0			
Number	**Questions**	**Response**	**Issues**
Chapter 3	**Multi-agency safeguarding arrangements; and new regulations on relevant agencies**		
1	Proposed not to set out who representatives of safeguarding partners should be	Do not agree - must stipulate that three partners are represented at chief officer level - with specific delegation allowed from that office holder to a named representative who carries that level of authorisation.	Chief police office is named in Act; should be COO officer level from CCG- not delegated to designated team; presumes DCS as lead - but what to do with twin hatters, and what role does the CE have? The issues of how decisions are reached and how disputes resolved are unclear.
2	Indicative list of relevant agencies	There is a potential confusion between agencies and functions- increasingly as more services are commissioned or provider at arm's length and by third partners- not all in public sector. The list already covers both organisations and activities. It should explicitly include housing and accommodation providers; primary care (incl GPs) and Public Health	The list is a compromise between organsiations and functions- it would be simpler to say that all local arrangements must include all commissioners and providers off services that apply to 0-25 age range? Or all to whom Section 11 duties apply? The text (paras 11-52) is more inclusive and helpful in setting out duties and involvement from a wider range of organisations- but these are not reflected in the proposed list of relevant partners- no sports or faith organisations for example.
3	Explicit reference to how partners plan to involve schools	Yes - essential	We have consistently agreed that all schools should be included with equal status with the other three Safeguarding partners
4	Scrutiny by independent person	Yes - but current description as being outside area or no prior involvement could exclude existing LSCB chairs and other candidates. Independency is established by performance and challenge, not by location or previous CV. Criteria should be made more inclusive.	Recruitment against a set of competencies and a description of the job role would be more relevant and provide a means of assessing performance and genuine independent and ability to provide effective challenge and scrutiny
5	Decisions of funding	This leaves open the possibility of significant withdrawal of resources from partnership arrangements - agree that should be equitable and proportionate - but needs to be agreed against a clear set of functions to be discharged- and independent scrutiny that this capacity is reasonable and sufficient. would be helpful if there was an agreed formula to detremine financial contribution.	Historic funding arrangements are inconsistent, inequitable and variable in terms of what is cover above and below the line, or through resource commitment from within agencies. In practice this clause will expect police and health to significantly raise their contributions as LA have traditionally covered the bulk of costs. Contributions from schools are not covered here but must be included
6	Annual Report	Agree that this is a vital part of public accountability. Guidance needs to stipulate what the 'What Works Centre' actions will be following all MASA's sending their Annual Reports to them (as per para 31).	The parameters are a starting point - and should include an annual assessment of the effectiveness of local safeguarding arrangements and actions required to address any shortfalls.
7	Thresholds and criteria for action	This seems to be a confused question and conflates threshold arrangements as articulations of how good joint working should proceed, with criteria for specific statutory responses. Thresholds are not just about access to social care (gatekeeping), but should be means of identifying with families the appropriate help for their needs. MASAs should be required to publish their threshold criteria (as LSCBs do now) so that the public can be informed/comment. And there needs to be some national baseline criteria to enable benchmarking, learning and a minimum safety net.	There is a lot of good evidence of LSCBs pioneering a move away from gatekeeping towards vantage points - essential if the shift away from too much statutory intervention in favour of more effective early help is to be sustained. If there is a total lack of consistency across the country this will result in significant difficulties in comparative analysis and learning by MASAs. And how can the public, including children and families, and independent scrutiny people, together with any key researchers, know what the threshold criteria for services should look like/include, and how it relates to other areas threshold areas – if not specified and clear? (currently LSCBs are required to publish their threshold document)
Chapter 4	**Learning from serious cases; and new regulations on local and national reviews**		

8	Arrangements for notification of safeguarding incidents	These arrangements are not adequate. 5 working days is unlikely to be sufficient to complete enquiries based on the experience of SCR Panels. Does not indicate how discussion between agencies and final decisions will be made. The current role of independent chairs is often critical in pursuing disclosure from agencies and in resolving and making decisions.	This provision does not recognise the considerable reluctance agencies often have to share information and the genuine differences of professional and agency views about whether a case raises issues of importance or it is likely to provide learning if further investigated. There is no provision for the arbitration and resolution of these issues. How is professional and particularly legal advice to be provided on behalf of the partnership rather than on behalf of each individual agency? There is no guidance about how local issues of importance are identified and how a case or incident may be viewed in relation to these issues or local criteria.
9	Criteria for local reviews	para 20 should apply to more than one organisation not just to LAs where families have moved	These criteria are OK but limited
10	Factors for selecting reviewers		These criteria are OK but limited. Experience or knowledge of implementing change and improvement as well as research knowledge are needed.
11	Procedures for local and national reviews	Too much emphasis on actions for improvement rather than practice development and learning - and on report rather than embedding learning. Little explicit reference to the multi-agency nature of learning	The explicit provision that LSCBS and chairs can agree an appropriate methodology is lost here - this could result in the reversion to a more prescriptive model which would not be appropriate or proportionate. We can describe in some detail the different elements that need to be weighed in agreeing a given approach
12	Expectations of final report	Again too much centered on report rather than learning	2-6 months is likely to be unrealistic for any complex case - particularly with parallel proceedings. It does not acknowledge the difficulty that agencies have in resourcing, releasing and analysing their contributions which are fundamental to any independent review work. There is not provision- if we are moving further away from IMRs and agency reports- for the reviewer to have compulsory access to all relevant material- duty to provide any requested information, case details and other information, including management and HR records needs to be in here.
13	National list of reviewers	Agree that there should be flexibility here- but perhaps also provision for training and development of both local and national reviewers.	
14	Regulations	There is no guidance on how, when and in what sort of detail local MASAs should identify issues of importance - should these be set out in the Annual Report - be subject to independent challenge and scrutiny?	
Chapter 5	**Child Death Reviews**		
15-24			The main issue here is that there is practically no read across between the CDR processes and the rest of the safeguarding arrangements- especially the notification and practice review provisions. This essentially sets up two separate systems where there is currently at least a connection- in many areas a very good one- between the SCR and the CDOP process.
15	child death review process should consider and identify “modifiable factors”	Agree	

16	new approach - changing the initial stages of the process	Do not think that the plans for an initial information sharing and planning meeting before the family leave the emergency department are practical. Includes a visit to the scene which is not something which can be routinely offered and does not fit with current practice.	Unclear as to what a non-forensically trained paediatrician doing a visit to the scene at this point would add (distinct from a bereavement visit to meet with the family and discuss the events of the death /resus etc) There is no local out of hours health rota for a Joint Area response and whilst initially out of hours a consultant paediatrician could take on that role currently this would then be taken over by the Designated Doc Child Death once they were back in work.
17	Area covered by child death reviews - geographical 'footprints'	We support the view that CDOPs need to operate over a sufficiently large footprint to be able to identify trends and patterns. However, in some parts of the country, such as here in the North East, there are geographical constraints to working in this way. It is also important to balance the need for local learning with numbers large enough to see trends. We agree to the principal that CDOPs should review 80 - 120 deaths per year and will look at how we move towards this model, but it needs to be recognised that this will be a substantial change to current practice and is likely to require increased workforce capacity.	
18	families should be assigned a "key worker"	Establishing a keyworker role for each CDOP would potentially be a more practical way of moving forwards locally.	The role of the keyworker may already be best practice but is not established in that way in our region. It would call for flexibility for partners in allowing practitioners to work outside of their usual remit and would have a cost burden associated with it. As set out in the proposals it would also mean various agencies working with various keyworkers.
19	child death review meeting for all child deaths	agree - but there should be flexibility to this approach to avoid the potential for duplication of work in meetings/meetings which function only to ensure that a meeting has been held.	
20	Practitioners involved in CDR meetings	agree	
21	change Form C domains	agree	
22	CDR report to CDOP to inform its independent review of the case	agree	
23	expectations re specific circumstances	agree	
24	Themed' reviews at CDOP meetings	Agree - this would be particularly helpful for neonatal deaths. Otherwise locally numbers for each potential themed panel would be too small to be helpful.	
Chapter 6	**Transitional Arrangments**		
25	CDOP 'grace period' - 2mths to complete CDRs	Disagree - Far too short given the length of time it takes for Post Mortem reports etc	
26	LSCB grace period of 12mths to compete and poublish O/S SCRs	agree	
27	info emerging from SCRs	agree	