crcf Centre for Research on Children & Families

University of East Anglia

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

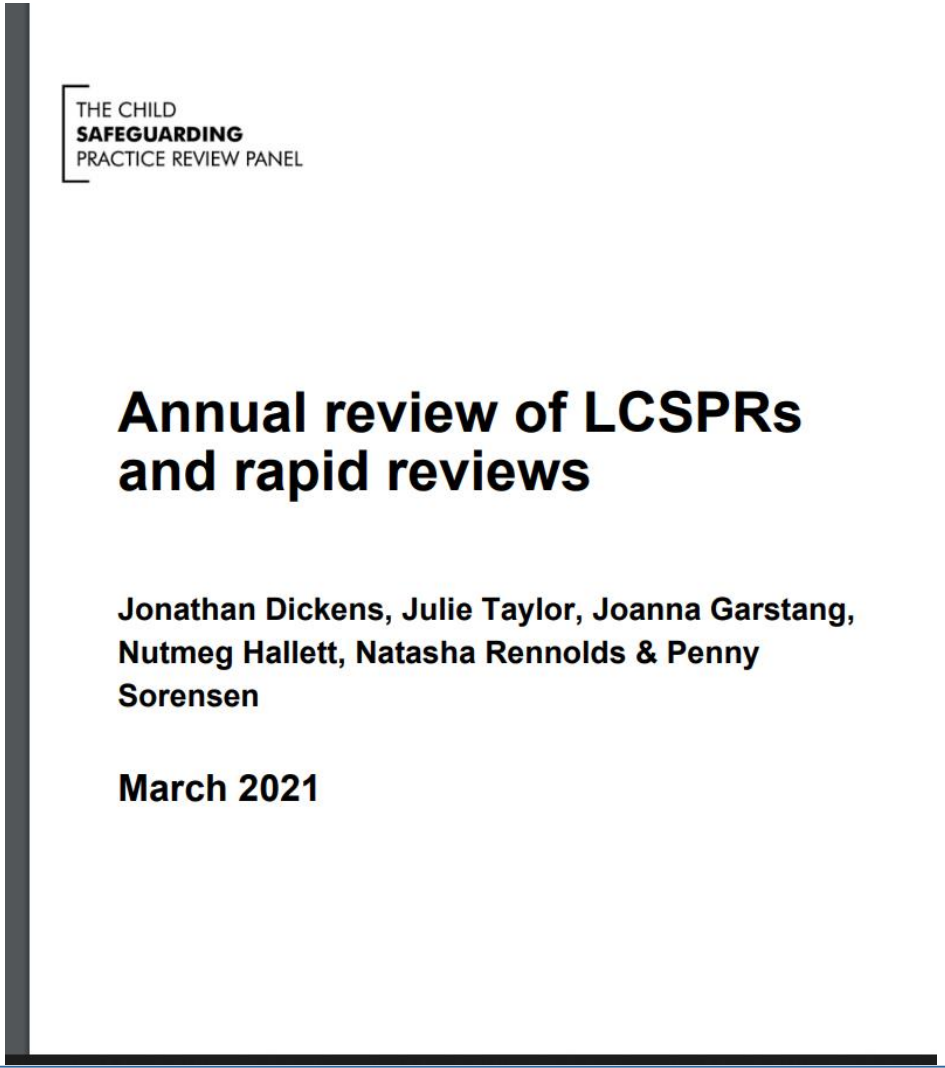
Prof Jonathan Dickens

School of Social Work, University of East Anglia

Drawing on research with Dr Penny Sorensen at UEA and colleagues at the University of Birmingham: Prof Julie Taylor, Dr Joanna Garstang, Dr Nutmeg Hallett

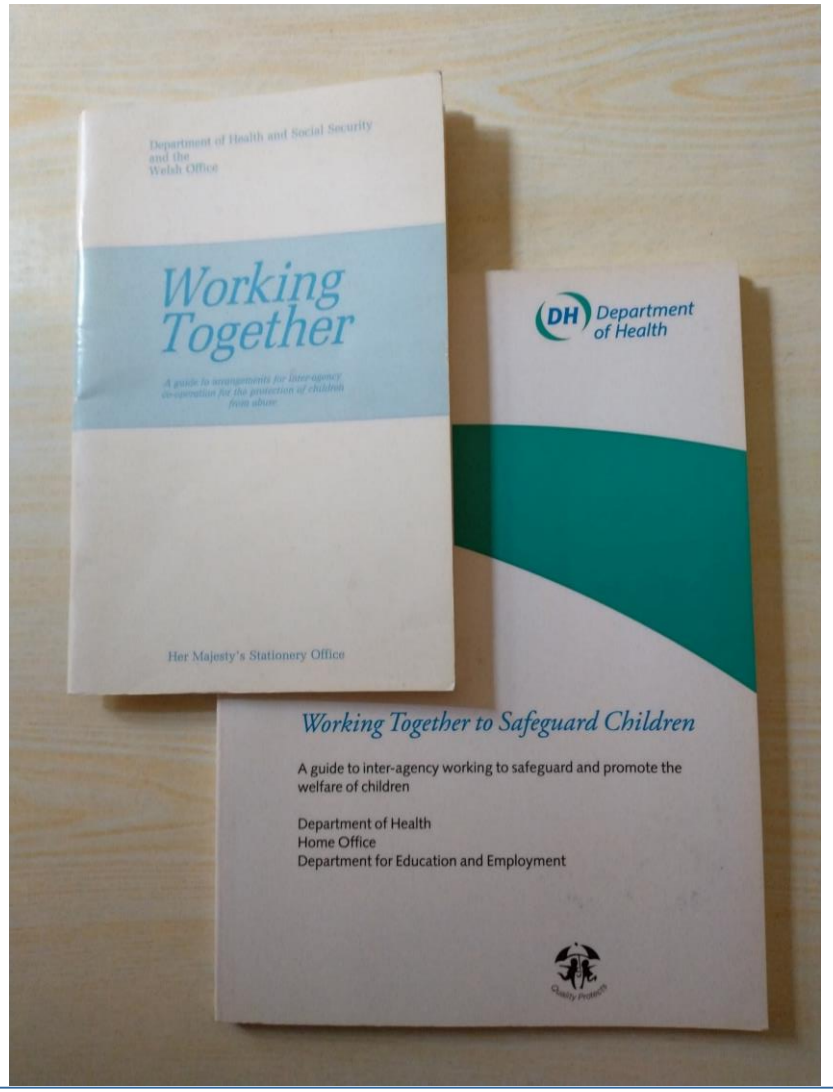
Introduction

- 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.

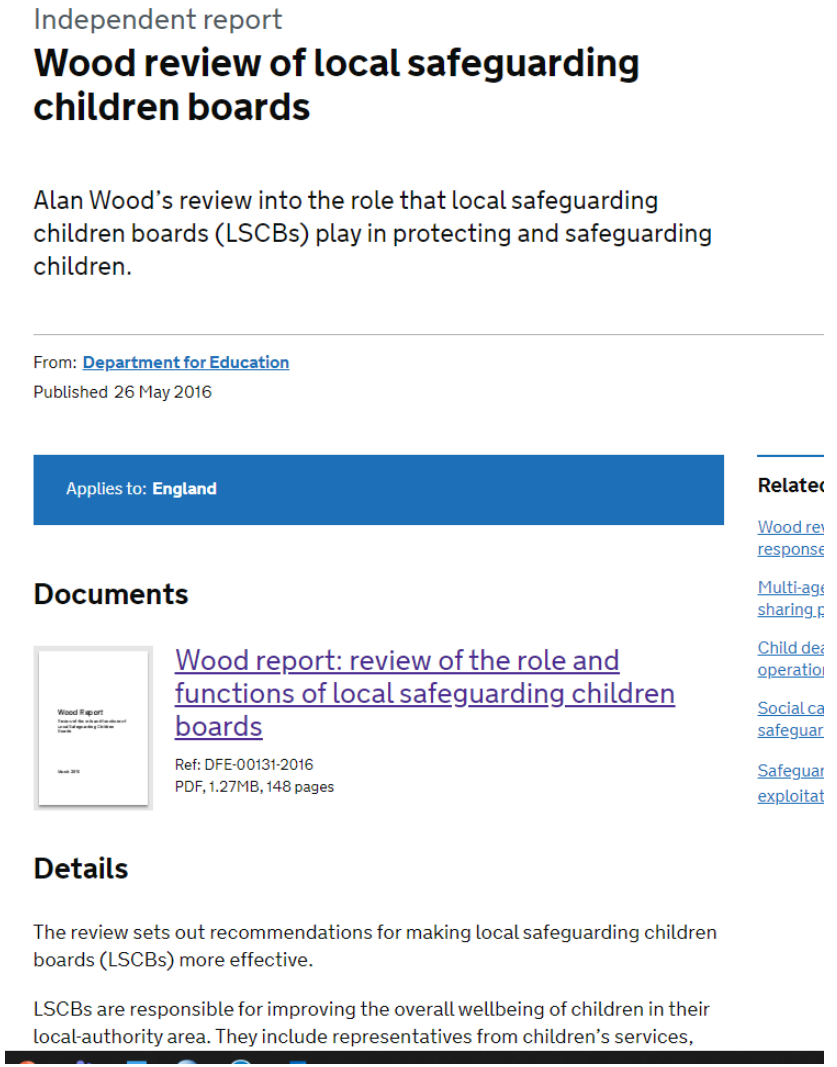


Background – a brief history of case reviews

- 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 SCRs!)



- *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**

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.

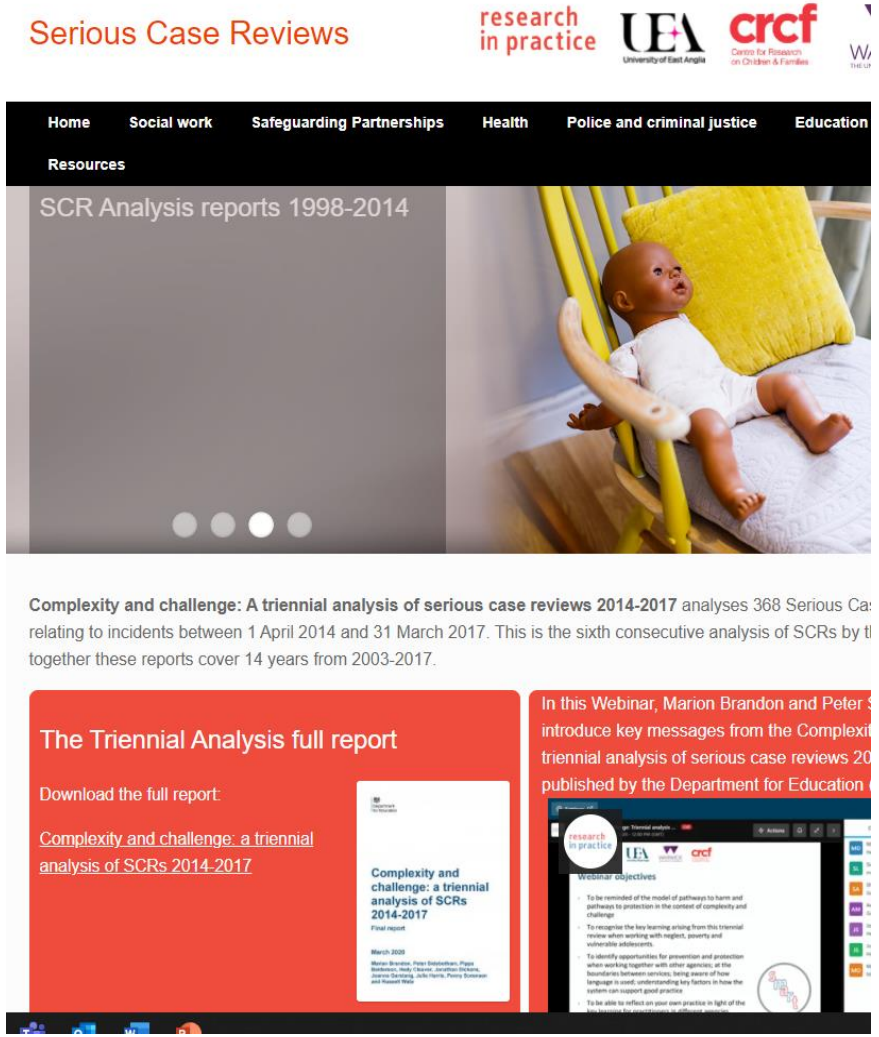
LSCBs are responsible for improving the overall wellbeing of children in their local-authority area. They include representatives from children's services,

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.

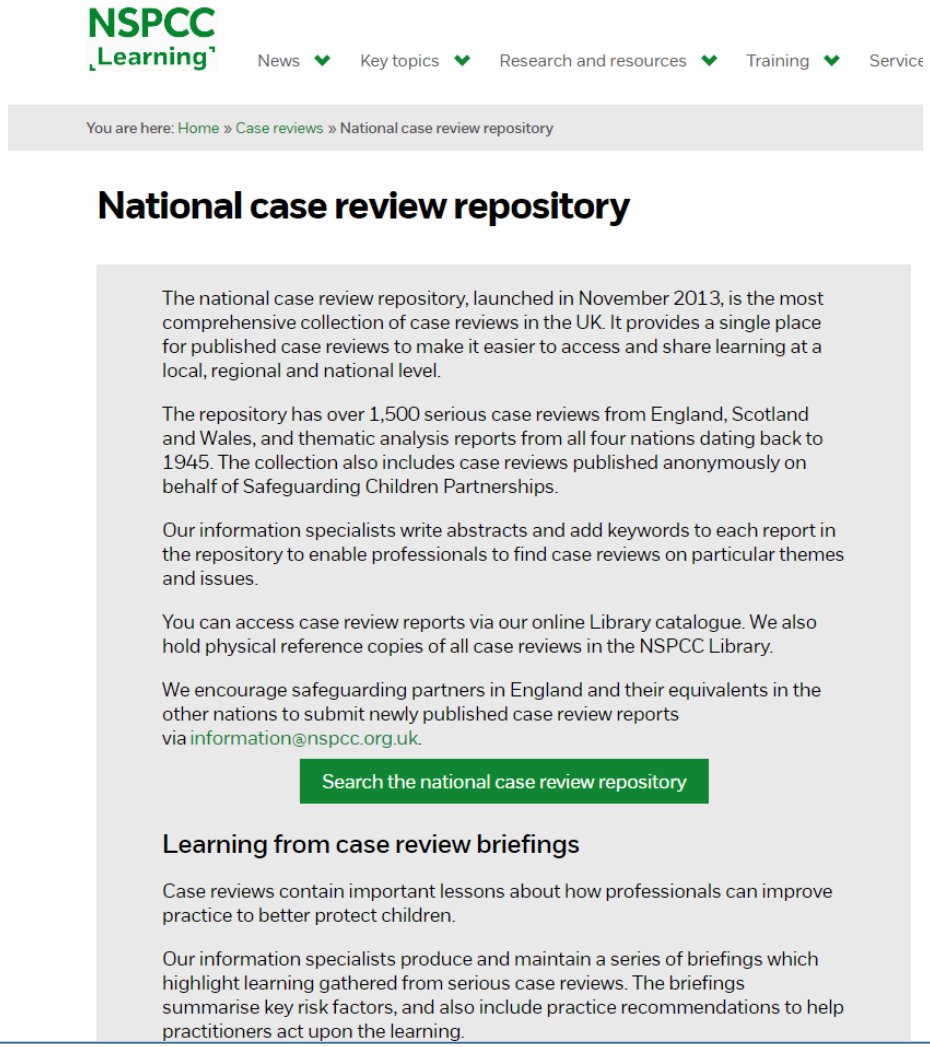
Building on SCRs

- 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.



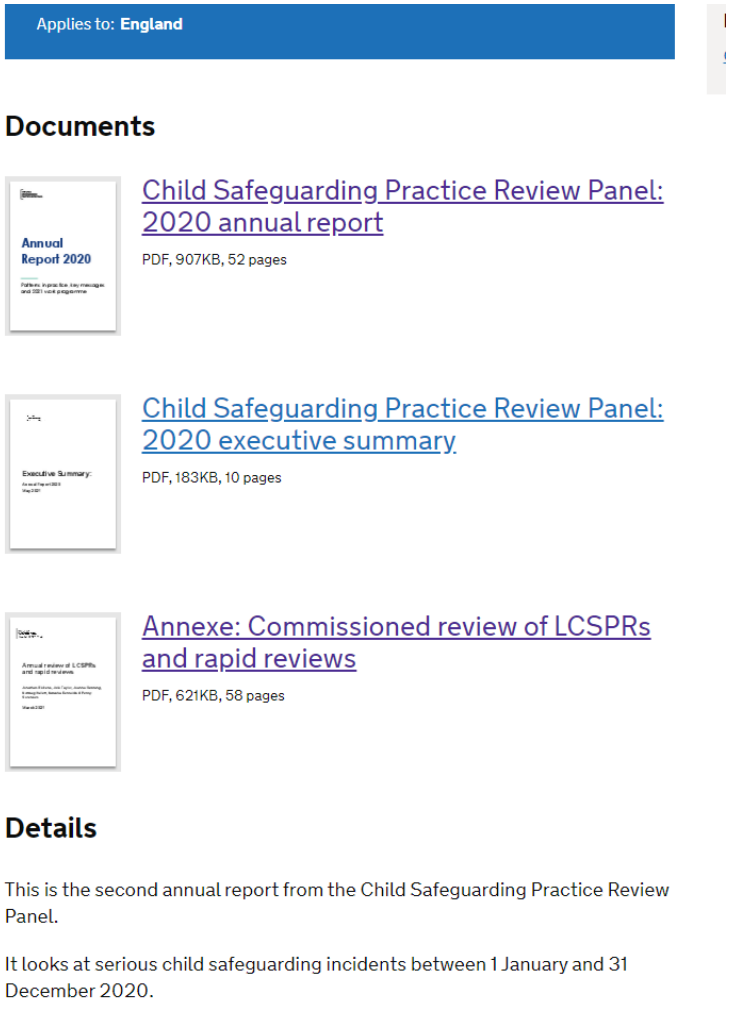
Learning from the new reviews

- 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.



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

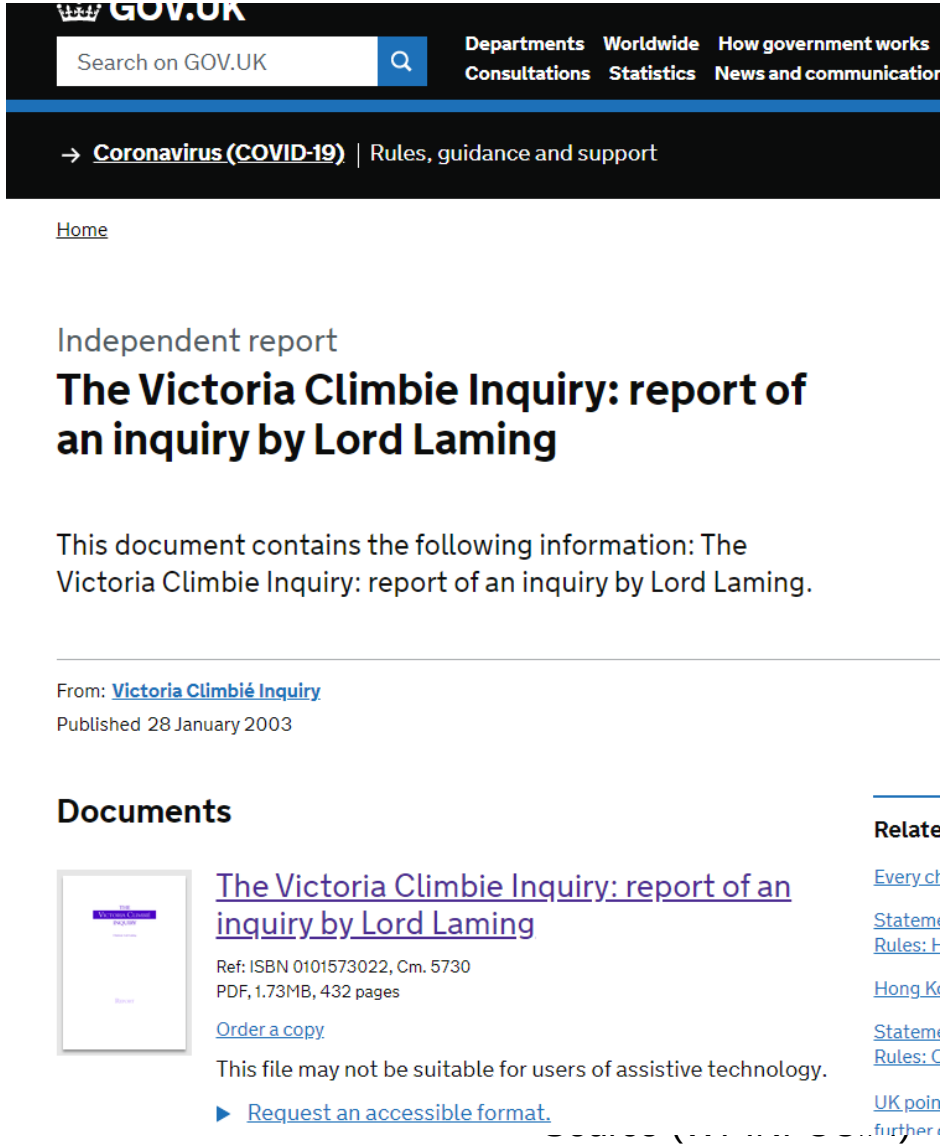
- Some rapid reviews showed good use of local templates, were focused and analytic; but in others, omissions, overly-long, limited reflection and analysis.
- Lack of central guidance on what makes a good LCSPR; the consequence is, they look very much like SCRs. But only 33 – from the first half of the 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)



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?”

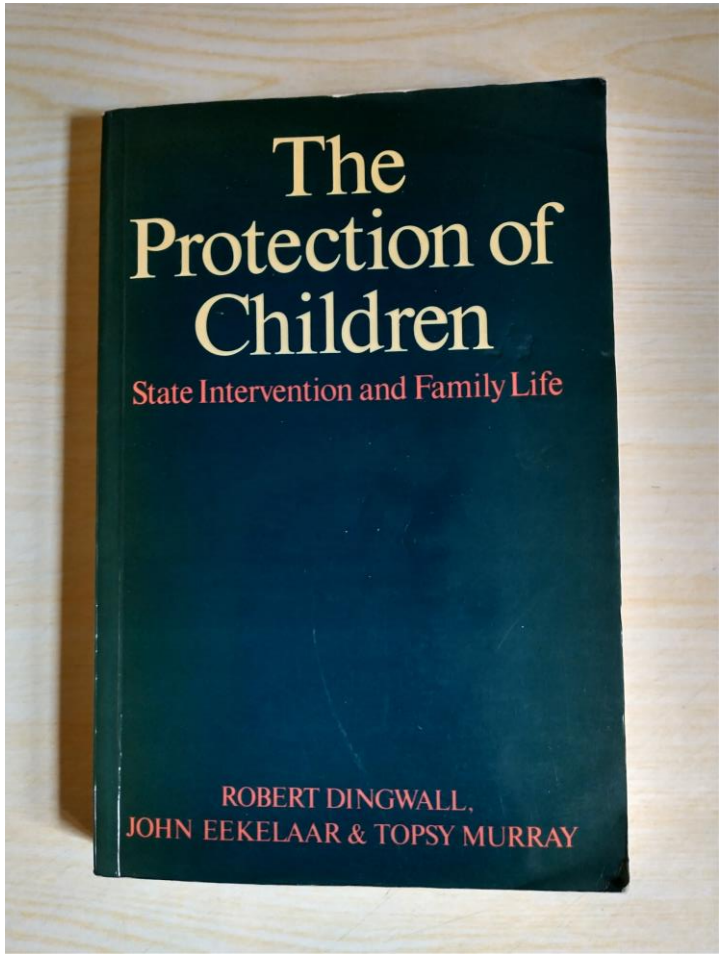
A ‘two-edged sword’…

- … 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*