Introduction - A Thematic Local Safeguarding Practice Review for the Somerset Safeguarding Children Partnership: Injuries to babies during the pandemic lockdown

Brief Background to this Thematic Review

This thematic review was commissioned by the Somerset Safeguarding Children Partnership (SSCP) where I am Independent Scrutineer.

Whilst it is not unprecedented for an Independent Scrutineer with a partnership to take on the role of an independent author, as I do here, some context and explanation is necessary.

I have found in several other roles as Independent Chair and latterly Independent Scrutineer, that undertaking a review of this sort as an independent author is the single best way to gain an accurate, up-to-date and unvarnished insight as to how safeguarding partnerships actually function on a day-to-day basis.

A view was taken by the Executive of the SSCP, following completion of rapid reviews for four very young infants presenting with suspected non-accidental injuries (NAI) that, whilst unlikely from initial consideration, there might be some connection between these cases, as well as opportunities for reflection and learning, that warranted closer independent consideration.

The rapid reviews concluded that a thematic review would be the best way to address these issues, and the response received from the national Child Safeguarding Practice Review Panel supported this view.

A fifth rapid review, relating to a further instance of suspected non-accidental injuries for a similarly very young infant, was not added to the baseline of the thematic review on the basis that immediate improvements and recommendations at practice level (across all five cases) might be put into immediate effect without undue delay, such that this thematic review might address any systemic, structural and strategic issues revealed.

An Independent author?

Other than having been Independent Scrutineer for the SSCP since January 2020, I have no previous professional association or connection with Somerset, or any of the agencies there to the best of my knowledge.

My professional background over the past thirty or so years lies wholly in the field of safeguarding and child protection; in practice, as an academic and as an independent researcher and Chair. For example, I am presently Independent Scrutineer for the child safeguarding partnership in Nottinghamshire in addition to Somerset and was previously Independent Chair for Lambeth and Leeds.

It is essential for any reader to understand from the outset that the views represented here are my own, working as an independent author, and follow from the evidence I have accessed and reviewed. Similarly, that 'evidence' in this instance reflects what I have read from 'case-recording' and other written material I have accessed OR was by what I was directly told by professionals and others who participated in the consultation process. This is not a legal or judicial process, and hence the use of the term evidence must not be misconstrued.

Finally, it was agreed with the Executive of the SSCP at the outset, that any errors in respect of fact included by mistake in any draft of this review, once spotted, would be corrected, but that any differences of opinion in relation to findings and recommendations would need to be agreed with me before any changes might be made.

The Pandemic and the Process of this Review

There are two elements to stress in this regard; the first being the implications of conducting this thematic review remotely, via MS Teams, the telephone, email and other written communications and recording, the second being the impact of the pandemic and lockdown on the safeguarding support received by the expectant and new mothers of the babies at the centre of this consideration.

In relation to the implications for this review, it is self-evident to say that it is less than ideal to conduct this sort of work remotely.

Overall, I have taken the view that I must do the best I can, given present constraints, looking to be creative where possible in terms of strong communication, and going the extra mile in terms of review of paperwork, recording and other documentary source material.

I will go on to address the implications of the pandemic and lockdown on the quality and quantity of support and other services that the families received in more detail in later sections of this review.

I certainly found evidence of creative attempts to offset the impact of the pandemic from professionals. For example, where expectant mothers were anxious about professionals coming into their homes and potentially bringing the virus with them into a confined space, of these becoming 'walking' outdoor meetings, to maintain contact, build relationships and continue to offer oversight, advice and support.

Similarly, where GP surgeries were not readily accessible in the usual way through the pandemic for clinic-based visits (weighing etc.) alternative spaces (family hubs) were swiftly put in place so this vital monitoring and contact could continue.

Initial Scoping and Review

My first step in taking this work forward was to request as much documentary evidence as I could get my hands on from the range of agencies involved and, in all instances these requests were met fully and without undue delay.

Completed rapid reviews for these infants were evidently the most important documentary sources consulted, as they enabled me to gain insight into what had happened in each case, some narrative and context in relation to the circumstances, and some overview of how the Partnership had supported and engaged with the families through the process of reflection and reassessment required by rapid review.

Quality of Rapid Reviews

My finding is that the quality of rapid reviews completed here, whilst relatively brief and somewhat lacking in analysis, were of good standard, to the extent that it is neither appropriate nor necessary for me to simply replicate the descriptive chronologies and other evidence presented in them here along with

actions for future learning and improvement included in rapid review. Furthermore, the rapid reviews have already been submitted to the National Panel, and responses received.

I choose instead to use the limited time available for this review to go beyond the scope of the completed rapid reviews, and address in particular systemic, structural and strategic issues following the evidence reviewed in a stepwise manner.

Contact with Family

All efforts were made to contact close family members such that they were aware of the progress of this review, and to invite them to participate if they wished to do so.

There has been no response to this invitation to date.

What does recent research tell us about NAI and very Young Infants?

The following information was sourced from the most up to date evidence-based research I could find published in April 2020 (Baird, E. **Non-accidental injury in children in the time of COVID-19 pandemic** 2020).

It is likely that additional research with respect to the impact of the pandemic on safeguarding generally, and NAI in particular, will take time to reach the point of publication, and **it is strongly suggested that an additional data trawl be undertaken by the Executive of the SSCP in this regard around one year subsequent to publication of this review, such that a more informed and potentially accurate understanding can be reached.**

Baird reviews early evidence of an increase in NAI during the pandemic, and concludes,

"Non-accidental injury is the tragic outcome of a complex interplay between the individual, relationship, community and society, and COVID-19 will only compound this. It must be a diagnosis which we seek to actively dismiss, to safeguard the children under our care, as it is the failure to recognise the abuse that often leads to the child's demise."

And goes on to suggest,

"Social isolation is a risk factor intrinsic to the perpetrator of abuse and intrinsic to the family structure. As we have all been asked to limit our social contact in the light of COVID-19, the support that normally comes with socialising with friends and wider relatives is lost. The sudden withdrawal of nurseries, schools, youth programmes and time with other relatives takes away not only the respite of childcare, but also the early warning system that these places would normally provide. Children with developmental delay and additional needs are at particular risk of abuse, and the loss of respite and support networks for these families is a particularly cruel blow. Social isolation to many families means confinement, often with multiple children, in small dwellings with no access to outdoor spaces in which families can relieve the stress of lockdown. These conditions make for a tense and volatile environment.

NAI is more prevalent in families with lower incomes, and financial uncertainty has been further associated with increasing this risk. This was seen during the last economic recession, where there was a substantial increase in abuse and mortality from non-accidental head trauma. Through financial uncertainty, COVID-19 further

adds an element of stress to a precarious situation for many children, and this effect will be long lasting.

Another known risk factor for NAI is the lack of access to healthcare. We are actively encouraging patients to stay away from hospitals to minimise the risk of spreading COVID-19, however we may also be inadvertently heightening the risk of NAI in the process. Child abuse and neglect will continue to happen, but behind closed doors; we just won't know about it. Mental health services are also particularly fragile at this time. Mothers with postnatal depression and psychosis may have less support, and infants are particularly vulnerable in this setting. Any member of the household may have mental health issues, including substance abuse, which may be less well supported in these challenging times, and this poses a risk to the child living with them."

The following risk factors for NAI were found to be especially important:

- Social isolation
- Lack of early warning system
- Loss of support systems
- Low income and financial uncertainty
- Lack of access to healthcare
- Healthcare systems under stress.

Baird concludes,
"Not only are many families under (additional) extremely stressful circumstances, (during the pandemic) but healthcare systems are too. The increasing burden of COVID-19 presents a real challenge to maintain the standards that are normally in place. Staff working (outside) their normal roles and may not be as familiar with the presentation of NAI".

Overall Findings at Micro level: a Review of Practice

I have not found that the actions or inactions of any professional or agency materially contributed to the harm suffered by the infants considered in this review. Indeed, there is considerable evidence of individuals and agencies doing the absolute best they could, in unprecedented and very challenging circumstances, for which they are to be commended.

On consideration of all the written evidence, and as a result of meetings with both practitioners and managers, I have not found any clear link or association between any of the cases reviewed. It would appear therefore that the non-accidental injuries presented reflect similar but unconnected separate episodes.

Once non-accidental injury was raised as a possibility, in each instance the evidence verifies that the response across the Somerset Safeguarding Children Partnership was swift and co-ordinated.

My overall finding however is that the pandemic and lockdown did affect the quality of universal safeguarding support these families received. Initial advice from professional bodies, in the early stages of the lockdown, to curtail or even stop face-to-face contact altogether, whilst quickly revised (within four to five weeks) to enable safe contact with expectant and new mothers to continue, and encourage professionals to use new technologies creatively to address any additional need and increased level of anxiety brought about by the pandemic, self-evidently changed the way in which universal safeguarding services were offered thereafter.

For example, health visitor and midwife contacts that would previously have occurred in family homes, (whilst evidently done well elsewhere or through the use of alternative means such as social media) could not directly 'pick up' on the subtle cues and changes within a household that seasoned professionals tend to 'sense'. Crucially, changes to family composition, deterioration in parental mental health, changes of partner all under the auspice of caring for a newborn infant with the additional stress of lockdown were not as directly evident as they would have been in the normal course of affairs.

This was exacerbated through:

- **Midwives and health visitors working from home, leading to the loss of discussion, reflection and 'soft supervision' that normally occurs between professional colleagues working closely together in the workplace, which, in turn, has carry-over implications for formal supervision.**

- **The impact of greater use of social media and emails for communication with expectant and young mothers, at a time of isolation and heightened anxiety around health, resulted in an 'avalanche' of emails. Time taken to respond to emails, simply ate into time for recording, reflection and review. So, whilst there have been gains from the adoption of new communications technologies, it is also fair to say there have also been losses.**

- **A contextual lack of professional curiosity, both in general terms, and more specifically in respect of the potential impact of new husbands/ male partners not being 'seen' and sufficiently taken into account their physical and mental health, their backgrounds with respect to safeguarding and the impact upon them and the wider family of having**

a newborn at home, whilst isolated through the pandemic was not considered sufficiently.

- **An underestimation of the degree to which the normal range of anxieties and concerns around pregnancy and childbirth might be exacerbated by fear of contracting Covid 19, the social isolation brought about by the lockdown and any pre-existing mental health issues.**

Evidently standard operating procedures could not be followed in such 'non-standard' circumstances, which is raised here not as a criticism, but rather a reflection of unprecedented circumstances.

Overall Findings at Macro Level: a Review of Systems, Structure and Strategy

In commissioning this thematic review, the Somerset Safeguarding Children Partnership was clear that they were positively open to the prospect of using the review to enable wider creative challenge and facilitate learning and improvement of arrangements for safeguarding.

Of course, as a review author, one is also always very much aware of a parallel and understandable wish on the part of commissioning Partnerships to come up with an 'answer': a magic bullet simple solution which guarantees that tragic and usually unprecedented events 'cannot happen again', an understandable wish, but perhaps other than in the simplest of circumstance, usually undeliverable.

So, I will take the partnership's *permission* to think outside the box seriously and look to challenge at the level of strategy and structure, as a means of assisting you to reflect, reconsider and re-evaluate, even if on balance you conclude that present arrangements remain satisfactory.

In their annual report (2020) the Child Safeguarding Practice Review Panel set out a summary of six key practice themes that 'make a difference'.

I would suggest that this thematic approach, derived directly from evidence, is useful not only in terms of conceptually grouping generic results, but also as a more analytic vehicle to think through the wider (macro) issues within a single review, as I will attempt to do here, with a slightly changed ordering.

As a result, I will pose a series of questions for the Somerset Safeguarding Children Partnership to address, based on the evidence considered in this review.

It is my view that the process of addressing and responding to these questions may serve to clarify and reinforce the Somerset *narrative* around safeguarding, while also drawing out and consolidating the potentially different perspectives of the statutory partners.

It is ESSENTIAL that any reader understands these questions are NOT reflective of problems or deficits I have found, but rather are raised as catalysts for discussion and dialogue for the Partnership.

(i) Practice Theme 1 - Sharing information in a timely and appropriate way

Baird's research (cited above) suggests that 'lack of an early warning system' is one of a series of risk factors associated with increased incidence of non-accidental injuries during the period of the pandemic.

As the cases reviewed here are indicative of just such an increase in non-accidental injuries, it is reasonable to examine the degree to which changes in the delivery of health visiting and midwifery services contributed to any impoverishment of the safeguarding early warning system in Somerset.

On balance of evidence, I think it is appropriate to speculate that the issues mentioned above around: time required to respond to much increased email and social media contacts, generally heightened public anxiety and fear during the pandemic, lack of 'soft supervision' and peer-to-peer support in the workplace and reduced access and oversight previously facilitated through direct contact and home visitation are at least some of the elements contributing to a reduced early warning system, and contextualising reduced professional curiosity.

Given that we are not yet through the pandemic, and that there is considerable uncertainty around how services will adapt and function in the short to medium term, all efforts need to be made to ensure that the early warning system provided by universal services is as effective as possible. All professionals with responsibility for safeguarding, and especially all universal service providers, should be reminded and positively encouraged to refer onward any concerns around possible risk of non-accidental injury they detect. In this sense, our 'early warning' system needs to be as sensitive as possible and accurately calibrated to whatever present circumstances prevail, especially where the prevailing circumstance takes us outside of the normal range, as has been the case during the pandemic.

Similarly, for example, it is appropriate to ask if arrangements for universal safeguarding, such as Midwifery and Health Visiting for example, are adequate and/or sufficiently flexible to meet demand, even if current increased demand is a temporary facet of the pandemic.

Q1

How will the Executive of the SSCP, support universal services with respect to exercising their expert professional curiosity and, where concerns are raised as a result, encourage appropriate information sharing and onward referral?

Q2

Does the increased demand for universal services, such as health visiting and midwifery, suggest that, in the light of the issues raised by the cases reviewed here, consideration should be given to reviewing present deployment, caseloads and circumstances in which enhanced support might be offered, and reflecting upon how this correspond to the Ockenden requirements?

(ii). Practice Theme 2 - Understanding what the child's daily life is like.

As I have already observed above, it is my view that the pandemic did impact on the degree to which universal services, such as health visiting and midwifery, had the opportunity to pick up on subtle changes within families.

The degree, to which any professional can gain an accurate *understanding* of what a child's daily life is like, requires access to good direct data, with respect of context, change and development, the ability to ask questions and exercise professional curiosity and, critically, the opportunity to reflect and seek the formal and less formal advice and guidance of others.

It is likely that, at the end of the pandemic, safeguarding services will not revert to previous modes of working and a new 'hybridised' model, incorporating some of the creative uses of technology for example, will become the new normal. Whilst there are evidently many benefits to extending the range of ways services can communicate with and support children and families, there may also be costs if such new ways of working inadvertently compromise opportunities for universal services to observe and take the whole ambit of a child's daily life into account. It is my opinion that there is no substitute for home visits, and that whilst technology can supplement them, it cannot and should not replace them.

Q3

How will the Executive of the SSCP ensure that as we emerge from the pandemic, universal services such as health visiting and midwifery have the capacity to retain the technological advances developed during the pandemic, whilst also ensuring that home visiting and other opportunities for direct contact remain the primary source of professional insight into what a child's daily life is like?

Additionally

How can the Partnership best ensure and evidence that the extended use of new technology around supporting vulnerable expectant and young mothers, is as efficient, effective and 'joined up' with existing safeguarding systems as possible, and is sufficiently resourced?'

Q4

If remote and home-based working are (to some extent) retained for safeguarding professionals, how will the Executive of the SSCP address issues around a potential diminution of workplace peer-to-peer support and reflection, and provide regular opportunities for professionals to continue to work together 'in the same room' whether directly or through creative use of technology?

(iii). Practice Theme 3 - Responding to changing risk and need

Q5

What was especially striking in undertaking this independent review was the lack of emergency planning AT NATIONAL LEVEL providing leadership for all constituent elements of safeguarding partnerships across the nation. Such a seeming lack of preparedness, especially in the early stages of the lockdown, directly contributed, in my view, to discrepancies and discontinuities in the safeguarding system as local responses, whilst well-intentioned and creative, were inevitably narrow, variable and piecemeal, as to some extent is evidenced here. The lack of central emergency planning and direction for safeguarding is all the more surprising given the warning of the SARS outbreak in 2003, and is something I feel should now be addressed to the National Child Safeguarding Practice Review Panel by the Executive of the SSCP for their consideration.

(iv). Practice Theme 4 - Working with families (and young people) where their engagement is reluctant and sporadic

Baird (cited above) describes a risk factor for non-accidental injury during the pandemic around circumstances in which the health system is under stress, which perhaps may seem something of a statement of the obvious in the context of a global pandemic! I would speculate however that here she is making a more generic point with respect to year-on-year funding in a context of increasing demand and competition for resources, and I will make that assumption moving forward.

Adding to my earlier comments around the costs as well as benefits of use of new technology in safeguarding, there has clearly been a massive and unprecedented evolution in this regard as a consequence of the pandemic.

It would however be fair to say that the professions around safeguarding have historically been at best slow (and some would argue at times resistant) to the use of new technologies and that consequently what has happened recently may be something of an aberration outlier.

A common theme in the consultation process for this review and indeed many others was concern and frustration with respect to accessing different IT data systems between and sometimes within agencies. It was evident that this reflected different and sometimes inaccurate understandings of data protection legislation. This is clearly a potential barrier to appropriate intra and inter-agency communications around safeguarding which, given the permissive nature of legislation around safeguarding, is unacceptable in 2021.

It seems appropriate therefore to ask a question with respect to how far the adoption of new technologies with regard to risk of non-accidental injury has been reactive OR is indicative of a more 'joined up' effective and efficient use of these new opportunities. Whilst this issue has general applicability, such consideration is beyond the remit of this review.

One of the following questions (6) whilst largely addressed to Health as a key safeguarding partner, should also be addressed I would suggest as a wider issue, and a consideration for the Partnership as a whole.

Q6

Why is easy and appropriate inter- and intra-agency professional communication specific to safeguarding still reported to me by practitioners as complex and problematic in Somerset? This should be considered both in terms of peer-to-peer contact and communication, but also in terms of the degree and ease with which safeguarding professionals from one agency can directly access (appropriate safeguarding) data held by partner agencies.

(*v). Practice Theme 5 - Critical thinking and challenge*

One of the consistent comments I heard in my meetings with practitioners especially, but from managers too, relates to decreased time available for record keeping during the pandemic. Practitioners will quite understandably prioritise direct work with public and the creative responses I have noted as a result of the unprecedented circumstances of the pandemic, all eat into the limited time available. Certainly

practitioners reported such a 'squeeze' on their time during the pandemic (especially during the early stages) and that recording was the area squeezed down as a result.

Giving priority to keeping services running and responsive during the pandemic is understandable, but it is worth asking a question here as to the possible 'impact' that reduced (and implicitly poorer) recording might hold for management, supervision, planning, reflection and assessment of increased risk.

Research in this area has historically found that good quality and timely recording is basic to professional reflection and case management, and in that sense records should be seen to be 'live' documents that officers should use regularly and refer to proactively. Clearly it is of concern therefore, if the impact of the pandemic has been to reduce the efficacy of recording, that this will potentially have carry-over detriment for safeguarding more generally, as is possibly so in relation to the cases reviewed here.

Q7

What impact has the pandemic had on the quality and currency of recording, and what implication (if any) does this hold for professional reflection, for supervision and assessment of risk? Case recording can and should be more than a simple retrospective 'listing' of contact and content. At best recording should be used as a proactive tool to assist professionals with reflection, spotting trends and changes which may impact on safeguarding and planning for the future. The evidence considered here however would suggest that (under the intense pressure of the lockdown and pandemic) recording was seen as a secondary, time consuming and relatively unimportant task.

Q8

Would there be value for key safeguarding partners in developing a common safeguarding recording protocol and shared recording system?

NB. I note that the continuation of separate inspection regimes for the three statutory safeguarding agencies make this an especially challenging question, and one which should also be considered by the National Child Safeguarding Practice Review Panel.

(vi). Practice Theme 6 - Organisational leadership and culture for good outcome

The focus of this thematic review has very largely been on the impact of the pandemic on universal services.

Elsewhere in this review I have used a term borrowed from Baird to describe these services as an 'early warning' system for safeguarding, which is so self-evidently the case that I would be surprised if this provoked any dissent or disagreement.

I would suggest however that, despite this being the case, the centrality and expert assessment that providers of universal services, such as health visitors and midwives, bring to the safeguarding conversation is (nationally) still not sufficiently strongly expressed or sufficiently carefully listened to and taken into account. This would certainly seem to have been the case, at least to some extent, in the cases reviewed here. If I am even partially right in this matter, this raises some serious potential questions in terms of the effectiveness of early intervention.

Q9

How might the health economy in Somerset, as a statutory safeguarding partner, take the lead across the safeguarding partnership to reassert the unique perspective and value of universal services like health visiting and midwifery in a safeguarding conversation that draws all partners closer together and encourages greater mutual appreciation of 'different' safeguarding perspectives?

Response from Somerset to this Thematic Review: Measurement of Effectiveness

This review contains nine questions that I suggest the Somerset Safeguarding Children Partnership should address and respond to by the end of April 2022 at the latest.

Response to the questions should initially be addressed by the Executive of the SSCP, with tasks delegated to subgroups, agencies, the SSCP Business Unit or individuals as felt appropriate. This with the caveat that the response as a whole must reflect the range of the statutory safeguarding partnership, and not be dominated in any way by the views or actions of any single perspective or agency.

The questions are posed to provoke reflection and, as such, there are not specific outcome data measures that I wish to append to them, other than my view that it may be of benefit to give serious consideration to the issues raised, whether that results in change or that going through the process simply reinforces your view as a partnership that the 'right' responses are already in place for Somerset.

I would expect the overall response to this thematic review to be 'published' by the end of April via the SSCP website, to thus be open to public scrutiny.

I would wish to be sent a copy of the overall response to this thematic review and reserve the right to respond, but would only envisage doing so *in extremis*.

Use and limitation of this review

There are three main issues to reflect on here:

1. An issue of 'timing' through, the pandemic.

In gross terms the safeguarding response to the pandemic can be broken down into two elements.

The period of initial response to the first lockdown when face-to-face contact was precluded, and the latter period through the second lockdown, when services had 'adapted' to new circumstances, and creative mechanisms to preserve face-to-face contact were in place.

The evidence I have considered in this review strongly underscores the exceptional efforts made by universal safeguarding services such as midwifery and health visiting in Somerset to accommodate and adapt to the unprecedented circumstance of the first lockdown, and find new ways of working following the best advice available at the time to maintain an effective service, that kept all involved safe.

By the time of the second lockdown, clearly much more was known, both locally and nationally, and a more nuanced and informed response was consequently possible, for example, with a degree of face-to-face visiting becoming feasible again.

It is my opinion that the issues for the cases reviewed here outlined in the rapid reviews, greatly reflect this period of adaption and transition through the pandemic and lockdowns, and hence of an issue of timing.

2. Mental health issues unique to circumstances of the pandemic.

The degree of anxiety and the effect of the isolation caused by the pandemic and lockdowns is well reported, but as yet insufficiently evaluated to analyse with any degree of authority or accuracy.

It is however pertinent to speculate that if this was found to be the case for the population in general, that it is likely to be even more so for expectant and young mothers and families, even where there was no prior suggestion of problems with mental health.

It was reported to me, for example, that one reason health visitors moved to offer face-to-face contact outside the home was in response to families not wishing to take the 'risk' of allowing professionals into their homes.

Whilst certainly not conclusive this is, I would suggest, indicative of a heightened level of anxiety, and the understandable (deeply human) need to keep children safe.

It is my opinion that the issues for the cases reviewed here outlined in the rapid reviews, greatly reflect this period of adaption and transition through the pandemic and lockdowns, and hence that the understanding and sensitivity of these circumstances as a catalyst to mental health issues, whilst initially and inevitably less than perfect, has subsequently improved considerably.

3. Invisible men.

The combination of issues reflected upon above, unique to the timing of the pandemic and lockdowns, drawing together the consequences of isolation and anxiety and requiring professionals to adapt immediately to hugely different working environment. Especially with regard to the squeeze on face-to-face contact and home visiting that would have happened in the normal course of events, would appear to have had an unanticipated effect of largely 'removing' the men involved from professional 'view' with regard to assessment of emerging safeguarding concerns.

Face-to-face contact with women alone outside the home was a logical and laudable response to a set of unique circumstances. But such arrangements lost the contextual richness of home visits.

It was reported to me, for example, that where there had been a change of partner, and a new man was now at home, this was sometimes not known, as would have been more readily apparent had home visits been possible.

It is my opinion that the issues for the cases reviewed here outlined in the rapid reviews, greatly reflect this period of adaption and transition through the pandemic and lockdowns, and that new arrangements for continuance of service sometimes had the effect of making the men involved to some extent invisible.

Post Script

The intellectual property of this review rests with both the author and the commissioning Somerset Safeguarding Children Partnership (SSCP).

The conclusions expressed here have been drawn from meetings with practitioners both individually and in groups, meetings with managers both individually and in groups, and from extensive reading of documents kindly made available to me through the Somerset Safeguarding Children Partnership Business Unit, or from professionals directly. I have supplemented the 'data set' drawn on here with reference to publications made by the national Child Safeguarding Practice Review Panel and a brief literature review of non-accidental injury during the pandemic. Given the limited time available to complete this work, I would suggest that the data drawn upon offers a reasonable 'snapshot' of what transpired, but no more and is not an attempt on my part to definitively 'tell the story' of the cases considered, as I set out in the introduction.

Dr. M. A. Peel

January 2022