should the criteria set out by the safeguarding partners be accepted and performance be measured against these criteria, or should it take a critical view of the local standards? In either case, in the absence of any national guidance on minimum standards means that performance cannot be compared across different areas.

One of our members suggested that the DfE should periodically provide an indication of the national average of thresholds for children being brought into care across the country as this might help to promote a more consistent national approach and inform the thresholds set by LA's – which in turn can inform Ofsted inspections.

BASW England is particularly concerned about thresholds given that in July 2017 we worked in partnership with the NCB to create a survey which was taken by over 1,600 social workers on thresholds. The findings of the survey include 70% of respondents saying that the threshold for qualifying as a 'child in need' had risen over the last three years and 60% saying that the resources available to children's services influenced decisions about whether to offer early help. Social workers also reported that

Question 7: Threshold document

thresholds for receiving more urgent support had risen. Half (50 per cent) said thresholds had risen for making children the subject of a child protection plan and 54 per cent said the same about applying for a care order. This survey contributes to research being undertaken by the National Children's Bureau (NCB) on behalf of a cross-party group of MPs which indicates that it is getting harder for vulnerable children to access the support they need. Thresholds for a range of interventions have risen over the last three years, meaning children have to reach a higher level of need before qualifying for help, with many saying financial pressures are to blame. As a result of the survey, the All-Party Parliamentary Group for Children are now undertaking a new inquiry into thresholds for children's social care which will be completed next year. It is important that findings from this inquiry inform policy and practice in safeguarding children.

2. Revisions to Chapter Four: Learning from serious cases; and new regulations on local and national reviews

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?

Yes		**No**	**X**

If no, please explain why.

The sequence of actions is well set out and the focus is placed firmly on identifying and sharing lessons to be learned. However, we have concerns about the timescale for reporting to the Child Safeguarding Practice Review Panel of 5 days. We think this needs to be lengthened as it's a very tight turnaround and could result in a less robust process of gathering relevant information. We also note that there is no timescale for the Panel to report back. Is there a reason for this?

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?

Yes		**No**	**X**

Question 9

If no, please explain why.

There is, understandably, overlap between the two sets of criteria, but they seem clear about the reasoning to be used in deciding whether a review is appropriate and, if so, whether it should be a national or a local review. It is noticeable however, that one of the criteria to be considered before deciding on a local review is whether the Child Safeguarding Review Panel has concluded that a local review is appropriate, but there is no equivalent consideration before deciding on a national review. Are we to assume that this is deliberate, and to avoid "borderline cases" becoming delayed through disagreement? If so, it might be useful to state clearly that the final decision lies with the Panel.

BASW England members have stressed to us the importance of those representing the safeguarding partners having appropriate professional training, knowledge, skills and experience in safeguarding. The links between the Panel and the practitioners also need to be effective. This is a sensitive area of work for our members largely as a result of media coverage of high profile cases and the pressures this places the profession under particularly in terms of a blame culture. It is therefore important that the right balance is struck when decisions are being taken to undertake reviews – they need to be fair and proportionate.

We reiterate in this section our concerns about the fragmentation and loss and retention of key health personnel as a result of streamlining services and reduction in jobs which can lead to a loss of a retention of knowledge of staff experienced in safeguarding.

We advise that the guidance should also include a brief statement about the need for co-ordinated child death reviews in emergency response situations such as the attack that occurred at the Manchester Arena earlier this year. It is vital that all panels include social workers and that they have equal partner representation.

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?

Yes		**No**	**X**

Question 10:

If no, please explain why.

BASW England is committed to upholding standards of excellence in social work practice and has been concerned that serious case reviews that come to prominence inevitably make for a politically charged environment which can undermine good practice and deter social workers from continuing to work in this highly specialised area. It is really important that this does not continue to happen as this is counterproductive to safeguarding and promoting the welfare of children. We need to move away from a blame culture to a learning culture as exhorted by Professor Eileen Munro. Previous iterations of Working Together gave a lot of prominence to the work of SCIE in relation to a systems approach and notably, 'Learning together to safeguard children: developing a multi-agency systems approach for case reviews' by Sheila Fish, Dr Eileen Munro and Sue Bairstow (2008). We hope support for this model does not get lost and we believe that previous reviews of Working Together provided copious amounts of evidence of effective models of practice which needs to be re-visited.

Many of our members who are independent social workers are engaged in this work and we are keen to both support them and contribute to the development of high quality national and local reviews which individuals and agencies can learn from to improve overall practice. This is a highly specialist area of work which requires consistency and quality. We have heard of instances where there is paritiality in selection of reviewers. Processes need to be stringent including effective quality assurance – we would suggest that in order to attract and retain high quality reviewers individuals are both accredited and supported including in terms of their CPD. We need to move from a deficit model to a strengths based model.

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?

Yes		**No**	**X**

Question 11

If no, please explain why.

The noticeable difference between these two sections is that Paragraph 25 requires that “The methodology should provide a way of looking at and analysing front line practice as well as organisational structures and learning … *[and]* should be able to reach recommendations that will improve outcomes for children” and these requirements are missing from Paragraph 43. Is it the expectation that when complex issues of national importance arise front line practice will not be a relevant consideration?

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?

Yes	X	No	

If no, please explain why.

It is essential that there is consistency in practice and standards across the country. BASW England would like to see the continuation of learning from local and national reviews -the biennial reports commissioned by the DfE analysing serious case reviews undertaken by Marian Brandon, Peter Sidebotham, Sue Bailey, Pippa Belderson, Carol Hawley, Catherine Ellis & Matthew Megson have provided an invaluable learning tool for our members. BASW England is concerned that this vital resource may be lost as a result of the changes being made to Serious Case Reviews.

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?

Yes		No	X

If no, please explain why.

A list of approved reviewers for national reviews would be feasible, but a required list for local reviews would pose practical issues - considerable effort would be needed to keep it up to date. This requires proper resourcing and administration. As already stated, this is an area of work that BASW England is committed to supporting its members in and so there could be some synergy between BASW and the local safeguarding partners in supporting the requirement to establish a pool of accredited reviewers for example.

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?

Yes		No	X

If so, please provide details below.

3. Revisions to Chapter Five: Child death reviews

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?

Yes	**X**	**No**	

If no, please explain why.

This approach is more realistic: modifying specific factors may reduce the likelihood of child deaths but it is rarely possible to say with certainty that a particular death would have been prevented by the alteration not a single factor. However Paragraph 1 of Chapter 5 is still very firmly worded in terms of "preventable deaths".

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?

Yes	**X**	**No**	

If no, please explain why.

This seems a more flexible approach which allows response to individual circumstances. Paragraph 27 seems critical in deciding on the appropriate response - but note that the second bullet (with its four subheadings) and the third bullet lack any

Question 16

statement of action. Also it is not immediately clear how this Paragraph relates to the detailed instructions in `*Child Death Review: Statutory Guidance.*

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?

Yes		**No**	**X**

If no, please explain why.

This sounds good in theory but concerns have been raised with us about the current fragmentation in services leading to the loss and retention of key health personnel with expertise in safeguarding so this is a potential weakness. The merger of local authorities could also be a weakness rather than a strength in terms of efficiencies, over stretched resources and reduced capacity.

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?

Yes	**X**	**No**	

If no, please explain why.

Question 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?

Yes	**X**	**No**	

If no, please explain why.

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 (see Appendix 4 of the Child Death Review Statutory Guidance). We propose that CDOP administrators should 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?

Yes	**X**	**No**	

If no, please explain why.

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?

Yes	**X**	**No**	

If no, please explain why.

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?

Yes	**X**	**No**	

If no, please explain why.

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?

Yes	X	No	

Are the suggested approaches for each of these appropriate and workable?

Yes	X	No	

If no to either or both of these questions please explain why.

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 neighbouring CDOPs and designated doctors for child death liaise and co-ordinate their approach.

Do you agree with this approach?

Yes	X	No	

If no, please explain why.

Yes in principle, as long as the appropriate resources are available

4. Transitional arrangements

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?

Yes		No	X

If no, please explain why.

There may be circumstances where two months is not sufficient and the transitional guidance should make allowances for exceptional circumstances

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?

Yes	X	No	

If no, please explain why.

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?

Yes	X	No	

If no, please explain why.

Any other comments

Are there any other comments you wish to make concerning the changes proposed?

The deletion of managers in the decision-making process in Annex C of the guidance has caused a lot of concern amongst our members. Furthermore, no reason has been provided by the DfE for doing this and our members are vehemently opposed to it given that managers are crucial in terms of accountability and shared responsibility. Moreover, when Working Together was revised in 2013 BASW England fought very hard for the inclusion of managers in the guidance as it was originally absence in the original draft consultation so we are extremely disappointed by this omission. In the words of one of our members: "*Anyone with any significant child protection experience knows the critical role that front line team managers play from the point of referral through to the outcome of any child protection enquiry. Their role is different to social workers but equally important. While social workers deal directly with the family managers deal with the case at arms length providing that impartial oversight. The two roles complement each other. Managers also have a major role in prioritising cases and as practitioners with years of experience this is not something that can reliably be left to less experienced practitioners. If this managerial oversight is lost social workers may well miss situations which need a more urgent response and spend time on situations which could be downgraded. This is likely to lead to inefficiencies and serious cases being missed."* In the current climate of high turnover rates, an inexperienced workforce we consider this to be a high risk strategy and urge the DfE to keep it in.

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