CKITT
INVESTIGATION & TRAINING

Professional Curiosity ?

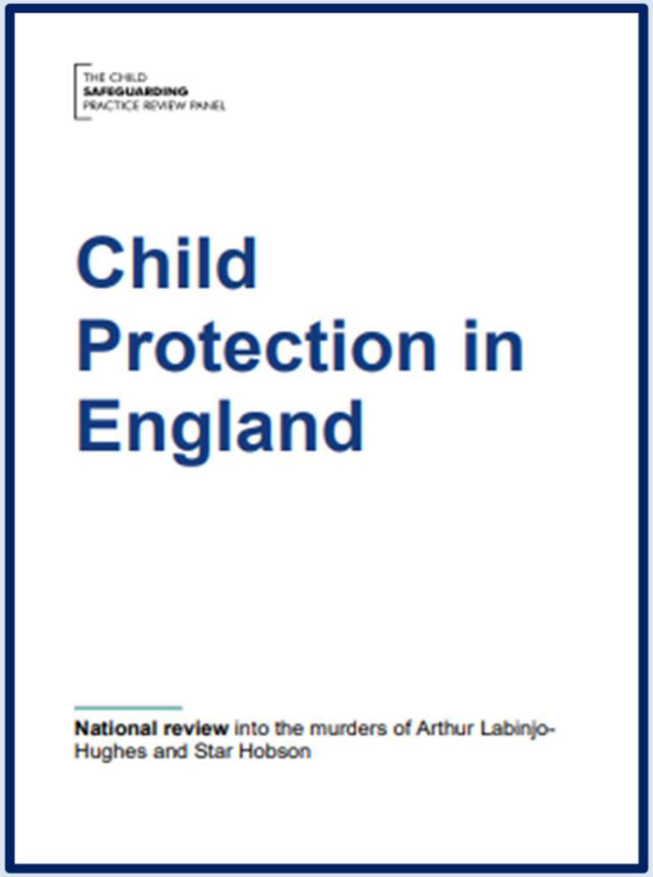
Learning Outcomes

- Professional Curiosity ?
- Barriers to Professional Curiosity?
- Potential impact(s) Lack of Professional Curiosity?
- The What, The Why & The How – Increase Confidence

What is Professional Curiosity?

‘Professional Curiosity is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value’

Resources



South Gloucestershire Children's Partnership
Learning from Rapid Review
April 2021
Family D

The Children's Partnership held a multi agency rapid review to look for learning on 26th April 2021.

Who are Family D?
Family D are a mum and two children. It has been widely reported in the media that mum and the youngest child were murdered in Scotland, and the older child survived. This learning brief does not relate to the investigation into what happened in any way, but looks simply at learning for professionals and organisations

Professionals from 15 different agencies took part in the review

Theme One: Professional Curiosity
What did we learn?
- Information taken at face value
- Process driven work without looking at wider picture
- Not enough consideration given about ways to contact a parent when details are not on the system
- Lack of curiosity shown when exploring the vulnerability of an adult

What should we do differently?
- Ask further questions, be nosy, explore what is happening. Be careful not to simply accept what is happening without thinking about why it is happening
- Make sure you hear the voice of the child and all key people in the child's life, don't rely on one person's view
- Explore what a day in the life of the person you are working with is like

If my work comes to an end – who else needs to know what I know?

When English is not the first language, always consider use of interpreters

Seek evidence of Parental Responsibility

Be a curious practitioner

Theme Two: Working Together
What did we learn?
- Not all professionals knew who else was involved and didn't know about the Child in Need plan
- The professionals who saw the family most, had the least contact with other organisations
- Information was not shared as well as it could have been

What should we do differently?
- If you undertake an assessment think about who else should be told of the outcome, and who needs this noted in records
- At a transition point – for example changing school, closing a support package, change of team or service. Make sure other professionals know what is happening and share safeguarding records so that information is not lost
- Speak to families about who else they are working with

Theme Three: Parental Responsibility
What did we Learn?
- Evidence was not always sought to check who does and does not have Parental Responsibility (PR) for a child

What should we do differently?
- Make sure this is routine practice, and that confirmation of PR is always seen

Evidence of Good Practice
- Speedy assessment by Social Care, and quick practical support
- Swift move to locality social work team.
- Appropriate DVA coding on GP records for the family
- Good communication and relationships with education settings
- Additional resources, including a laptop, provided for home learning during covid
- Support for immigration status
- Regular contact from multiple agencies
- Good communication between agencies when unable to make contact
- Good multi agency response to missing episode

Theme Four: Children and Domestic Abuse
What did we learn?
- Two children left the home with their mother and were provided with emergency accommodation following a disclosure of domestic abuse, but there were other children in the home who remained.
- The remaining children were not considered by police or subsequently by children's social care despite living in the same house and witnessing the same incident.
- Lack of voice for mum in family court process

What should we do differently?
- Consider the impact of domestic abuse on all children within the family.
- Remain curious even when another agency has already made an assessment of risk
- Ensure all appropriate information is available to court, especially relevant while case are being heard in a virtual space and ensure parents are aware when the case is happening

What is happening Now?
There is a single agency and a multi agency action plan to ensure the learning identified throughout this process is acted on in a timely manner. This is being monitored by the Child Safeguarding Practice Review Sub group on behalf of the Executive of the Children's Partnership.

South Gloucestershire Children's Partnership
Child Safeguarding Practice Review
Family A
January 2023

The Children's Partnership commissioned Nicki Pettitt, an independent reviewer to lead this CSPR

Professionals from all of the involved agencies took part in the review

Members of the family also contributed their views to the CSPR

Family A
The South Gloucestershire Children's Partnership agreed to undertake a Child Safeguarding Practice Review (CSPR) by considering the engagement of professionals with a family of three children who are anonymised as Family A.
When the children were under 5 years old, their father died and their mother has been convicted of his murder. At the time of their father's death, the children were on child protection plans and a decision had been made to implement the Public Law Outline due to concerns about domestic abuse, the impact on the children of the parent's poor mental health and substance misuse, and the emotional neglect of the children.

Recommendations
1. SGSCP considers the practice briefing on safeguarding children in families where there is domestic abuse that was commissioned following the National CSPR 'Child Protection in England' to align learning
2.Consider the learning from this CSPR in the review of Domestic Abuse Training that is underway
3.All agencies review paperwork to ensure all GPs for the family are recorded and that relevant information is shared with them all
4. Partner agencies provide assurance regarding what they are doing to promote the Domestic Abuse Act 2021 in respect of children as victims of domestic abuse
5. Consider making 'including fathers as equal parents' a priority for 2023 onwards
6. Share this CSPR with Safeguarding Adults Board and Community Safety Partnership with a view to considering commissioning of services for lower level perpetrators of Domestic Abuse
7. Information about orders or plans in respect of Domestic Abuse (e.g. MARAC and DVPOs) are shared with all professionals working with children in the family, and that the MARAC plan and any plan/s for the children reflect and compliment each other
8. SGCP considers how it can ensure that professionals in all partner agencies are aware of the responsibilities for and services available to care leavers

Theme: Working with Fathers
- Fathers need to be fully considered in assessments and plans
- There is routine questioning for women about Domestic Abuse, but this doesn't happen for men
- There were opportunities for improved professional curiosity about Domestic Abuse in respect of Father in this case

Theme: Full understanding of family history is needed for an assessment:
- Impact of childhood trauma needs to be considered in assessment by any agency.
- Practitioners need to be curious about multiple presentations and what lies behind this and not treat incidents in isolation
- Vulnerabilities need to be explored, mental health, drug or alcohol misuse, domestic abuse, being a care leaver

Theme: Domestic Abuse
- Making assumptions about who is the victim and who is the perpetrator in a family can lead to ineffective plans
- When there are claims and counter claims it is vital to unpick 'who does what to who'
- Understanding the power dynamic is crucial
- Building a good relationship - trust is key to effective working

Theme: Remain child centred when there are dominating parental factors
- Consider what a day in the life of this child is like
- Be aware that a child's behaviour may be their 'voice'
- Recognise and challenge child blaming language

Click here to see resources about Domestic Abuse and links to MARAC

Couples in an abusive relationship sometimes decide not to separate and safety planning needs to happen

The policy of separate and isolate does not always work

Evidence of Good Practice
- The Transitions team are providing Freedom Programme work with a group of care leavers as a preventative measure. This is good practice and consideration should be given to widening this approach
- Parent Link worker at the school has been consistent and attended core group meetings and had regular check-ins with the child at school and continues to do this now
- Support is available to care leavers until the age of 25, and this is good practice and responsible corporate parenting

Mother told the review that the requirement to separate from her partner meant she had to be secretive and could then not ask for help or be honest with professionals in case she would 'lose' her children

You can read the full CSPR Family A by clicking here

South Gloucestershire Safeguarding Adults Board
Practitioner Learning Brief
Learning Review/DHR: Family S November 2020

Background Summary

Mr S* was in his early 60s when he died in 2019 and Miss S* from the same family died later in the same year in her late 30s.
A joint review took place to learn from what had happened for both adults. The element of the review about Miss S was a Domestic Homicide Review (DHR) Both Mr S and Miss S spent time in two different parts of the country together and so both regions took part in this review. The review was complex and the chronology contained over 1500 entries from agencies across both local authorities. This learning brief aims to share the key themes and learning identified.

*Names and identifying features have been changed to protect the identity of the family

Learning

18 agencies across 2 LAs took part in the review

The relationship between Mr S and Miss S was not a healthy one, at best co-dependent and at worst, controlling & abusive

Key Finding: Person centred work is critical

Themes for learning identified:

- Violence, Abuse and Exploitation
- Housing
- Engagement
- Safeguarding and Risk Management
- Professional Curiosity and Challenge
- Interagency Working

Miss S experienced repeated patterns of physical and sexual abuse and exploitation from a number of men including when she was a child and young adult. There are examples of Miss S being both a victim and a perpetrator of violence and abuse

Concerns were raised about Mr S potentially being a victim of financial abuse by Miss S

Good Practice identified:

- Continuous joint work to hold and manage risk
- Comprehensive and detailed safeguarding referrals
- Holistic, assertive, person centred approach taken with Miss S
- Attempts by one organisation to refer into links in another local authority when Miss S and Mr S moved from one place to another.

This work was not person dependent as different roles in each organisation worked with Miss S therefore the network and practice was embedded in the culture of the organisations.

Cross-boundary communication between Police Forces for investigations, arrests and concerns for welfare was, on the whole, timely and targeted

A good knowledge and understanding of domestic abuse (including financial abuse) and sexual violence and exploitation amongst practitioners

Sirona provided an effective, timely and comprehensive service to Mr S, the parallel organisation in the other LA was well organised but work was frustrated by continual moves

Engagement

Assertive Outreach proved the most effective method to reach complex families: This approach includes:

- Relationship building. Investing time in getting to know an individual, obtaining trust/respect and understanding triggers and behaviours in order to formulate a targeted response and make meaningful interventions;
- Assertiveness/Persistence. Proactively tracking her down and engaging, keeping in touch, going to where the individual is, sourcing options to meet needs, rethinking and representing options/approaches if they didn't work first time;
- Staying alongside/advocacy. Accompanying an individual to significant meetings when they would not otherwise attend and discussing and representing her needs to other agencies
- Proactive and pre-emptive. Working with others to anticipate risk and behaviours and identify solutions and responses

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The full review has not been published to protect the identity of the family

Mental Capacity

Mental capacity became a barrier to exercising professional curiosity for Mr S. Practitioners listened and respected his views and rights, but the issue of capacity prevented relationship building with him. Good practice in assessing mental capacity sits in a developed relationship with an individual, and this was never established with Mr S

Think Family

There were opportunities missed to adopt a whole family approach to safeguarding that would have established a fuller understanding of needs and risk (present and future) and enabled Mr S, Miss S and the children to be the subject of a joint, coordinated approach by Adult Social Care and Children's Services. Mr S, Miss S and the children's needs were responded to separately even though the welfare of all were clearly linked.

Information was taken at face value by practitioners who failed to recognise and factor in the complexity of their relationship. Without the bigger picture relating to Mr S and Miss S at the forefront of decision making and practice, the system response was to individuals and their needs in isolation.

Housing

The review found that securing accommodation was deemed a prerequisite to establish the stability and safety necessary to allow agencies to address Miss S's underlying trauma, experiences of abuse and alcoholism whilst at the same time these were the very issues which prevented her from sustaining any type of housing. There is a lack of accommodation available for vulnerable women with multiple and complex needs

Hearing the Voice of Mr S

Miss S often spoke for Mr S both in discussions with agencies in respect of his medical condition and in respect of wider decisions about his care. Efforts were made to speak to Mr S without her being present but are not able to do this for any sustained, meaningful period of time. There are few records of him engaging independently

Miss S was involved with 20 different agencies which she said was overwhelming

Moving between two counties impacted on the continuity of services and levels of engagement as well as the degree to which people could build a relationship with Mr S

There has been excellent cooperation with this review from the partner agencies in both areas, which was essential in establishing the learning from this case

Although Domestic Abuse was well understood there was less consideration for Coercive Control

You can book training about Coercive Control by clicking this circle

Training about Mental Capacity is available by clicking this link

Complexity and Risk

Co-occurrence of mental health, substance abuse and domestic violence and abuse are a common presentation. Agencies need to find ways to work collaboratively to address this complex combination of needs rather than expect the individual to cease/manage a behaviour before they can receive support.

The review found a lack of clear recording in respect of the steps taken to explore the issues in respect of safeguarding. This had a number of consequences: It prevented a more coordinated approach being adopted from the outset, resulted in a lack of a shared approach to risk assessment and management and an absence of clarity in terms of roles and responsibilities.

Including Families

Within the safeguarding process there should be an opportunity to bring together the individual, their family and other agencies who have involvement to produce a clear plan of what is trying to be achieved and to agree a shared understanding of risk. Family members are usually best placed in knowing the individual and can provide a valuable perspective to planning and decision making relating to support and management of risk. This was missing for the family in this review.

Action Planning

Although this learning Review/Domestic Homicide Review has not been published the Safeguarding Adults Board has an action plan to monitor the implementation of the recommendations.

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What Makes a Professionally Curious Practitioner? - KUSAB

Knowledge

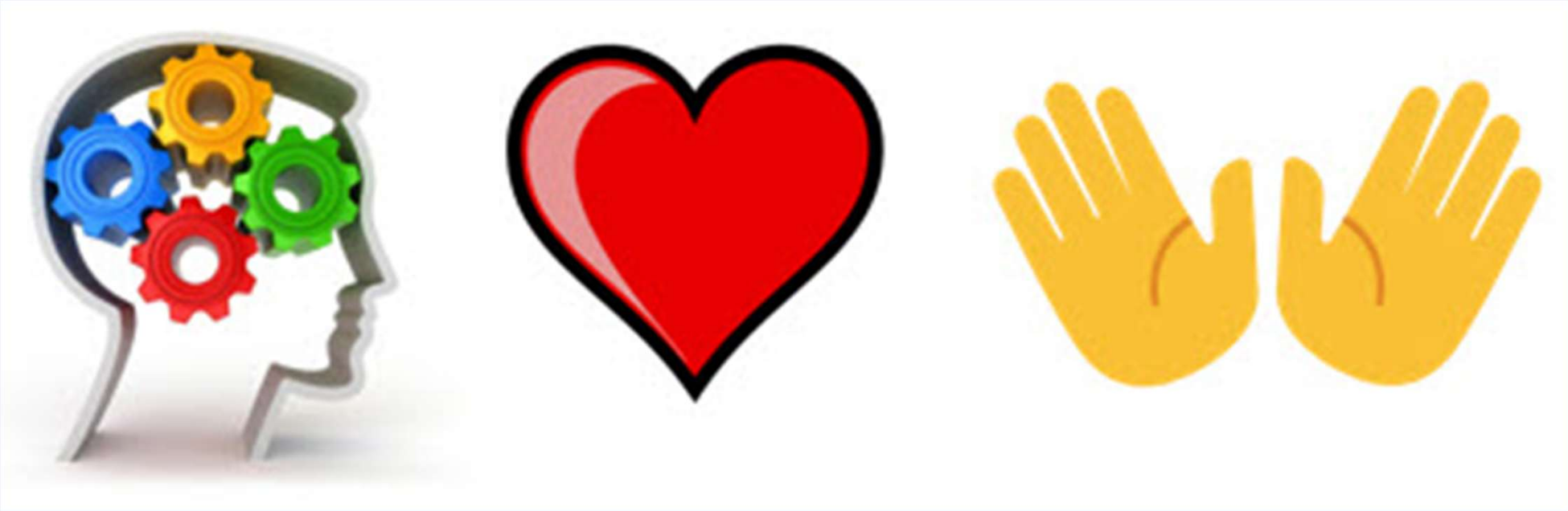
Understanding

Skills

Attitudes

Behaviours

Whole Self – Head Heart Hands !



What you know
What you don't know

Having the desire to
explore and discover

Develop the skills you need

What is Professional Curiosity?

‘Thinking the Unthinkable’

What is Professional Curiosity?

‘Respectful Uncertainty’

What is Professional Curiosity?

‘I Wonder Why?’

What is Professional Curiosity?

‘Respectfully Nosey?’

What is Professional Curiosity?

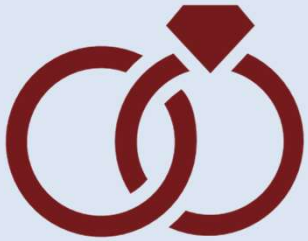
‘Healthy Scepticism?’

Barriers to Professional Curiosity ?

Time Constraints

Knowledge

Partnership Working & Rule of Optimism



Engagement & Disguised Compliance

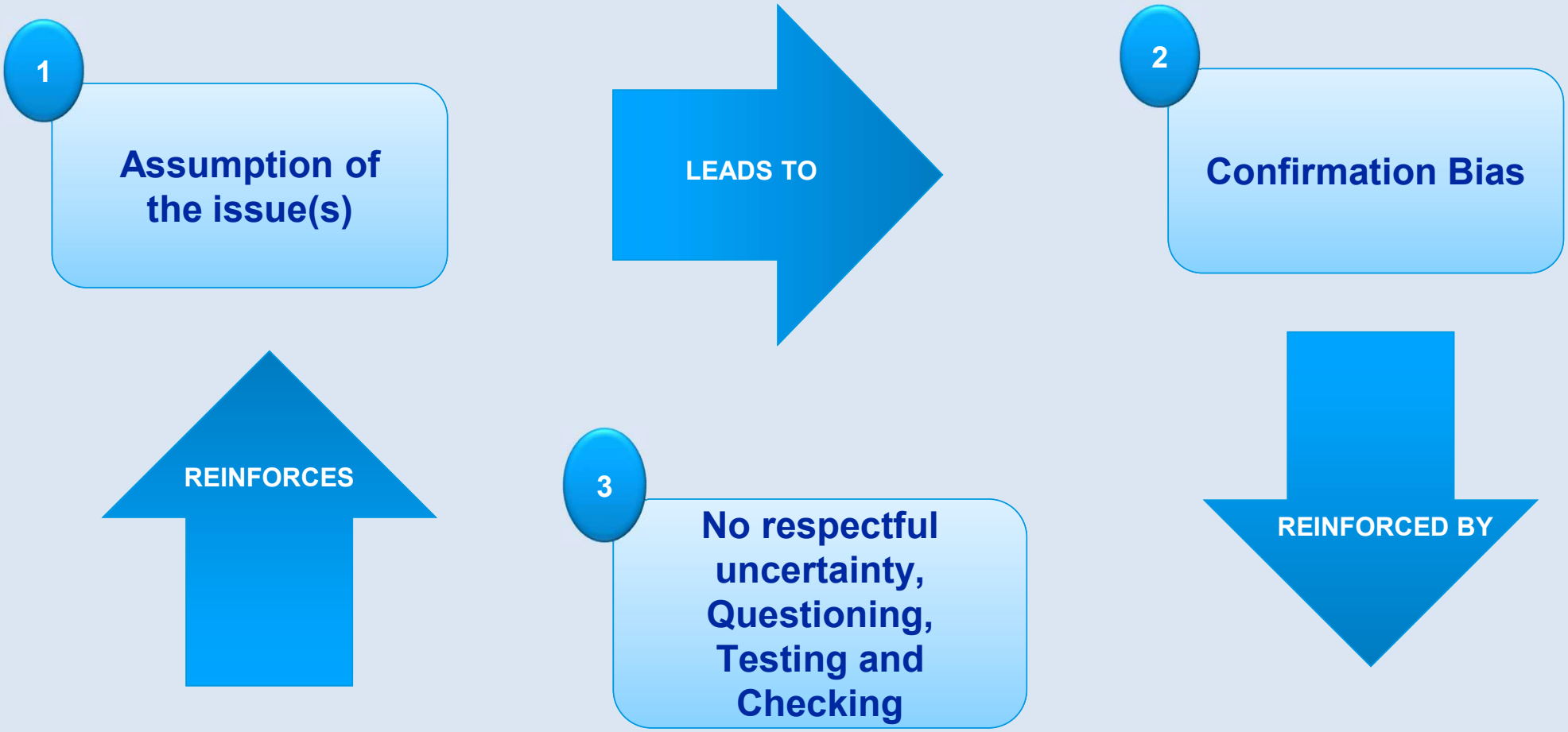
Skills & Self Awareness

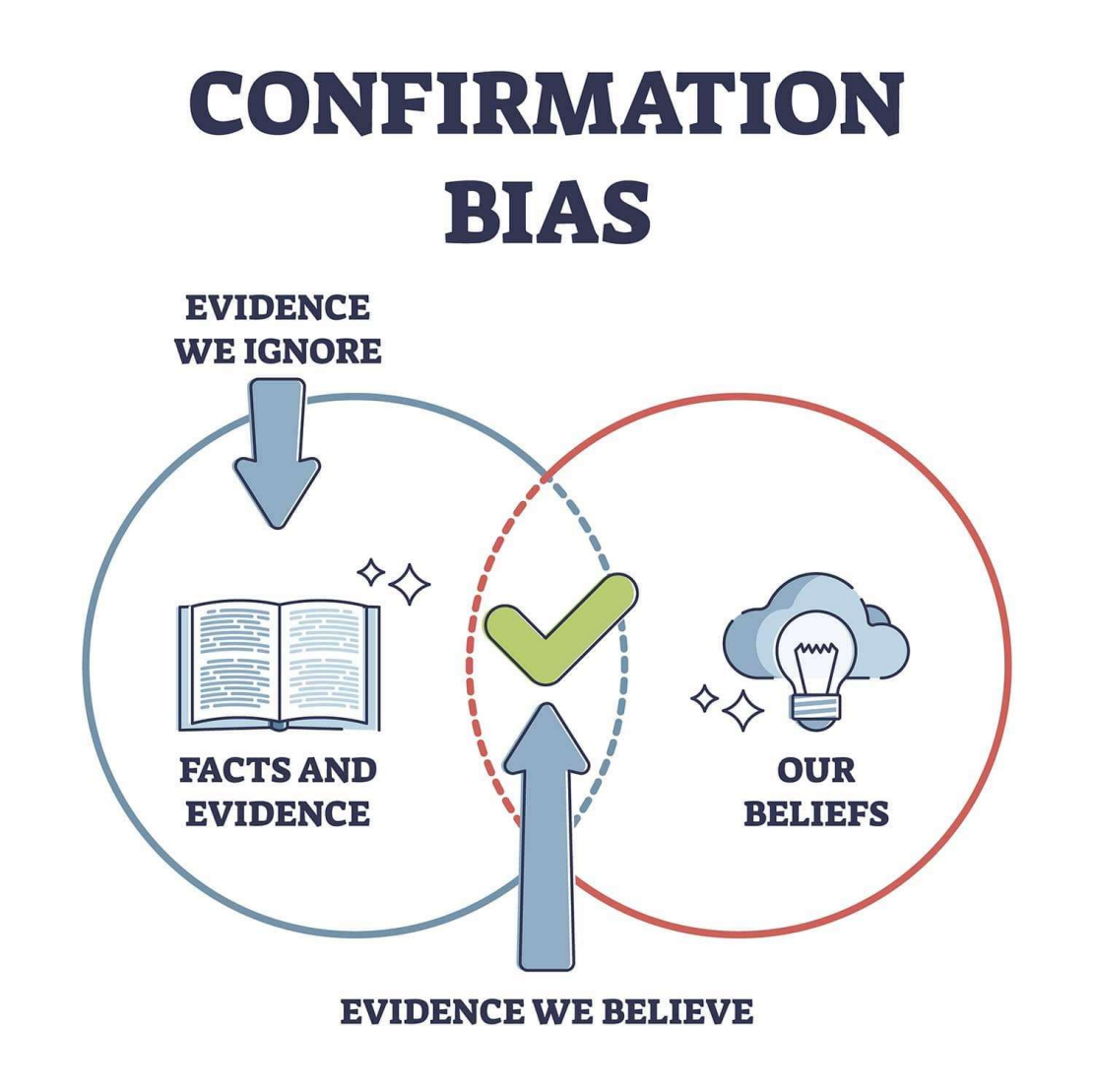
Understanding Risk & Professional Difference

‘Confirmation Bias’

Aka – ‘Case Theory’

(We just can’t help ourselves!)



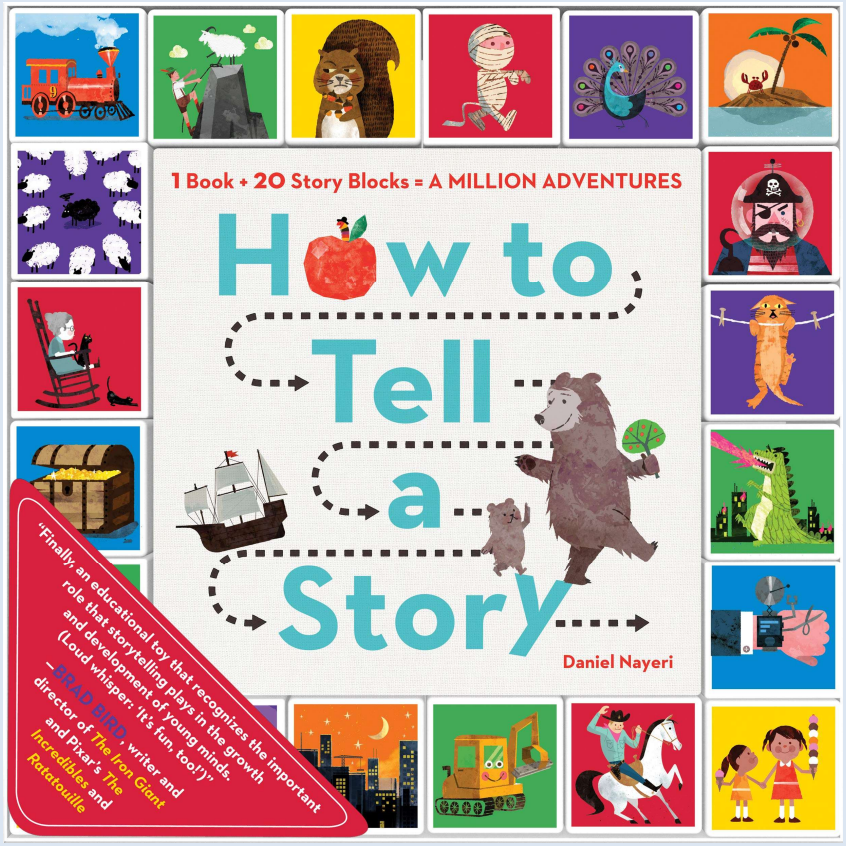


Assume Nothing!

Believe Nothing!

Check Everything!

Moving Beyond Story Telling !

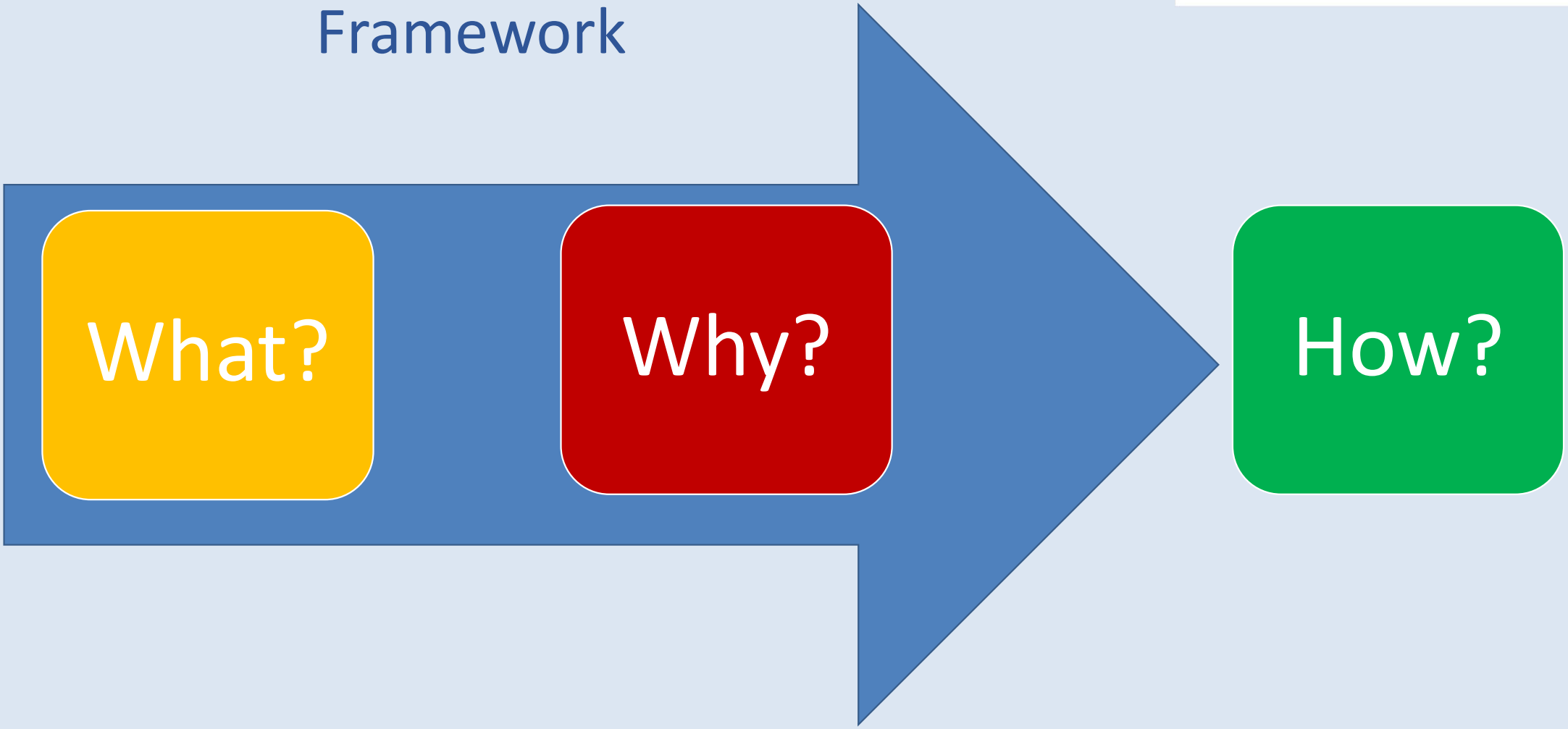


Think about it, stories have a lot of…

- What happened
- Where it happened
- When it happened
- Who was there

But not a lot about…. Why? & How?

The What? Why? How? Framework



Professional Curiosity is…

- Looking
- Listening
- Asking
- Checking

Top Tips

See It

Hear It

Explore It

Check It

Look

See It

- Is there anything which prompts questions or makes you feel uneasy?
- Indicative behaviour?
- Support or contradict?

Listen

Hear It

- Does something need further clarification?
- Are you concerned about what you hear family members say to each other?
- Is someone trying to tell you something but finding it difficult?

Ask

- What questions could you ask to help understand vulnerability?

Explore It

- ✓ How do you spend your day?
- ✓ Who do you live with?
- ✓ Who is with you?
- ✓ When were you last happy?
- ✓ When do you feel safe?
- ✓ What do you look forward to?
- ✓ Why are you not at school?
- ✓ What stopped you going to the appointment?

Test it

Check It

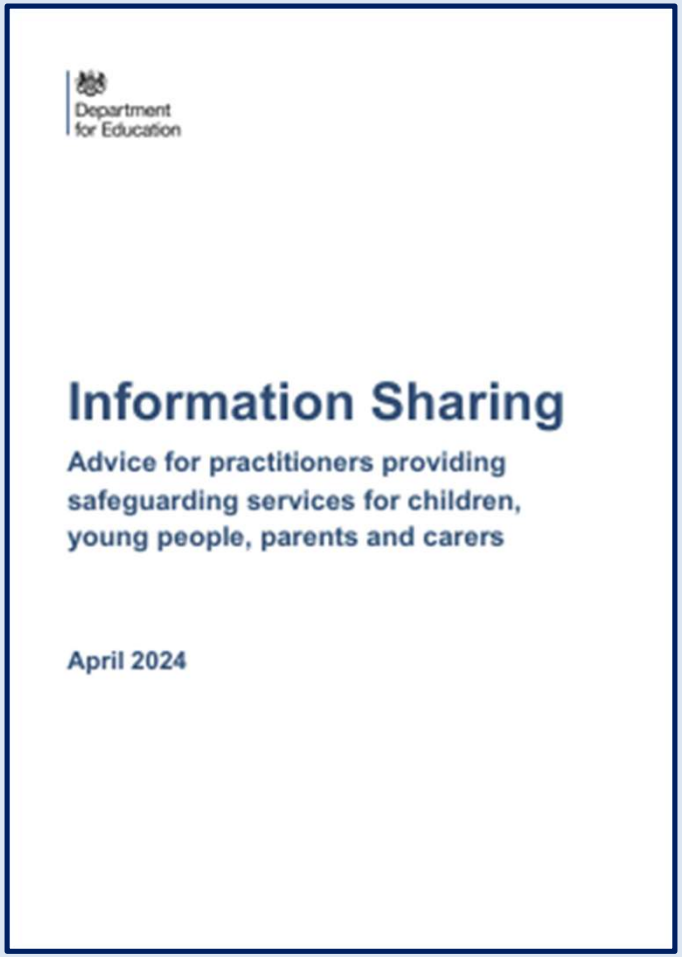
- Are other professionals involved?
- Are others seeing the same as you?
- Are others concerned?
- What action has been taken so far?
- What else could or should be done?
- Are you checking what you are being told?

Information Sharing

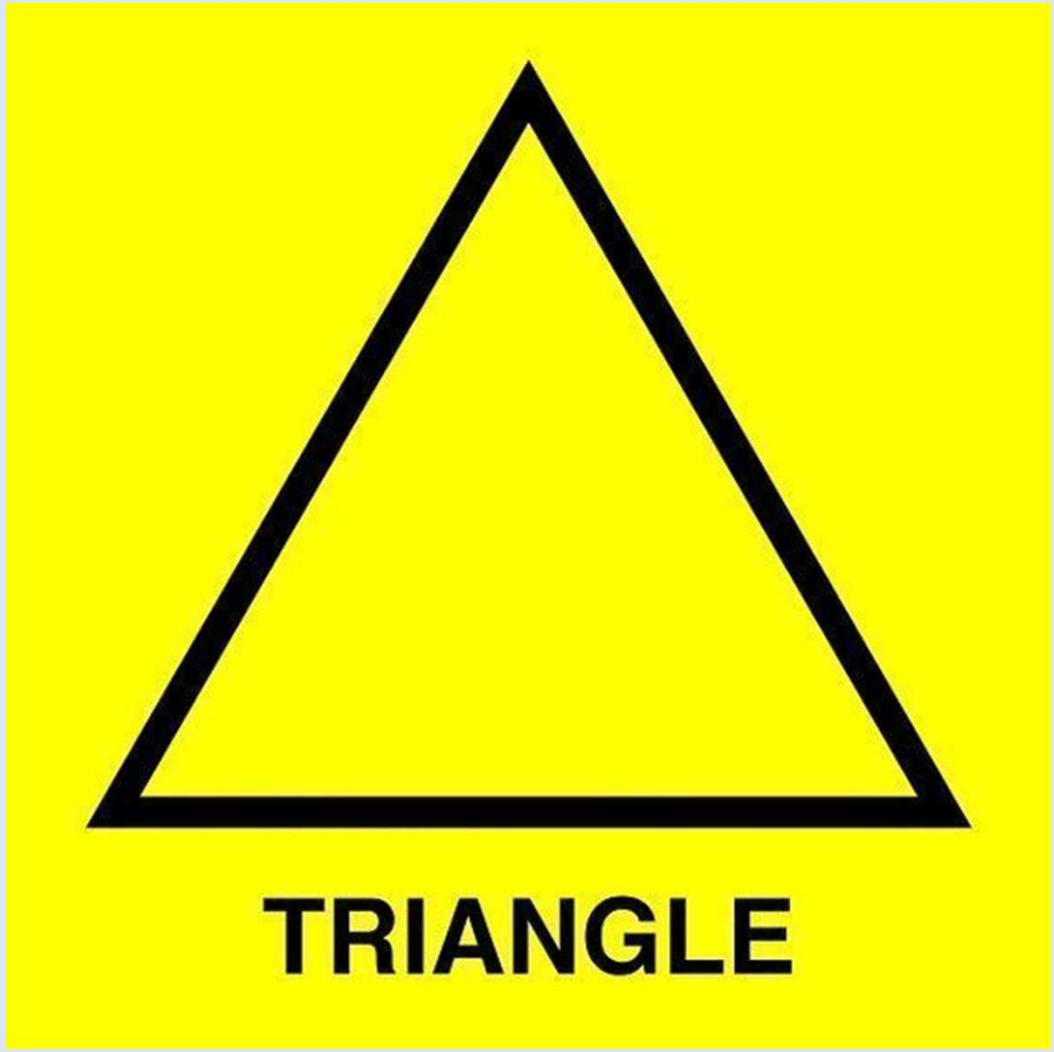
Processing condition that allows practitioners to share
Special Category Personal Data
when
'Safeguarding children and individuals at risk'

This allows sharing without consent, where consent cannot be reasonably gained or if to gain consent would place a child at risk

- Necessary
- Proportionate
- Relevant
- Accurate
- Adequate
- Timely
- Secure



Triangulate Your Thinking



Wants Analysis

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Interviewee:	Case:	Date:	
Wants?	**Why?**	**Where From?**	**Complete?**

A Person Centred Approach

- Unsubstantiated / Inconclusive
- Retracted
- Rely on professional judgement not tools
- Triangulate and ‘Weighing it All Up’

Patrick has dementia. He no longer communicates through words. He has recently moved into a residential care setting. Patrick has always been a strict vegetarian and so he is given vegetarian meals. One day by mistake he is given and eats a roast dinner. He enjoys it so much he seeks out the food of other residents.

His wife and sons are very upset about this. They feel that Patricks rights have been violated. There are safeguarding concerns. Patricks family feel that there is a safeguarding issue if staff allow him to eat meat. The Staff feel that there is a safeguarding issue if Patrick's wife and family continue to seek to prevent him making the choice to eat meat.

What will you do and Why?

The Why ?

Benefits of Professional Curiosity ?

News

Bristol World

Autistic adult who had ‘never eaten hot food’ rescued from years of ‘self neglect’

The sad case has had a happy ending thanks to intervention from friends and health authorities

By Adam Postans, Local Democracy Reporter
Tuesday, 7th June 2022, 1:00 pm

Top Tips

See It

Hear It

Explore It

Check It

Curiosity Check List
Broadhurst et al. 2010

- Am I remining curious and inquisitive ?
- Am I open to new information ?
- Would I be willing to change my mind about this ?
- Is there sufficient quality and quantity of evidence for judgement ?
- Am I exploring process as well as content ?
- Am I able to challenge this person ?

Safeguarding Check List

- Were Risks Identified ?
- What was the response to identified risk to ensure safety for all ?
- ‘Voice of Child / Family / Person’ considered and recorded ?
- What other agencies were involved in case discussion ?
- Was the decision-making rationale recorded and appropriate ?
- Are outcomes and actions clearly recorded ?

What have you done ?

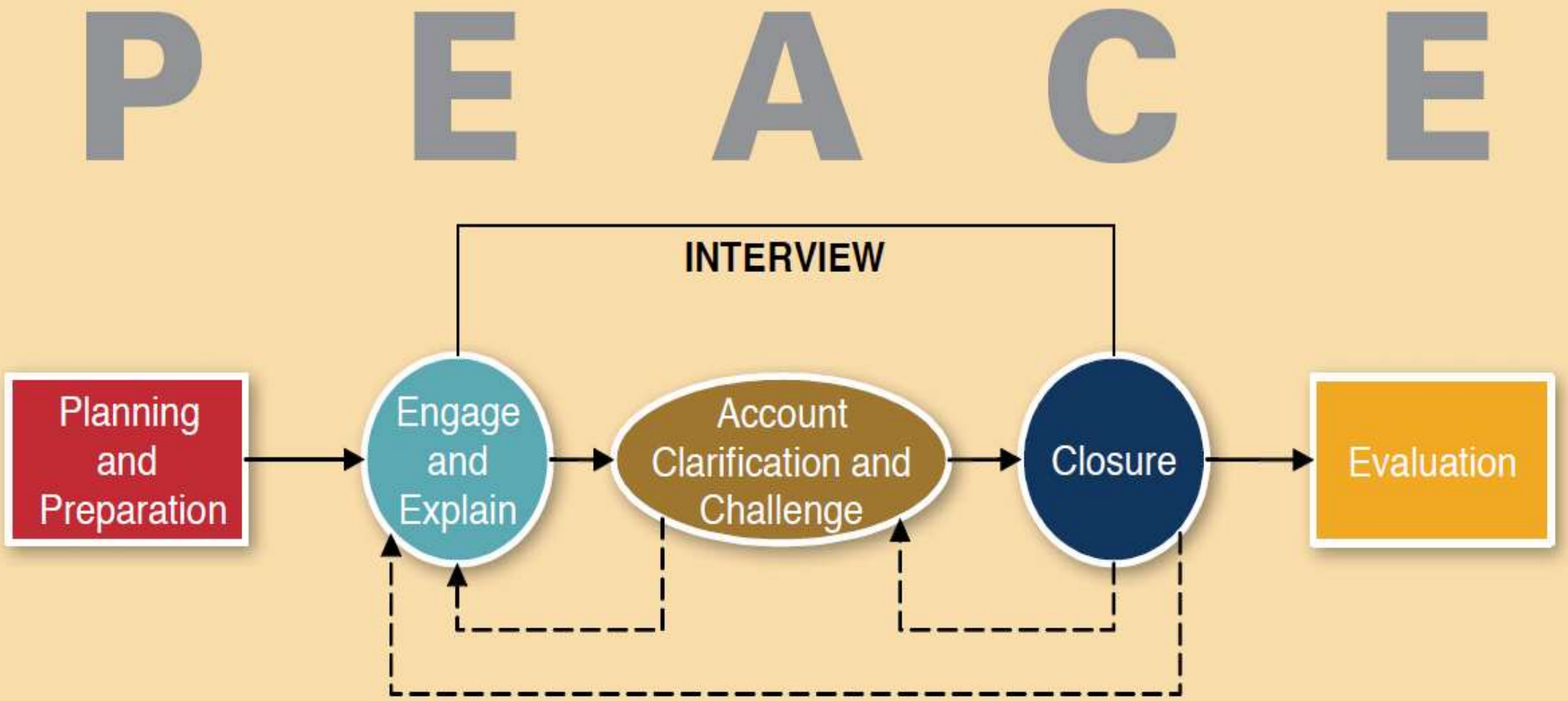
R	EMOVE
A	VOID
R	EDUCE
A	CCEPT

10 Principles of Decision-Making
College of Policing

Principle 4

Harm can never be totally prevented. Risk decisions should, therefore, be judged by the quality of the decision making, not by the outcome.

Figure 1: PEACE interviewing model



Planning & Preparation ?

Wants Analysis

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Interviewee:	Case:	Date:	
Wants?	**Why?**	**Where From?**	**Complete?**

Topics

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Engage & Explain ?

- R - Respect
- E - Empathy
- S – Support
- P - Positive Mindset
- O - Open
- N - Non-judgmental
- S - Straightforward talk
- E - Equality Signals

Question Types ?

- Open
- Closed

- Leading
- Multiple
- Complex
- Rhetorical
- Assumptions

TED ?

Tell

Explain

Describe

So….What About TED S ?

Tell

Explain

Describe

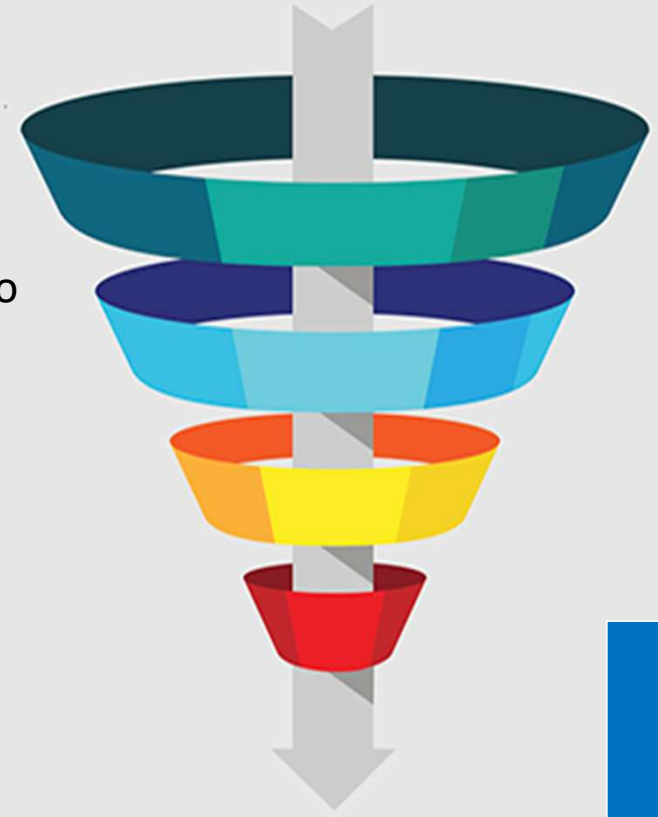
Show

Remember 5WH ?

Funnel Technique ?

Start with broad open questions to obtain maximum information

General Open
'How do you like to spend your time ?'



Specific Open
'What do you like about watching sport?'

Use clarifying questions to funnel down to the missing information and fill gaps

Use closed questions to research specific points

Closed
'What is your favourite sport to watch?'

What Does Conflict/Disruptionn Look Like ?

- Monopolising the Talking Turn
- Overtalking (at same time)
- Interrupting
- Pays No Attention
- Minimal Responses
- Assumer (Finishing your sentence)
- Word Picker
- Fogging / Distracting
- Verbally Aggressive


'Bad' Behaviour Iceberg
What we see
What might be underneath
Context
CONTROL
WETTING
HOARDING
RAGE
Swearing
Hitting
LYING
Refusal
Biting
Smearing
ANGER
SHOUTING
Tears
COMMUNICATING DISTRESS
Anxiety
Stress at home
Sensory Overload
STRESS in School
TIRED
SHAME
Past trauma triggered
Disempowered
BORED
Discomfort
Anticipating rejection
feeling threatened
Sadness
Hunger
©Creative.cinical.psychologist
LIFE PRESSURE
FAMILY DYNAMICS
PEERS
AVAILABLE SUPPORT
HARMFUL SOCIETAL NARRATIVES
CULTURE
©Juliet Young

Are you a Trauma Informed Practitioner?

How to DEAL with Conflict / Disruption?

D – Describe

E - Explanation

A - Action Required

L - Likely Consequences

Challenging ?

Planning to Challenge ?

- Take time to prepare
- Least to most impactive
- Comparative Style
- Keep it conversational
- Don’t get drawn into arguments
- Make your point and then move on
- Summarise challenges to round things off
- Make it impactive

Challenges

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Interviewee:	Case:	Date:
A = What You Said	B = What We Have	C = Help Me Understand What Happened?

Challenges – As Simple as ABC

A

‘Earlier you told us that you never leave your children at home at night’

B

‘The police inform me that last Wednesday they were called to your house at 01.30 a.m. and that the only people in the house were your two children’

C

‘Help me understand what happened?’

Professional Challenge?

- Can help find a better way to improve outcomes
- Respect views of others (regardless of position or experience)
- Remember all responsible for own cases, action and decisions
- Resolve as quickly and easily as possible
- Expect to be challenged, seek feedback, safe reflection
- Clarify roles and responsibilities to avoid need to challenge

Closure?

Polite – ‘Thanks for assisting me today….’

Positive – ‘What I’m going to do now is….’

Perspective – ‘This is what will happen….’

Professional – You may have to speak to this person again !

Evaluate?

What have you got?

What will you do with it?

What next?

What will you do next time to improve?