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# Background

- New arrangements for a safeguarding children (Working Together to Safeguard Children, 2018) took effect on 29 September 2019
- The three statutory safeguarding partners Local Authority, Clinical Commissioning Group, and Avon & Somerset Constabulary have shared and equal duty to make arrangements to work together to safeguard and promote the welfare of all children in Somerset
- Serious Case Reviews replaced by rapid reviews and, where appropriate, local Child Safeguarding Practice Reviews.

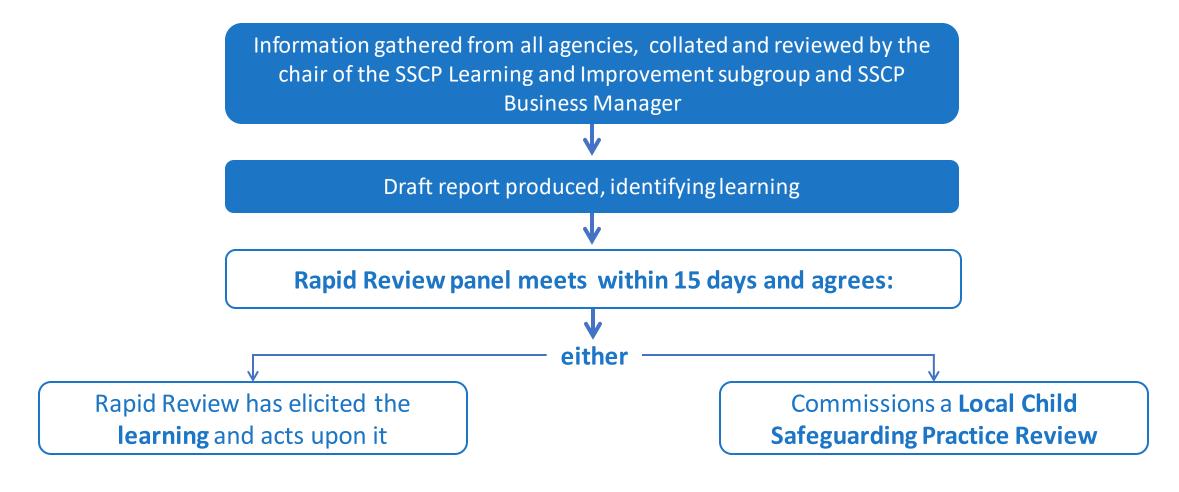


# Significant incidents of harm

Significant Incident of Harm, as defined in Working Together to Safeguard Children (2018) CSC notifies the National Child Safeguarding Practice Review panel within 5 days of the incident Triggers a multi-agency Rapid Review Information gathering from all agencies involved



#### Rapid reviews





#### Somerset rapid reviews

- ☐ Since September 2019, 11 rapid reviews
- Three were adolescents, one of which progressed to LCSPR in another authority
- Of the remaining eight children subject to a rapid review, two reviews were concluded at the rapid review stage
- Two progressed to LCSPRs in Somerset, published August 2021
- ☐ A further four will be considered as part of a thematic review of similar circumstances where children have been harmed. Not yet in public domain.



☐ Two local Child Safeguarding Practice Reviews were published in August 2021 relating to non-accidental harm to very young children

□ Since the inception of both reviews in spring 2020, the SSCP has been committed to implementing the learning relating to more effective identification of risks to children in the pre-birth period, better support to fathers and male carers, and improved communication across agencies.



Child Charlie: died unexpectedly aged sixteen weeks in care of father. Possible co sleeping. Poor home conditions with father, mother had no permanent home. Alcohol and substance use, domestic abuse.

☐ Child Alex: child presented to hospital early 2020, aged ten weeks, with serious and unexplained injuries. Mother in a relationship with a new partner, and concerns noted by agencies following premature birth.





#### Key learning

- Scope for better identification of risks in the pre-birth period
- Greater involvement of fathers/male carers
- Better understanding of levels of need
- Strengthening of multi agency strategy discussions with clear plans
- Consideration of domestic abuse incidents cumulatively
- Improved information sharing across borders



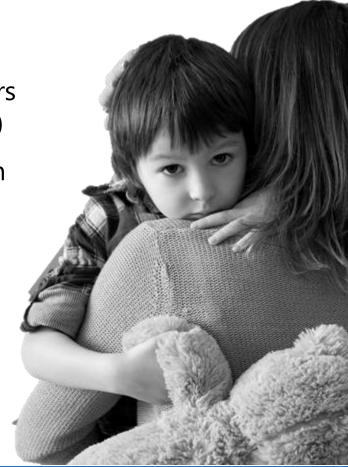


- South West Child Protection procedures for identifying risks in the prebirth period have been updated
- ☐ Multi-agency collaboration to strengthen strategy discussions
- Multi-agency linked professional initiative during the lockdown ensured that the most vulnerable families continued to be supported
- ☐ Introduction of multi-agency pre-birth tracking initiative
- Health partners reviewed their supervision policies and training with immediate effect
- ☐ Threshold guidance for services is being refreshed ('Effective Support')
- Development of a prebirth workbook and refresh of the neglect toolkit





- Avon & Somerset Strategic Safeguarding Partnership leading on force wide approach to domestic abuse notifications
- ☐ Forum weeks held twice per year for all Somerset safeguarding partners have raised awareness of the learning (Dec 2020, June 2021, Dec 2021)
- Summer 2020, series of events to share early learning which reached in excess of 200 frontline staff
- ☐ Forum week in December 2021 will focus on support for fathers/male carers





# Somerset Safeguarding Children Forum Week



