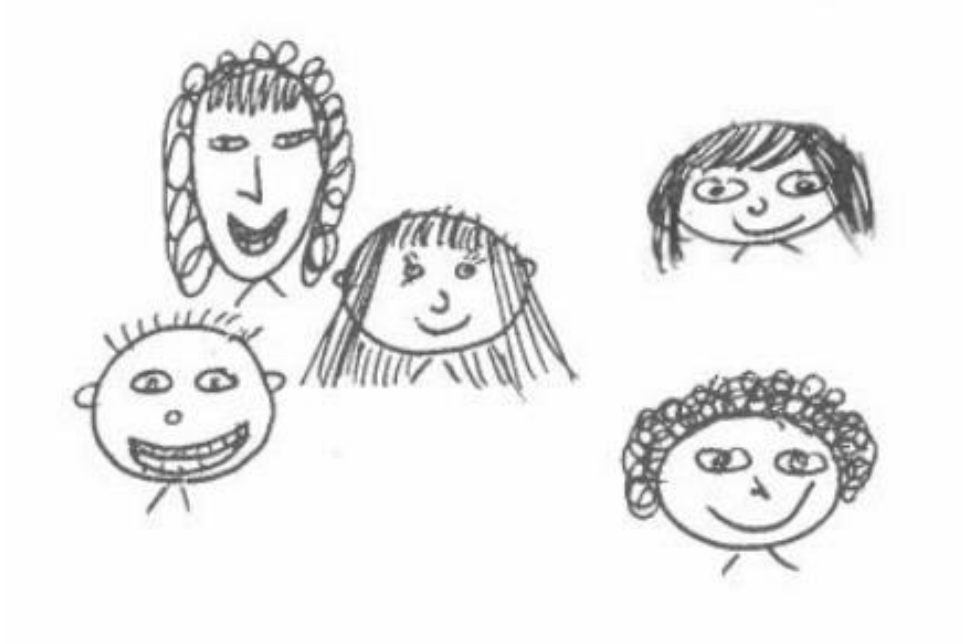
1

This storyboard is about Sophia's safeguarding practice review.

It has been written for people who work with children and families to help them understand why the review was completed, how and what it found.

The storyboard is a summary of the full safeguarding practice review report, which can be found here → Sophia's Safeguarding Review



In March 2023 Sophia was so poorly she needed to go to hospital. The paediatricians caring for her were really worried she would not survive.

Services and workers had been working with Sophia and her family at the time.

When there are worries like this it is important to understand what happened, to try and prevent it from happening again. This is called a safeguarding practice review.

2

The lead reviewer was called Catherine. It was her job to understand everything that services and workers did to try and help Sophia between June 2020 and April 2023.

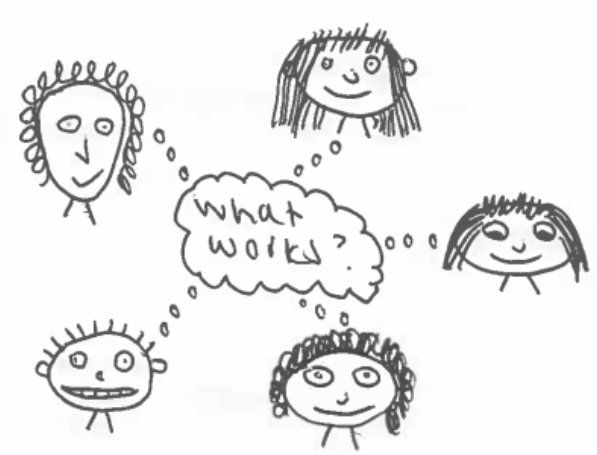
Catherine had read lots of reviews, but she thought if there was not a way to share all the good ways people worked with Sophia and her family it could mean the challenges would not be addressed and it could create a delay in developing how people work with children and their families. She understood if this happened people might start to feel frustrated or anxious.

Catherine knew people could learn about working with children and their families from what happened to Sophia if she could help find and talk about the good examples of things that happened.

So Catherine started to read more about appreciative inquiry (AI) and a collective approach to think about best practice, planning, culture and change.

She really liked that this encouraged questions like:

- ❑ Out of all the things you did to support or help Sophia what made the biggest difference and why?
- ❑ What would Sophia have said she appreciated the most about what you did?
- ❑ Even though that did not happen as planned what would you do differently in the future?



3

Catherine was a bit worried that people might think she was minimising the challenges that happened in Sophia's situation by focusing on the strengths and successes. However, she remembered an appreciative inquiry can also help to understand how strengths and successes can be developed to address the challenges too.

She read something that made her think carefully about how she wanted to completed Sophia's review.

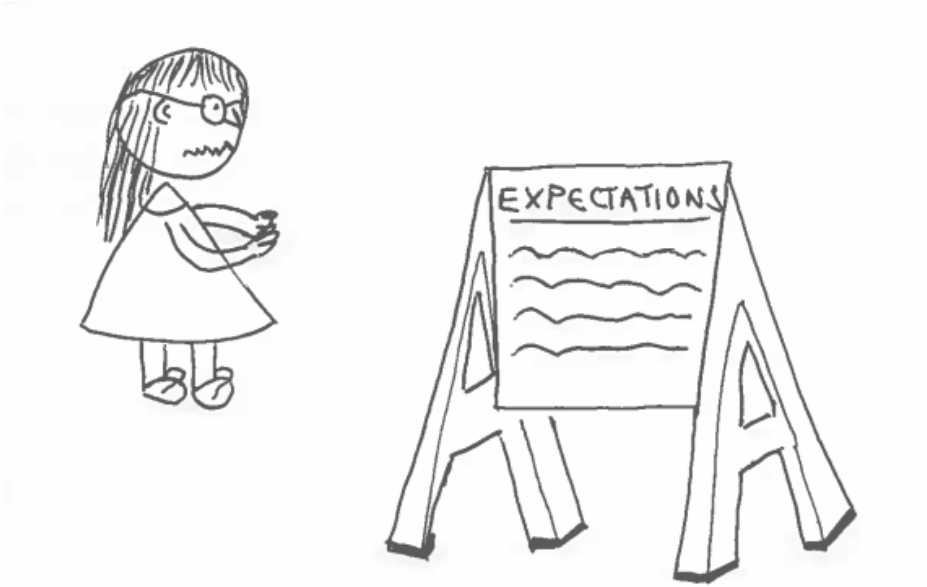
If you focus on problems, you find problems. But if you focus on successes, you find successes.

Catherine liked the idea that Sophia's review would have a greater chance of success if people could learn together from what worked well or what was useful to Sophia, to the adults in her life or to the workers, managers and leaders that has worked with her.

Catherine knew an appreciative inquiry was a different approach to other reviews that had been completed in Northumberland.

She knew some people would find it strange at first, that they might feel anxious to share or talk about what they did or how they felt at the time or that they might feel worried about writing or saying the "wrong thing".

So she decided to develop some rules. These included no blaming, lots of opportunities to share and learn, to explore situations of success and difficulties with questions, and to reflect on what happened.



4

Catherine asked agencies and services that knew Sophia to look at their records between June 2020 and April 2023 and write a report about what they found.

She asked them to focus on:

- what they knew about Sophia's day to day experiences,
- how they asked for and shared information with each other,
- how they listened to what Sophia said and how they understood her thoughts and views,
- how Sophia's mental health and education was considered when decisions were made,
- what was known about Sophia's experiences when she was younger and the impact.

She asked them to explain what the information meant to Sophia and what difference their actions as an agency or a service made.

Catherine arranged a meeting and invited people from all the agencies and services that had worked with Sophia.

The information from their reports was shared.

In the meeting she asked everybody lots of questions to understand more about what happened between June 2020 and April 2023 and why, what could have been different and how, and what was different now.

We know this event worked really well because people said things like:

- it felt "non-threatening and supportive",
- It "encouraged active dialogue between partner",
- it was focused on "building on the strengths identified and how to replicate that in other areas", and
- it was a "collaborative approach" and "everyone felt at ease to share their experiences".

Catherine was pleased that Sophia wanted to be part of her review.

Sophia answered Catherine's questions in a letter which really helped to understand her experience of working with services and workers between 2020 and 2023.

Catherine also met with some of Sophia's family to understand their views and experiences of working with services and to hear what their biggest hopes were for the future.

Thinking about all the information Catherine had read and heard, she identified **35** examples where something happened that she knows helps to keep children safe or where something made a positive difference to Sophia.

Some examples included:

- ❑ The creative and flexible ways to try and build a relationship with Sophia to support her back into school.
- ❑ The persistent but respectful follow up of identified actions after Sophia's discharge from a service.
- ❑ Clear records of discussions and observations.
- ❑ Recognition that specialist services needed to be involved.
- ❑ Exploring concerns from different perspectives, rather than assuming or accepting a single source of information.

Catherine said all 35 examples should be celebrated.

Catherine also identified key learning that people need to think about and do things differently when they work with children and their families.

Some examples included:

- ❑ Experiences and the impact on how Sophia thought and felt about herself and how she communicated throughout her whole childhood were not considered and understood.
- ❑ The record of Sophia's life did not consider her strengths and successes. This was important information about her, and it would have avoided blame.
- ❑ Information was open to an interpretation of peoples understanding. It could have used plain language, been clearer and identified where it came from.
- ❑ Sophia did not feel listened to or that her experiences were understood. She was not seen regularly, consistently or alone.
- ❑ People did not feel confident to identify Sophia's significant health concerns or know where to get support.
- ❑ Information was not always shared because it was not part of a process or people's roles and responsibilities were not understood.
- ❑ There were opportunities to develop a multi-agency plan for Sophia.
- ❑ Despite workers efforts there was no change to Sophia's circumstances.

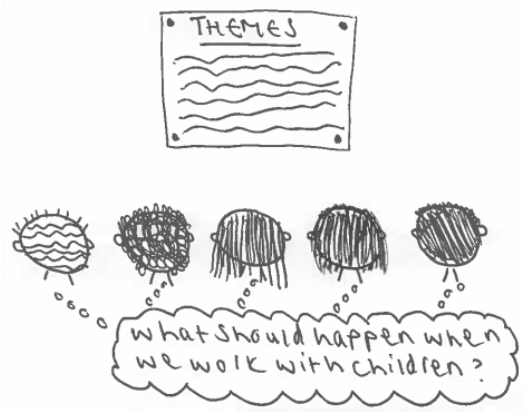
From all the information about Sophia, Catherine thought about what working with children and families should look like.

She identified **6** themes.

1. Understanding a child's day-to-day experiences.
2. Recording information.
3. Information seeking and sharing.
4. Having a co-ordinated plan and review.
5. Understanding healthy child growth and development.
6. Access to quality supervision.

Cathrine arranged another meeting and this time everybody thought about what needed to happen to know that each theme was consistently happening, based on what they already knew worked or was working well.

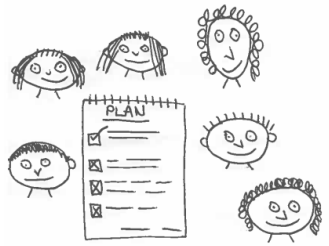
People then thought about what actions were needed to make sure each theme can be achieved.



There were **19 recommendations** from Sophia's review.

They included:

- ❑ Understand what difference the developments between 2020 and 2023 in agencies, services or the NCASP have made and how.
- ❑ Consider how to introduce shame sensitivity and shame sensitive practice.
- ❑ Gather detailed family histories, including roles and responsibilities of important people.
- ❑ Reflect the detail within the six theme statements across single agency and/or NCASP policies and procedures.
- ❑ Record information about a child to the child.
- ❑ Review procedures for information sharing in the front door arrangement.
- ❑ Clearer discharge planning expectations.
- ❑ Guidance about the lead professional role for any type of plan for a child.
- ❑ Guidance about healthy child developmental milestones.
- ❑ Information for families about the support they can expect to receive from a service and the purpose of interventions.
- ❑ Key focus areas for supervision discussions across the NCASP.
- ❑ Safeguarding supervision for DSLs.
- ❑ Multi-agency group learning and reflection.



When Sophia's family read the review, they said:

We liked the way it was written. It was professional but it was like a story that was easy to read, even for us.

The shame theory made me think, maybe I wasn't a bad mum after all; it helped to explain some things.

Thank you for involving us, listening and explaining things. Our views and feelings are right there in the report.

Catherines biggest hopes from Sophia's review are that people will ***have the chance to learn and reflect*** about what happened to her between 2020 and 2023, people will ***think about how they will work with children and families*** in the future based on the possibility statements, and people will ***feel confident and optimistic*** about the changes that have been identified.

Why the review is written in the way it is:

- **Sophia was not seen or heard for such a long time**. So the review has been written in the first person to remind people they are reading about Sophia and the events that have happened in her life.

- **It was important to give Sophia the opportunity to be involved in her review**. This was not possible initially due to other enquiries. It was constantly reviewed to reflect the learning that she was not always spoken to or that her views were often presented by other people. Speaking with Sophia offered some insight to her thoughts and feelings.

- **The documents are written using clear and simple language.** This is so they are easy to read and so everybody can understand the information, even Sophia at a time in her life when she feels ready. Writing in this way avoided key events being open to interpretation, which was learning from the review.

- **Relationships are identified with words children use and reflect how they speak about the important people in their lives**. This reflected one of the recommendations - to write in a way a child and their family can relate to, because it is a record of their life.

- **The storyboard was used instead of an executive summary, so the information is more accessible to everyone**. This is a successful way of explaining complicated information using simple words and pictures, which was confirmed by Sophia's family.

Read Sophia's Safeguarding Review