

# Creating a Culture of Learning in Safeguarding Following a Crisis

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# Creating a culture of learning in Safeguarding

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# What do we mean by safeguarding

- Definition – **Safeguarding** and promoting the welfare of children is protecting children from maltreatment; preventing impairment of children's health or development; ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- **Child Protection** is part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm
- Effective child protection is essential as part of wider work to safeguard and promote the welfare of children

# The journey of learning in Newcastle

- Serious Case Reviews
- Scrutiny and media attention
- Lowering staff morale, never good enough
- National perspective
- Expectation that failures have occurred
- Study of Serious Case Reviews – gap between learning lessons and identifying what needs to change and doing it
- Stronger learning culture
- Learning from effective safeguarding practice rather than from mistakes
- Appreciative Inquiry champions group established

‘Few people get up in the morning thinking:  
I really want to make a lot of mistakes today.  
Rather people wonder, what do I need to do  
around here to succeed?’

Appreciate Leadership Dianna Whitney et al

# Refocussing our attention

‘A compulsive concern with what’s not working, why things go wrong and who didn’t do his or her job, demoralises and reduces the speed of learning and undermines relationships. Knowing what doesn’t work and why doesn’t tell us what would work for us instead’

David Shaked

‘Appreciative inquiry starts with a different kind of conversation, working with people’s experience, energy and passions to create exceptional change’

David Cooperrider

# AI is an approach to change...it invites people to:



Explore and describe what makes the organisation/team work for them and for others (discovery)



Engage in building the kind of organisation/team in which they wish to work (dream/imagine)



Weave this new knowledge into existing systems to create change (design and delivery)

# Why it works: Principles of the approach

Begins with the assumption that in every society, organisation, team and group, some things are working well (strengths based)

What we focus on grows. Organisations grow in the direction of what they ask questions about (anticipatory)

Create successful futures by building on past success and existing strengths (continuity and innovation)

Stories have wings, create meaning and are transformative – they help us understand and connect to our reality as well as co-create it (narrative, social construction)



# Using AI – Five ‘D’ Cycle

## Definition:

Decide where you want to get to



## Discovery:

Explore, inquire  
Themes - Positive Core

## Appreciative Topic

What do you  
Want More of?

## Design:

Finding innovative ways to  
create that future;  
Breakthrough propositions

## Dream/Imagine:

Picture what might be;  
create shared images for  
a preferred future

**Delivery:**  
Sustaining the Change

# Case Reviews – methodology

- Appreciative Inquiry and systems methodology
- AI – generative open questions
- Rigorous and inclusive learning inquiry process
- Moves away from blame
- Challenge and strengthen multi-agency safeguarding arrangements

# Case Reviews – methodology

- Professionals and organisations protecting children need to reflect and learn from own practice
- Good practice should be shared – grow understanding of what works well
- Professionals must be involved fully without fear
- Families should be invited to contribute
- Ensuring the child is at the centre
- Improvement must be sustained – monitoring and follow up

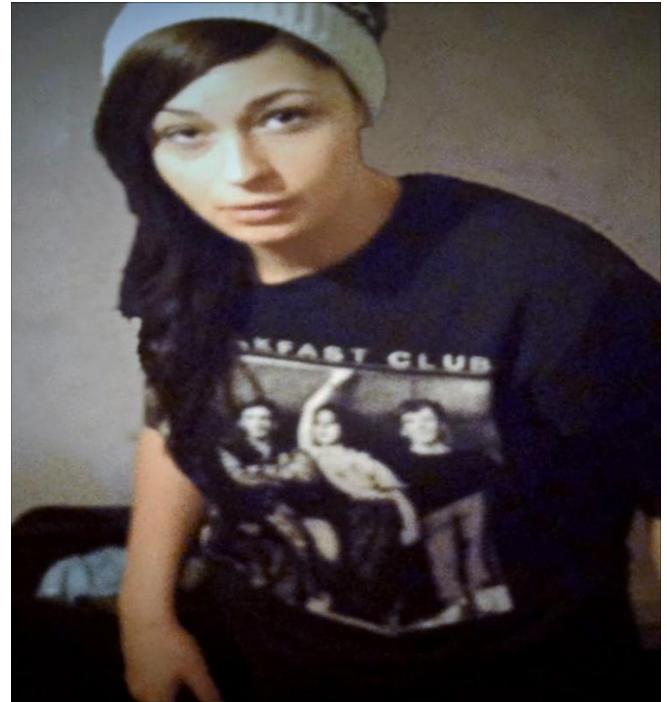
# 2 case examples

Whole day events, including between 20 - 25 professionals in each, 6 stages:

1. Best strengths in challenging times
2. Inquire into one another's work with the child i) those interventions that were successful in keeping child safe; ii) those things that we could have done differently (**Discovery**)
3. Create a multi-agency timeline
4. Reflect together on all the things that had worked well and all the areas that people could now see could have been done differently (**Dream/imagine**)
5. Seek new ideas about the redesign of those things that must change to enable the whole system to get better at keeping children safe (**Design and delivery**)
6. Make individual and shared commitments to ongoing development, action and change (**Delivery**)

# Young Person: A

- 17 year old female
- Committed suicide by hanging
- Vulnerable adolescent
- Family history – DV
- Brother committed suicide by hanging
- Alcohol
- Prior to her death was making good progress



# A – Services Involved

- Youth Offending Team
- Child Mental Health Service
- Children's Social Care
- Drug and Alcohol Service
- Hospital
- Health Services
- Housing
- Police

# A – Learning – Good Practice

- Commitment
- Persistence
- Continuous efforts by professionals
- Creativity and flexibility of roles
- Identified as vulnerable adolescent
- Procedures followed
- Strong – information sharing/communication

# A – Learning – Areas for development

- Prediction of level of risk and vulnerability
- Understanding the challenge of this vulnerable group
- Managing risk
- Role of Child Mental Health Services
- Role of Risk Management Group



# A – Family Views

- Impact and damage of domestic violence
- Confirmed that A was doing well prior to death
- ‘A liked the SW, she was genuine and really cared, one of the good people in the world’.
- ‘They did all they could for A’
- ‘Never give up’
- Impact of A’s brother’s death and earlier history

# Feedback from those involved

- ‘Drawing agencies together in a forum which encouraged frank discussion’
- ‘Positive and inspiring experience’
- ‘The openness and willingness shown by all to explore the practice issues’
- ‘No blame supportive approach’
- ‘Good to hear reflection from Senior Managers not just the front line practitioners’
- ‘Motivated me to promote change’
- ‘I felt I was able to express the organisations perspective freely in a motivational environment’
- ‘I did the best I could and it wasn’t my fault!’

# A – What we have done and are committed to

- Findings – linked to outcome focused action
- Evaluation – impact on practice
- Immediate learning and feedback
- Multi-agency briefings and training
- Workshop – identifying and managing risk

# Child: N

- 2 month old baby girl
- Suffered respiratory arrest
- Responded to treatment
- Ingested methadone
- Currently well and placed for adoption
- Teenage parents –history LAC
- Domestic violence
- Chaotic lifestyle

# N- Services Involved

- Police
- Children's Social Care
- Children's Social Care (2 Local Authority areas)
- Midwifery
- Residential units
- Youth Offending Team
- Substance misuse services

# N – Learning – Good Practice

- Engagement with teenage mother
- Commitment
- Separate workers with defined roles
- Good inter-agency working and information sharing
- Continuity with both parents 16+ social workers
- Well engaged with midwifery services
- Prompt identification of concerns when admitted to hospital

# N – Learning – Areas for development

- High investment in teenage mother to succeed
- Attention on mother
- Father story
- Cross boundary issues
- Use of chronologies
- Hearing from everyone as part of the planning
- Role of the Independent Reviewing Officer
- Disguised compliance
- Role of legal services

# N – Views of the family

- Showed some insight
- With hindsight would not have lived with relatives



# Feedback from those involved

- 'A safe environment in which people felt comfortable in sharing their experience and professional judgements in an open and honest manner'
- 'Excellent process where lessons can be learnt in a safe environment and practitioners ideas and recommendations taken forward'
- 'The opportunity to hear all the story which enabled the whole picture to be seen'
- 'Lack of blame made reflecting openly and honestly easier'
- 'Fear and anxiety create paralysis. Open and safe processes create leaning and movement'

# N – What we have done and are committed to

- Findings linked to outcome focused action
- Evaluation – impact on practice
- Immediate learning and feedback
- Multi-agency briefings and training
- Role of Independent Reviewing Officers
- Improve use of chronologies
- Raise awareness – methadone (national issue)

# Impact on social workers

‘Being able to reflect and learn without feeling guilt or reducing confidence’

‘I have not felt as motivated for quite a while and this day has inspired me’

# Anne Radford explains...

## Appreciative Inquiry involves:

*‘the art and practice of asking questions that strengthen a system’s capacity to discover and develop its potential.*

*It is not about ignoring problems, it is about approaching them from a different perspective’.*

# Thank You