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**Professional Curiosity**

**What do we mean by 'professional curiosity'?**

Professional curiosity is a combination of looking, listening, asking direct questions, checking

out and reflecting on information received. It means not taking a single source of information and

accepting it at face value. It means testing out your professional assumptions about different types of

families. It means triangulating information from different sources to gain a better understanding of

family functioning which, in turn, helps to make predictions about what is likely to happen in the

future. It means seeing past the obvious.

**Is this a new approach and will it mean extra work for me?**

Not if you are already doing your job well. But if you apply a 'tick box' approach to completing

assessments or conducting consultations with children and families then it will require you to take

more time to be curious and ask questions, and to check out what you are told with other family

members and other professionals.

**Why is it important in working with children and their families?**

Learning from case reviews, both nationally and locally, is that responding to presenting issues in

isolation and a lack of professional curiosity can lead to missed opportunities to identify less obvious

indicators of vulnerability or significant harm, and we know that in the worst circumstances this has

resulted in death or serious abuse.

**Is exercising professional curiosity easy and straight forward?**

Not always. Especially with those parents/carers or other family members who demonstrate disguised compliance or coercive control. Families can appear to be engaging with professionals, but are not able or willing to change as a

result of an intervention or certain family members are unable through fear to be open and honest

about the family dynamics. It is with these families that professionals need to exercise most curiosity although professional curiosity should be always exercised when working with children who are at risk. Professional curiosity should be applied consistently to all cases.

* Question your own assumptions about how families function and guard against over optimism
* Recognise how your own feelings (for example tiredness, feeling rushed or illness) might impact on your view of a child or family on a given day
* Demonstrate a willingness to have less than 'comfortable' interactions with families when this is necessary
* Address any professional anxiety about how hostile or resistant families might react to being asked direct or difficult questions
* Remain open minded and expect the unexpected
* Appreciate that respectful scepticism and challenge are healthy – it is ok to question what you are told
* Ensure you can recognise disguised compliance and consider how you will address the issue
* Understand the impact of coercive control on the behaviour and responses of family members
* Understand the cumulative impact on children of multiple or combined risk factors, e.g. domestic abuse, parental drug/alcohol misuse, parental mental health (previously referred to as 'toxic mix')
* Ensure that your practice is reflective and that you accessed good quality supervision

**Top tips**

**Looking**

⇒ Is there anything about what I am seeing in my interaction with this child or family which prompts questions or makes me feel uneasy or concerned?

⇒ Am I observing behaviour which is indicative of abuse or neglect?

⇒ Does what I am seeing support or contradict what I am being told?

**Listening**

⇒ Am I being told anything which requires further clarification? If so, how am I going to seek clarification?

⇒ Am I concerned about what I am hearing family members saying to each other? If so, how will I address this?

⇒ Is someone in this family trying to tell me something but finding it difficult to express themselves? If so, how can I help them to do so?

**Asking**

⇒ Are there direct questions which I could ask in my direct contact with this family which will provide more information about the vulnerability of individual family members?

* How do members of your family deal with conflict?
* How do adults in the household respond to stress?
* What arrangements are in place for the child or young person to access education?
* Who are the professionals working with individual members of your family?
* What is it like to be (name) living in this family/household?
* What is a typical day like for you?
* Who is this with you at this appointment?
* Who is living with you?
* Why are you not at school?
* What is the first thing you think of when you get up in the morning and/or the last thing you think of before you go to sleep?
* When were you last happy?
* How safe do you feel at home or with your family?
* What do you look forward to?
* Are there people who regularly visit your home apart from those who live there?
* Are you in fear of the consequences of doing something, or not doing something?

**Checking out**

Professionals may often form a working hypothesis (an unproven theory, proposition, or supposition) which serves as the basis of understanding around what is happening with the family. A holistic approach should be taken when gathering information, regardless of whether it confirms or denies your hypothesis, to allow for a fully informed assessment. Be open to incorporating information that does not support your initial hypothesis but provides further clarity and understanding around the lived experience of the child’.

To confirm or deny your working hypothesis, you could ask questions such as:

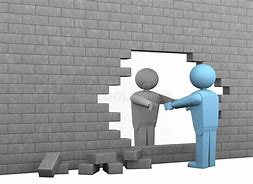
⇒ Do I know what other professionals are involved with this family?

⇒ Have other professionals observed what I have seen?

⇒ Are professionals being told the same or different things, or do explanations from family members change over time or according to who you ask?

⇒ Are other professionals concerned? If so, what action has been taken so far and is there anything else which should or could be done by me or anyone else?

**SEE PAST THE OBVIOUS …. LOOK FURTHER, SEE MORE …. THINK WIDER, LOOK FOR THE SIGNS**

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**Barriers to Professional Curiosity**

Important to note: When a lack of professional curiosity is cited as a factor in a tragic incident, this does not automatically mean that blame should be apportioned. It is widely recognised that there are many barriers to being professionally curious.

* A person-centred approach requires practitioners to remain mindful of the original concern and be professionally curious.
* ‘Unsubstantiated’ concerns, allegations that are seen as ‘hearsay’ and inconclusive medical evidence should not lead to case closure without further assessment.
* Retracted allegations still need to be investigated wherever possible.
* The use of risk assessment tools can reduce uncertainty, but they are not a substitute for professional judgement.
* Results need to be collated with observations and other sources of information.
* Social care practitioners are responsible for triangulating information such as, seeking independent confirmation of information, and weighing up information from a range of practitioners, particularly when there are differing accounts and considering different theories and research to understand the situation.
* Disguised compliance: A family member or carer gives the appearance of co-operating with Social Services (any professional) to avoid raising suspicions, to allay professional concerns and ultimately to reduce professional involvement. There is a need to establish the facts and gather evidence about what is actually happening alongside a need to focus on outcomes rather than processes to ensure the process remains person centred.
* The ‘rule of optimism’: Risk enablement is about a strengthsbased approach, but this does not mean that new or escalating risks should not be treated seriously. The ‘rule of optimism’ is a well-known dynamic in which professionals can tend to rationalise away new or escalating risks despite clear evidence to the contrary
* Accumulating risk: seeing the whole picture. Reviews repeatedly demonstrate that professionals tend to respond to each situation or new risk discretely, rather than assessing the new information within the context of the whole person or looking at the cumulative effect of a series of incidents and information.
* Normalisation: This refers to social processes through which ideas and actions come to be seen as 'normal' and become taken-for-granted or 'natural' in everyday life. Because they are seen as ‘normal’ they cease to be questioned and are therefore not recognised as potential risks or assessed as such.
* Professional deference: Workers who have most contact with the individual is in a good position to recognise when the risks to the person are escalating. However, there can be a tendency to defer to the opinion of a ‘higher status’ professional who has limited contact with the person but who views the risk as less significant. Be confident in your own judgement and always outline your observations and concerns to other professionals, be courageous and challenge their opinion of risk if it varies from your own.
* Confirmation bias: This is when we look for evidence that supports or confirms our pre-held view and ignores contrary information that refutes them. It occurs when we filter out potentially useful facts and opinions that do not coincide with our preconceived ideas.
* ‘Knowing but not knowing’ This is about having a sense that something is not right but not knowing exactly what, so it is difficult to grasp the problem and take action.
* Confidence: in managing tension, disagreement, disruption and aggression from families or others, can undermine confidence and divert meetings away from topics the practitioner wants to explore and back to the family’s own agenda.
* Dealing with uncertainty: Contested accounts, vague or retracted disclosures, deception and inconclusive medical evidence are common in safeguarding practice. Practitioners are often presented with concerns which are impossible to substantiate. In such situations, ‘there is a temptation to discount concerns that cannot be proved’
* Other barriers include: Poor supervision, complexity and pressure of work, changes of case worker leading to repeatedly ‘starting again’ in casework, closing cases too quickly, fixed thinking/preconceived ideas and values, and a lack of openness to new knowledge are also barriers to a professionally curious approach

**Useful information:**

<https://www.kirkleessafeguardingchildren.co.uk/safeguarding-2/briefing-guides/>

4 minute clip where Sue Woolmore talks about disguised compliance and the importance of professional curiosity. <https://www.youtube.com/watch?v=1juU2B6cD_Q>

2 minute clip encouraging practitioners to identify children as ‘Was Not Brought’ as opposed to ‘Did Not Attend’ when referring to them not being presented at medical appointments. (Nottinghamshire Safeguarding Partners) [Rethinking ‘Did Not Attend’ - YouTube](https://www.youtube.com/watch?v=dAdNL6d4lpk)

3 minute clip from Waltham Forest Safeguarding Partnership which provides some context when working with families. <https://www.youtube.com/watch?v=iAxlVsP_oCI>

NSPCC Learning from case reviews where [professional curiosity has been a theme](https://learning.nspcc.org.uk/case-reviews/recently-published-case-reviews).