One minute guide

Working Together to Safeguard Children

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What is Working Together to Safeguard Children?

Working Together to Safeguard Children (usually referred to as just Working Together) is statutory guidance produced by the government which outlines how practitioners working with children, young people and families should work together in order to ensure that children and young people remain safe from harm. In this guidance, a child is defined as anybody under the age of eighteen; though the guidance does also apply to the safeguarding of unborn children.

Why do we have Working Together?

The Working Together statutory guidance was initially published in 1999, and set out how all agencies and professionals should work together to promote children's welfare and protect them from abuse and neglect. It was revised in 2006 following the public inquiry into the death of Victoria Climbié.

Victoria was brought to the UK from the Ivory Coast in 1999 by her great aunt, and died in Haringey in February 2000 at the age of eight. She had sustained a number of serious injuries, and had been tied up for significant periods of time. Before her death, Victoria had been in contact with numerous different agencies, but the investigation found that none of these agencies had fully investigated and, due to a lack of information sharing between them, none had a full picture of the abuse Victoria was suffering.

In response to Victoria's death, the government commissioned a public inquiry, led by Lord Laming. The findings of the inquiry led to the government's Every Child Matters green paper, which proposed changes in legislation and policy to maximise opportunities for agencies to work together in order to effectively safeguard children. This green paper became the Children Act (2004).

The Children Act (2004) placed a duty on all agencies to make arrangements to safeguard and promote the welfare of children, and in 2006 the revised version of Working Together was published.

Since 2006, there have been four further updates to the guidance. In 2010, the update expanded the focus on interagency working and took into account the recommendations of Lord Laming's 2008 progress report The Protection of Children in England, which emphasised the importance of frontline practitioners getting to know children as individuals. The 2013 update was in response to the review of child protection in England, carried out by Professor Eileen Munro. The update in 2015 focused on the need for Early Help **(guide)** responses to identify and support the needs of children and young people as these needs emerge and are identified.

The most recent update in 2018 continues a focus on the need for early help, but also focuses on complex and contextual safeguarding as well as a review of how local safeguarding arrangements are implemented and governed following a review of Local Safeguarding Children Boards (LSCBs) by Sir Alan Wood in 2017.

What changes were made in the 2018 Working Together update?

Working Together 2018 places a statutory duty on three key agencies to hold local responsibility for safeguarding; the Local Authority, the Police and Health (through the Clinical Commissioning Groups — CCGs). It provides these three agencies with the freedom to develop local multi-agency safeguarding arrangements in line with the needs of their locality, whilst removing the statutory requirement for Local Safeguarding Children Board (LSCB). Working Together 2018 provides guidance with regards to what new arrangements in local authorities should include. The Leeds multi-agency safeguarding arrangements are available on the Leeds Safeguarding Children Partnership (LSCP) website.

The guidance also outlines changes in the statutory functions of undertaking Child Safeguarding Practice Reviews (CSPRs), concluding any Serious Case Reviews (SCRs) and the Child Death Overview Process (CDOP).

Once a local area has published its new multi-agency safeguarding arrangements, SCRs will be replaced with **Child Practice Safeguarding Reviews** (CSPRs) which will be undertaken when the local safeguarding partners identify serious child safeguarding cases which, in their view, raise issues of importance in relation to their area and through which new learning can be identified.

A serious child safeguarding case is one whereby:

- abuse or neglect of a child is known or suspected and
- the child has died or been seriously harmed.

Child Death Overview Processes (CDOP) have been reviewed and the key changes are:

- The statutory responsibility for Child Death Reviews (CDRs) will lie with the CCGs and the Local Authority;
- The criteria for undertaking a CDR has expanded. A CDR will be required for live born babies where a death certificate has been issued. This now includes babies born under 22 weeks gestation;
- A Key Worker (this will usually be a healthcare professional) will be allocated, as a single point of contact, to the bereaved family.

The guidance also reflects national safeguarding agendas including an emphasis on areas which are collectively known as complex or contextual safeguarding including children missing **(guide),** those at risk of, or experiencing exploitation, trafficking (guide) and peer on peer abuse.

Alongside the updated Working Together document, the Government also updated and published Keeping Children Safe in Education 2019 and published Information sharing; Advice for practitioners providing safeguarding services to children, young people, parents and carers

What practitioners should do and for more information

Practitioners should familiarise themselves with the updated version of the Working Together guidance which can be viewed online. As can the Child Death Review Statutory and Operational Guidance (England).

Training is available through the LSCP on many aspects of safeguarding. To identify which training is right for you, please visit their website.

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