

***Being curious about professional curiosity: learning
from local reviews of child safeguarding practice***

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**Drawing on research with Dr Penny Sorensen at UEA and colleagues at the
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Introduction

- A new system of rapid reviews and LCSPRs replaced 'serious case reviews' in 2018-19, part of a new architecture for multi-agency child safeguarding.
- A team from UEA and Birmingham was commissioned in 2020 to undertake the first annual review of LCSPRs and rapid reviews.
- A frequent criticism of practitioners was that they did not demonstrate 'professional curiosity' – it has become a cliché – but why this happened is under-explored – we need to think more carefully about the reasons why.

THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

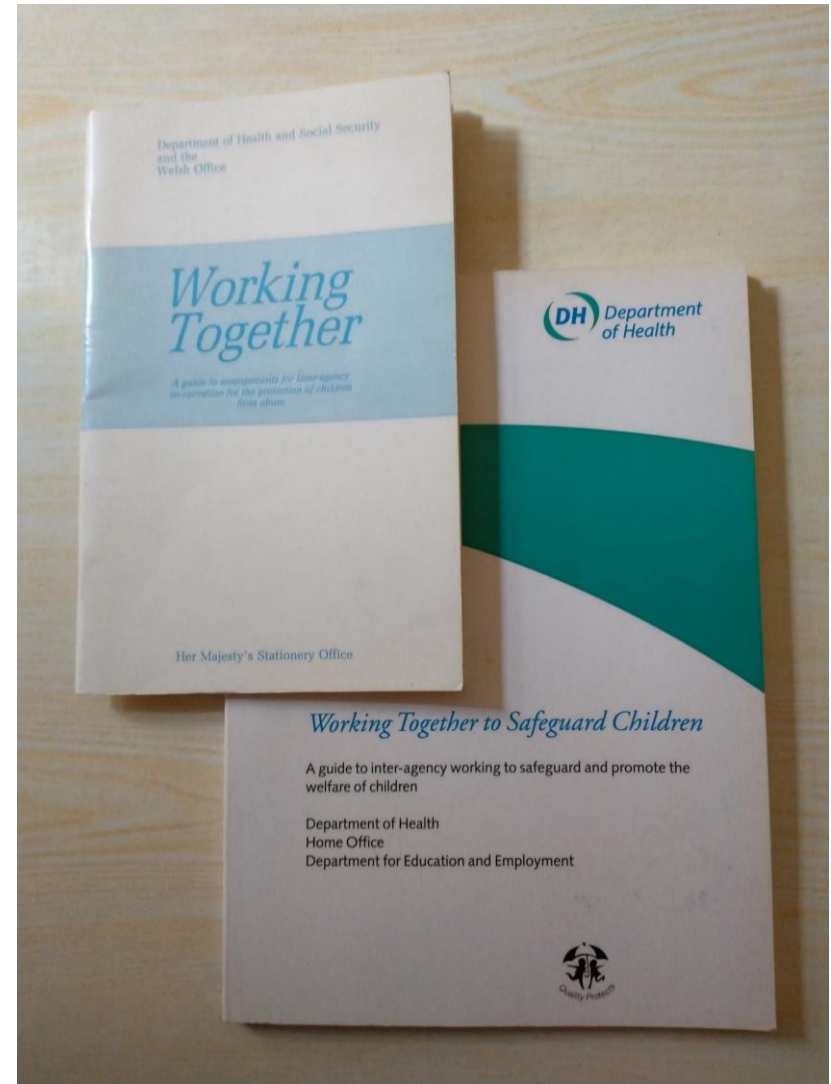
Annual review of LCSPRs and rapid reviews

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Background – a brief history of case reviews

- 1988 *Working Together* introduced ACPCs and the system of case reviews – to reduce the need for the large scale public inquiries of the 1980s.
- 1999 *Working Together* further developed – New Labour – 2000 Assessment Framework, wider focus, emphasis should be on learning, more extensive guidance.
- 2006 *Working Together* – post-Climbié; *Every Child Matters*, CA 2004 ‘duty to co-operate’; introduces LSCBs, ‘Serious Case Reviews’ (2007 Baby Peter – 2 SCR’s!)



- *2011 Munro review* of child protection – recommends a systems approach for better learning: ‘... it explicitly focuses on a deeper understanding of why professionals have acted in the way they have, so that any resulting changes are grounded in practice realities’.
- *2016 Wood review* of the role and functions of LSCBs – concluded SCRs were costly, slow, ‘the recommendations tend to be predictable and/ or banal, unfocussed ... e.g. better information sharing; ... more curious inquiry; do more to engage the young person/family’.

Independent report

Wood review of local safeguarding children boards

Alan Wood’s review into the role that local safeguarding children boards (LSCBs) play in protecting and safeguarding children.

From: [Department for Education](#)

Published 26 May 2016

Applies to: England

Related

[Wood review response](#)

[Multi-agency sharing](#)

[Child development](#)

[Social care safeguarding](#)

[Safeguarding from exploitation](#)

Documents



[Wood report: review of the role and functions of local safeguarding children boards](#)

Ref: DFE-00131-2016
PDF, 1.27MB, 148 pages

Details

The review sets out recommendations for making local safeguarding children boards (LSCBs) more effective.

LSCBs are responsible for improving the overall wellbeing of children in their local-authority area. They include representatives from children’s services,

The new safeguarding architecture – Children and Social Work Act 2017, *Working Together* 2018

- *Child Safeguarding Practice Review Panel*
- *‘Multi-agency safeguarding arrangements’ – local child safeguarding partnerships*
- *Serious incident notifications* – made by LAs when a child has died or is seriously harmed, and abuse or neglect is known or suspected. 5 days.
- *Rapid reviews* for each notification – to gather the facts, ensure immediate action is taken as necessary, consider the potential for learning and decide whether or not to undertake a LCSPR. 15 days. Not published.
- *Local Child Safeguarding Practice Reviews* (LCSPR) – commissioned by the local partnership when there is the potential for further learning to avoid similar incidents occurring in the future. To be written for publication. 6 months.
- *National reviews* – commissioned by the Panel, on complex or national issues.

Building on SCRs

- For SCRs, dissemination was via the reports, plus LSCB annual reports, and a long tradition of overview studies – 8 biennial or triennial reviews commissioned by the government covering reports since 1998; 6 undertaken by teams based at UEA; the most recent in 2020, covering 2014-17.
- The national Panel started on 29 June 2018. LSCBs had until 29 Sept 2019 to move to local partnership arrangements. After this it was no longer possible to initiate SCRs; but there was a 12-month grace period to complete and publish any remaining SCRs.


Serious Case Reviews

research in practice UEA University of East Anglia crcf Centre for Research on Children & Families

Home Social work Safeguarding Partnerships Health Police and criminal justice Education

Resources

SCR Analysis reports 1998-2014

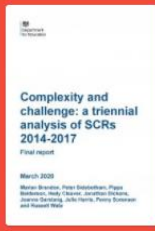


Complexity and challenge: A triennial analysis of serious case reviews 2014-2017 analyses 368 Serious Case Reviews relating to incidents between 1 April 2014 and 31 March 2017. This is the sixth consecutive analysis of SCRs by the Department for Education. Together these reports cover 14 years from 2003-2017.

The Triennial Analysis full report

Download the full report:

[Complexity and challenge: a triennial analysis of SCRs 2014-2017](#)




Complexity and challenge: a triennial analysis of SCRs 2014-2017

Final report

March 2020

Marion Brandon, Peter Brandon, Nigel Brandon, Holly Clark, Jonathan Edwards, Emma Gilling, with Helen, Penny, Sophie and Russell Wade

In this Webinar, Marion Brandon and Peter Brandon introduce key messages from the Complexity and challenge: a triennial analysis of serious case reviews 2014-2017 published by the Department for Education



Webinar objectives

- To be reminded of the model of pathways to harm and pathways to protection in the context of complexity and challenge
- To recognise the key learning arising from this triennial review when working with neglect, poverty and vulnerable adolescents
- To identify opportunities for prevention and protection when working together with other agencies, at the boundaries between services, using none of these language is used, understanding key factors in how the system can support good practice
- To be able to reflect on your own practice in light of the findings of the triennial analysis

Learning from the new reviews

- So, how to capture and disseminate all the learning from the new system?
- The rapid reviews are not published, but LCSPRs should be published on partnership websites (and NSPCC repository), annual reports from the partnerships, an annual report by the Panel, and an annual review of the rapid reviews and LCSPRs.
- In the Panel's 2020 annual report, published May 2021, it says it will start to share data and learning quarterly.

National case review repository

The national case review repository, launched in November 2013, is the most comprehensive collection of case reviews in the UK. It provides a single place for published case reviews to make it easier to access and share learning at a local, regional and national level.

The repository has over 1,500 serious case reviews from England, Scotland and Wales, and thematic analysis reports from all four nations dating back to 1945. The collection also includes case reviews published anonymously on behalf of Safeguarding Children Partnerships.

Our information specialists write abstracts and add keywords to each report in the repository to enable professionals to find case reviews on particular themes and issues.

You can access case review reports via our online Library catalogue. We also hold physical reference copies of all case reviews in the NSPCC Library.

We encourage safeguarding partners in England and their equivalents in the other nations to submit newly published case review reports via information@nspcc.org.uk.

[Search the national case review repository](#)

Learning from case review briefings

Case reviews contain important lessons about how professionals can improve practice to better protect children.

Our information specialists produce and maintain a series of briefings which highlight learning gathered from serious case reviews. The briefings summarise key risk factors, and also include practice recommendations to help practitioners act upon the learning.

First annual review of rapid reviews and LCSPRs

- The UEA and UoB review covered an approx. 25% sample of rapid reviews completed in 2020, and all LCSPRs completed between 1 Oct 2019 and 31 Dec 2020. The DfE brief anticipated about 90 LCSPRs.
- There were 482 notifications in 2020. From June 2018 to end of 2020, 257 LCSPRs were initiated.
- We were supplied with a sample of 135 rapid reviews (81 serious harm, 54 deaths) and 33 LCSPRs (19 harm, 14 deaths). There were 27 pairings.
- This was all the LCSPRs that had been received by the Panel by 31 Jan 2021. Only 15 had been published by March 2021.

Applies to: England

Documents



[Child Safeguarding Practice Review Panel: 2020 annual report](#)

PDF, 907KB, 52 pages



[Child Safeguarding Practice Review Panel: 2020 executive summary](#)

PDF, 183KB, 10 pages



[Annexe: Commissioned review of LCSPRs and rapid reviews](#)

PDF, 621KB, 58 pages

Details

This is the second annual report from the Child Safeguarding Practice Review Panel.

It looks at serious child safeguarding incidents between 1 January and 31 December 2020.

Variable quality of the reviews

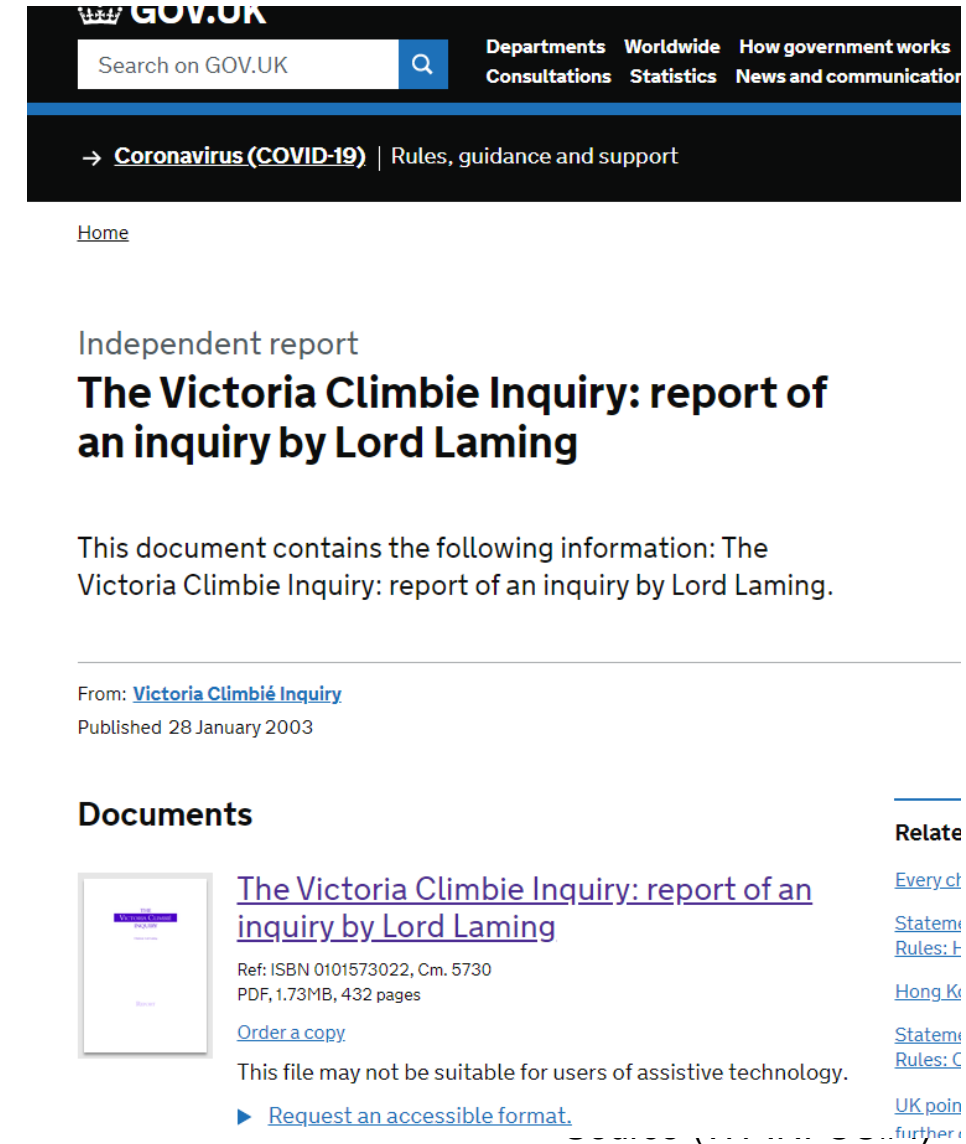
- Some rapid reviews showed good use of local templates, were focused and analytic; but in others, omissions, overly-long, limited reflection and analysis.
- Lack of central guidance on what makes a good LCSPR; the consequence is, they look very much like SCRs. But only 33 – from the first half of the period, and from just 27 partnerships. For nearly all, it was their first one. Our sample is a snapshot of a new system bedding in.
- Wide range of cases, but the well-known problems are often at the heart of them – the same difficulties for the families, similar problems in practice.
- There is some discussion of the challenges of high workloads, lack of specialist services, poor support and supervision, overly-quick case closure.

LCSPRs

- *WT 2018* gives local partnerships some flexibility about calling local reviews – the key question is ‘is there the need for further learning?’, and what is proportionate.
- BUT – notable uncertainty and disagreement about this decision. The Panel’s annual report states that they ‘agreed with 69% of the decisions by partnerships to either initiate or not to initiate an LCSPR’. So in nearly a third of cases the Panel disagreed, usually where the partnership had said ‘no LSCPR’.
- Most LCSPRs did generate further learning, and some were excellent at linking that to specific recommendations for change; but often it was unclear how the changes might come about, or how they would be evaluated. Follow-up studies are needed to see what actions were taken, and how well they worked.
- The Panel plans to hold ‘solution-focused round table discussions’ about the timeliness and quality of reviews.

‘Professional curiosity’

- A regular criticism was of workers showing a lack of ‘professional curiosity’ – e.g. about parents’ drug use, about the behaviour of adolescents, the reasons for non-engagement, children’s views, injuries to a pre-mobile baby, the role of fathers and men in families, and about the needs of children and families from diverse cultures.
- Laming used the phrase ‘respectful uncertainty’ in the Climbié report (2003: 205)
- The term ‘professional curiosity’ appears in the biennial reports on SCRs for the first time in the 2003-05 overview (Brandon et al 2008)



The screenshot shows the GOV.UK website interface. At the top, there is a search bar and navigation links for Departments, Worldwide, How government works, Consultations, Statistics, and News and communication. Below this, a banner for 'Coronavirus (COVID-19)' is visible. The main content area is titled 'Independent report' and features the heading 'The Victoria Climbié Inquiry: report of an inquiry by Lord Laming'. A summary line states: 'This document contains the following information: The Victoria Climbié Inquiry: report of an inquiry by Lord Laming.' Below this, it says 'From: Victoria Climbié Inquiry' and 'Published: 28 January 2003'. A 'Documents' section displays a thumbnail of the report cover, followed by the title 'The Victoria Climbié Inquiry: report of an inquiry by Lord Laming', the reference 'Ref: ISBN 0101573022, Cm. 5730', and the format 'PDF, 1.73MB, 432 pages'. There are links for 'Order a copy' and 'Request an accessible format'. On the right side, there is a 'Related' section with links to 'Every child matters', 'Statement of findings', 'Rules of procedure', 'Hong Kong', 'Statement of findings', 'Rules of procedure', and 'UK point of contact'.

On the other hand

- ‘Chief social worker for children and families Isabelle Trowler said the care review offers a chance for a “completely new offer for children and families” that is more generous and leaves fewer feeling “persecuted and unsupported”.’
- “Why don’t we design our service responses to family difficulty based on the belief that most people most of the time want to do the right thing for children? Shouldn’t we start from a position of trust and work from there?”

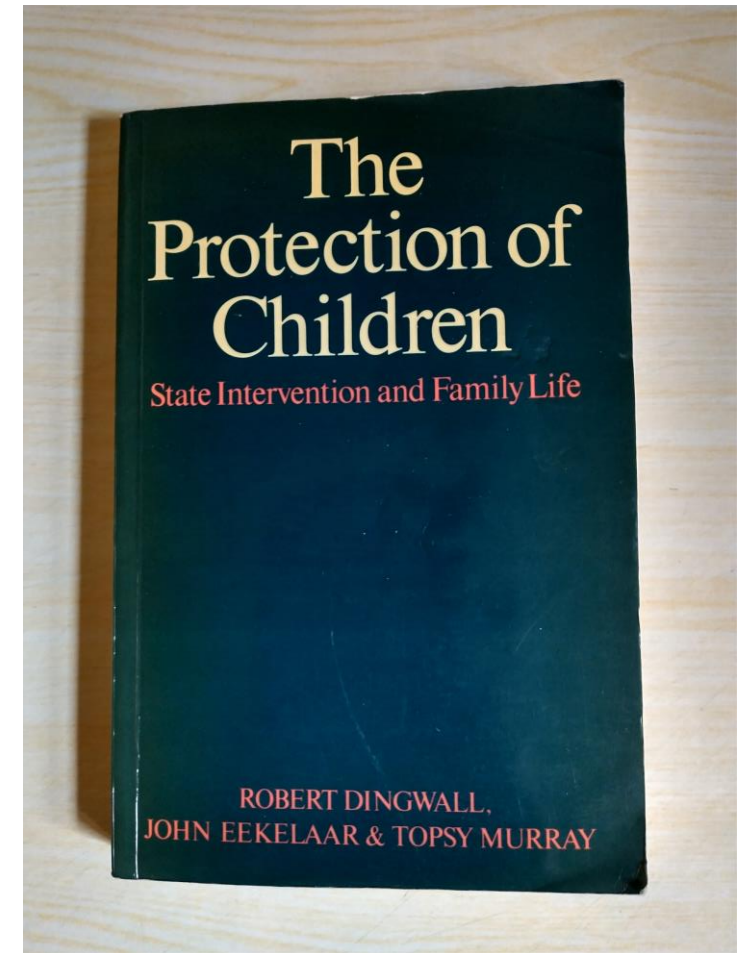


A 'two-edged sword'...

- ... it is evident there has been long-term neglect in this family, but circumstances appear to have significantly deteriorated Until the recent anonymous referrals there has been no contact with agencies that triggered concerns for safeguarding. ... What is clear, based on the current information, is that professionals could have been more curious and challenging to parents about the reasons for non-engagement.
-the core purpose of our front-line practitioners is to be able to develop significant and authentic relationships with those with whom they are working and then be able to use those relationships to help drive change and improve safety for those at risk. If that is accepted, then it follows that to do that effectively, being curious and asking the second question is what we expect of all our practitioners.

Why ought we to be curious about ‘professional curiosity’?

- Individualised – we need to take account of occupational and organisational dimensions
- Decontextualised – multiple work pressures and imperatives – and beyond that, social and policy forces – the ‘rule of optimism’
- These are the ‘hard cases’, and only now do we have the benefit of hindsight
- The reviews don't do it themselves! It has become a cliché that hinders analysis
- Why don't they ask the second question?



Let's be more curious about professional curiosity

‘We need to question and challenge ourselves when we talk about issues such as poor ‘risk assessment’, ‘disguised compliance’ and weak ‘professional curiosity’, thinking carefully what we mean and why these issues are coming about. The Panel is prioritising addressing some of these perennial problems in its 2021 to 2022 work programme.’

- *Recognise the ambiguities and subtlety of ‘professional curiosity’*
- *Recognise that curiosity has to extend to organisational and policy actions / inactions*

THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Annual Report 2020

Patterns in practice, key messages
and 2021 work programme