Revisions to Working Together to Safeguard Children March 2015

Following consultation the government has updated and replaced the current statutory guidance *Working Together to Safeguard Children* revised and published in 2013. The revisions include changes to:

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

1. The referral of allegations against those who work with children;

The proposal was 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, e.g MASH. It was proposed that the person(s) dealing with allegations against staff must be qualified social workers.

New guidance no longer refers to 'LADO's' but says 'Local authorities should have designated a particular officer, or team of officers (either as part of multi-agency arrangements or otherwise)'. All new appointees to LADO should be qualified social workers, unless an existing LADO moving between authorities.

Changes to LADO	
March 2013	**March 2015**
County level and unitary local authorities should have a Local Authority Designated Officer (LADO) to be involved in the management and oversight of individual cases. The LADO should provide advice and guidance to employers and voluntary organisations, liaising with the police and other agencies and monitoring the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process; Any allegation should be reported immediately to a senior manager within the organisation. The LADO 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; and 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.	Local authorities should 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 sufficiently qualified and experienced to be able to fulfil this role effectively, for example qualified social workers. Any new appointments to such a role, other than current or former designated officers moving between local authorities, should be qualified social workers.

2. **notifiable incidents involving the care of a child**

There has been an addition to Chapter 4 'Notifiable Incidents'. This is because local authorities were unclear both about the requirement to notify and what constitutes a notifiable incident. During the consultation it was proposed to clarify the guidance and place it within *Working Together.* This has now been added as per below.

March 2015 (from page 74)

A section on Notifiable Incidents has been added.

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 has died (including cases where abuse or neglect is not known or suspected) ; or
- a child in a regulated setting or service has died (including cases where abuse or neglect is not known or suspected)

The local authority should report any incident that meets the above criteria to Ofsted and the relevant LSCB or LSCBs promptly, and within five working days of becoming aware that the incident has occurred.

For the avoidance of doubt, if an incident meets the criteria for a Serious Case Review then it will also meet the criteria for a notifiable incident (above).

There will, however, be notifiable incidents that do not proceed through to Serious Case Review.

3. **The definition of serious harm for the purposes of serious case reviews.**

Working Together 2015 now provides a definition of 'seriously harmed'. There were concerns –flagged by the national panel - that some LSCBs were failing to make appropriate decisions on what constituted serious harm. It is also hoped the new wording will help support local authority decision-making when determining whether to notify an incident.

To note - Some respondents to the consultation had asked for clarification about the 'and'. Working Together 2015 has not changed and it is not explicitly stated that there should be a causal link between the child's death or injury, and abuse or neglect [as stated in 2006 and 2010]. It still remains for LSCBs to decide whether it is appropriate to undertake an SCR, and the SCR panel is in place to review those decisions.

(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.

March 2015 (page 76)

"Seriously harmed" in the context of paragraph 18 below 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 and/or likely 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. LSCBs should ensure that their considerations on whether serious harm has occurred are informed by available research evidence.

4. Additional changes to WT2015 (Detail)

CSE Set out some new expectations on LSCB annual reports, to reflect government decisions relating to Child Sexual Exploitation page 70
LSCBs should conduct regular assessments on the effectiveness of Board partners' responses to child sexual exploitation and include in the [annual] report information on the outcome of these assessments. This should include an analysis of how the LSCB partners have used their data to promote service improvement for vulnerable children and families, including in respect of sexual abuse. The report should also include appropriate data on children missing from care, and how the LSCB is addressing the issue. There the LSCB has a secure establishment within its area, the report should include a review of the use of restraint within that establishment and the findings of the review should be reported to the Youth Justice Board.

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 page 53
[organisations should have in place] clear whistleblowing procedures, which reflect the principles in Sir Robert Francis's Freedom to Speak Up review and are suitably referenced in staff training and codes of conduct, and a culture that enables issues about safeguarding and promoting the welfare of children to be addressed.

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	
2013 Definition of preventable child deaths	**2015 Definition of preventable child deaths**
For the purpose of producing aggregate national data, this guidance defines prevent able child deaths as those in which modifiable factors may have contributed to the death. OLD 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.	For the purpose of producing aggregate national data, this guidance defines preventable child deaths as those in which modifiable factors may have contributed to the death. NEW These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future child deaths could be reduced.

Information sharing – Updated to refer to new information sharing advice	
2013 Information Sharing page 15	**2015 Information Sharing page 17**
Information Sharing: Guidance for practitioners and managers (2008) supports frontline practitioners, working in child or adult services, who have to make decisions about sharing personal information on a case by case basis. The guidance can be used to supplement local guidance and encourage good practice in information sharing.	Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers (2015) Supports front line practitioners, working in child or adult services, who have to make decisions about sharing personal information on a case by case basis. The advice includes the seven golden rules for sharing information effectively and can be used to supplement local guidance and encourage good practice in information sharing.

5. Additional Changes (At a glance)

Young Carers and Parent Carers – WT2015 includes the new duties to assess young carers and parent carers, as introduced in the Children and Families Act 2014 and the Care Act 2014. Page 97 – 98
Special Educational Needs / Educational Health and Care Plans include guidance with the new SEN provisions following the Children and Families Act 2014. Page 94.
Child protection for foreign national children WT2015 includes change to reflect the publication of new guidance on Working with foreign authorities on child protection cases and care orders (published July 2014)**.** Page 23
Children returning home from care WT2015 makes explicit the requirements and expectations for continued assessment, planning, support and review for children who return home where this is both planned and unplanned. See flowchart on Page 51.
Probation WT215 Reflects the structural changes to probation under the Transforming Rehabilitation Programme and the findings of HM Inspectorate of Probation thematic inspection on protecting children. Page 60.
Channel panels WT2015 reflects duties set out in the Counter-Terrorism and Security Act 2015 regarding Channel panels, due to come in to force on12 April 2015. Page 19.
Schools WT2015 clarifies 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 *Keeping Children Safe in Education.*