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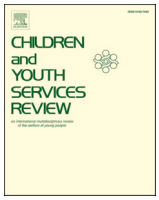

Re-envisaging professional curiosity and challenge: Messages for child protection practice from reviews of serious cases in England

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ABSTRACT

Learning lessons from cases where children have been killed or seriously harmed from abuse or neglect is important for child protection policy and practice around the world. In England there is a long-established system of locally based, multi-agency reviews. Three recurrent themes over the years have been the poor quality of assessments, shortcomings in inter-agency working and information sharing, and not knowing the children and understanding their experiences. The reviews often identify a lack of 'professional curiosity' and insufficient 'challenge' on the part of child protection practitioners as the cause of these problems. This paper analyses these concepts, drawing on four recent studies of child safeguarding reviews conducted by the authors and their research team. It uses qualitative data from the reports and the views of local professionals in online focus groups. The reviews tend to use the perceived lack of curiosity and challenge as the explanation for poor practice without interrogating why, when and in what circumstances it becomes more difficult for professionals to remain curious and appropriately challenging. Professional curiosity and challenge are complex, multifaceted concepts, and applying them in practice is difficult and skilled work. The paper argues for a more nuanced and grounded understanding of the concepts and their application in practice. It sets them in wider frames of communication and courage, and the ambiguous policy context of a preference for cooperative engagement with families but high expectations about protecting children. It offers recommendations for future research into the review process, authorship style, practice in local agencies and national government policy.

1. Introduction

This paper explores the concepts of 'professional curiosity' and 'challenge', analysing the ways that they are used in reviews of cases where children have been killed or seriously harmed from abuse or neglect. There is a long-established process in England of locally-based reviews into how such cases were handled by the agencies involved. The system was revised in 2018–19, and the reviews, previously called 'serious case reviews' (SCRs) are now known as 'local child safeguarding practice reviews' (LCSPRs). This paper draws on four studies conducted over the period 2020–2022 by the authors and their research team, of the final set of SCRs (2017–19), the first two years of LCSPRs (2020 and 2021), and an overview of the history of SCRs (1998–2019). The principal aim of the three contemporary studies was to draw out common themes across the reviews and identify the implications for policy makers and practitioners. The aim of the historical analysis was to identify the major changes and continuities over time, and again pull out the implications for policy and practice. Three recurring themes in local reviews across the four studies were to do with poor assessments; poor inter-agency working and information sharing; and failure to get to know the children and understand their experiences.

In each of these three areas, reviews often commented on a lack of professional curiosity and insufficient challenge on the part of child protection professionals which left children at risk of harm. Review authors identified that professionals did not respond to important behavioural clues that children were at risk, did not engage with

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children and consider their views and experiences, did not pursue explanations given by parents or carers for matters such as injuries to the children or not keeping appointments, and did not question the views of other professionals even if they did not understand them or were unhappy about them. However, the reviews tended to use the absence of professional curiosity and challenge as the explanation for poor safeguarding practice without interrogating why, when and in what circumstances it becomes more difficult for professionals to remain open, curious and appropriately challenging. Drawing on data from the four studies, this paper argues for a more nuanced and grounded understanding of the concepts and their application in practice. It sets them in wider practice contexts of communication and courage, and the ambiguous socio-legal and policy context which warrants coercive state intervention in family life only as a last resort, but (in England) generates extreme anger and blame towards child welfare professionals when children are harmed.

Our data are from England, but concerns about errors and mistakes in formal child protection systems feature in other high-income nations too, as shown by the range of countries represented in Biesel et al. (2021). The other countries of the United Kingdom have their own processes for reviewing serious child abuse cases, but there is considerable cross-border learning and borrowing (currently 'learning reviews' in Scotland, 'child practice reviews' in Wales and 'case management reviews' in Northern Ireland: NSPCC 2022). Another example is that the USA has had a federally mandated system of 'citizen review panels' since 1996 to assess cases where children have died who were known to child protection services and make relevant recommendations (Berrick and Chambers 2021; Paloschi et al., 2010). 'Learning the lessons' from awful cases is an important goal for child welfare policy and practice around the globe, so our findings speak to a wider audience than England alone.

We use the general terms 'professionals' or 'practitioners' throughout the paper to capture the whole range of staff who have responsibilities and opportunities in the course of their work to protect children from harm, not only children's social workers. The local authority children's social care department is the body that usually employs children's social workers and has the principal legal responsibilities for child safeguarding. However, the mantra is that 'safeguarding is everyone's responsibility' and effective partnership working between the different agencies and professionals is essential for this. The range of practitioners includes roles such as family support workers, social work managers, health visitors, midwives, nurses, generalist and specialist doctors, paediatricians, police officers, probation officers, teachers, youth workers and housing officers.

2. Background: Reviews of child safeguarding cases in England

The central government prescribed system for local reviews of cases where children have been killed or seriously harmed because of abuse or neglect was established in England in 1988, in the first edition of the statutory guidance *Working Together* (DHSS and Welsh Office 1988). The new arrangements for reviewing serious cases were introduced in the 2018 edition (HM Government 2018).

Since 1998 there have been nine government-commissioned periodic overviews to help disseminate the lessons from the reviews (Brandon et al., 2008, 2009, 2010, 2012, 2020; Dickens et al., 2022a; Rose & Barnes, 2008; Sidebotham et al., 2016; Sinclair & Bullock, 2002). The final periodic analysis of SCRs, 2017–19, was undertaken by a research team from the universities of East Anglia and Birmingham (Dickens et al., 2022a), together with a historical overview of the nine reports (Dickens et al., 2022b). All the reports can be accessed for free on the Serious Case Review website hosted by *Research in Practice*: https://scr.researchinpractice.org.uk. This site also has sector-specific briefings (for children's social care, health, education and police) and videos of discussions about the findings.

The nine reports draw on data from more than 1,700 cases, indicating what a large 'industry' the reviewing of child safeguarding cases has become. That large number lies behind the criticisms that have been made of them – that despite all this time and expense, lessons have not been learned, the same messages come round again and again, they have been ineffective in improving practice (see especially Wood 2016). The new LCSPR system is intended to help reviews become more focused, analytic and effective (DfE 2016; CSPR Panel 2022b). It is easy to bemoan 'the same old failings' but that is with the benefit of hindsight and a tendency to generalise across cases, to look for the similarities rather than the variations and complexities. There is a habit for reviews to echo one another, repeating 'explanations' used in previous reviews, even if those terms are unclear and potentially problematic. Lack of curiosity and challenge are two prime examples. They are often at the heart of the criticisms in the reviews, but the concepts and their application in practice are far from straightforward.

3. 'Professional curiosity' and 'challenge'

The term professional curiosity first appears in the 2005–07 overview of SCRs, and can be understood as a development of the term 'respectful uncertainty' used by Lord Laming in his inquiry into the case of Victoria Climbié (a well-known case in England concerning a girl who was awfully abused and killed by her great-aunt in 2000):

> *While I accept that social workers are not detectives, I do not consider that they should simply serve as the passive recipients of information, unquestioningly accepting all that they are told by the carers of children about whom there are concerns. The concept of "respectful uncertainty" should lie at the heart of the relationship between the social worker and the family.* (Laming 2003: 205)

Laming talks in terms of keeping an 'open mind', but as the concept has evolved a more active, investigatory element has come to the fore. This is captured in the demand that social workers and other practitioners question and challenge parents and other professionals to unearth inconsistencies and get to the truth of the matter. For example, professionals are encouraged to openly challenge instances of 'disguised compliance' – a contested term (see Leigh et al. 2020) used to describe instances where parents appear to cooperate with professionals in order to allay concerns and end their involvement.

A quick internet search shows how ubiquitous professional curiosity and related terms such as 'healthy scepticism' have become. Many local child safeguarding partnerships have produced briefing documents to try to promote the notion. However, it is not as simple as it may appear at first sight. In everyday use, curiosity is not always a good thing – it can easily come across as intrusive and prying. The English-language proverb 'curiosity killed the cat' warns people off asking too many questions. Presumably the word 'professional' at the beginning is meant to justify it, but it is not clear why that alone warrants intrusion into private and family life (there should be good reasons for the questioning) or why that might make it any more acceptable to the person on the receiving end. Healthy scepticism can easily breed distrust, and of course it is not reciprocal – the parent who is sceptical or who challenges back is likely to be labelled as non-co-operative (Reed 2015).

Burton and Revell (2018) argue that the term professional curiosity is poorly defined in local reviews and fails to take proper account of the emotional, organisational and political dimensions of child protection practice. They highlight the overwhelming demands of the work, both in terms of quantity and its often distressing nature, the organisational context of proceduralisation, resource limitations and inadequate support for staff, and a political climate of austerity, inequality and mistrust of social work. This is a helpful framework, but to understand the working-out of the tensions we need to look more closely at what happens in practice and how this is addressed by the reviews.

The related criticism in SCRs and LCSPRs is that practitioners showed a lack of 'challenge'. This term has also become widely used, but it too has a number of different meanings and has evolved over time. In the

early SCR overviews, safeguarding work itself is described as challenging; dealing with high demands and resource limitations is challenging; some children may exhibit challenging behaviour; implementing the lessons from serious cases is challenging. The notion of being ready to challenge other professionals is discussed for the first time in the 2003–05 overview (Brandon et al. 2008), but the idea that social workers (and other professionals) should be prepared to challenge the parents takes longer to emerge, not becoming an explicit topic of discussion until the 2009–11 overview (Brandon et al. 2012). The term 'authoritative practice' is also used to capture this aspect.

A key sign of this evolution may be detected in the government's commission for a review of child protection in England in 2010, undertaken by Eileen Munro. This came swiftly after a change of government, to a Conservative-led coalition, and in the wake of intense public and political outrage about another distressing child abuse case, that of Peter Connelly ('Baby Peter'). One of the criticisms was that practice had not been sufficiently authoritative (Haringey LCSB 2009, Warner 2015). The letter of commission from Michael Gove, who was responsible for the review as the secretary of state for education at the time, is reproduced as an appendix in Munro's first report. The letter specifies:

> *I want social workers to be clear about their responsibilities and to be accountable in the way they protect children. I particularly want social workers to have the confidence they need to challenge parents when they have concerns about the circumstances in which children are growing up, and to know they will be supported by the system in doing so.* (Munro 2010: 44-46)

Here we see a politician setting out expectations for social work practice to be more challenging long before the review had drawn any conclusions. Munro's review subsequently held that the practice of individuals must be understood within the wider systems that shape their actions and decision-making. She highlighted the heavy bureaucratic demands of having to comply with extensive prescriptive guidance and inflexible procedures, but other social, professional and practical considerations also play a part, particularly the tensions between scepticism and the wider societal and legal imperatives of respecting parents' rights and family privacy (as has long been known: e.g. Dingwall et al. 1983). Overtly challenging a parent is far from straightforward given this social and political context; furthermore, there is a subtle practice context, that trusting relationships are more likely to facilitate positive change than antagonistic ones (discussed further in Part 6 of this paper).

As for challenging other professionals, within one's own agency or across agencies, it has long been recognised that this can be a daunting thing to do, especially to question those in senior positions, or with greater professional and social status (e.g. Hallett and Stevenson 1980). One of the earlier SCR overviews reported that practitioners preferred to talk in terms of 'resolving professional differences' rather than challenge (Brandon et al. 2020); but whether a change of terminology is really enough to help people pursue the hard questions is open to debate.

The frequent criticisms of a lack of professional curiosity and absence of challenge give a disturbing picture of inadequate practice, of workers being naïve and missing the obvious. The questions we explore in this paper are whether this is fair, and what can be learned about the realities of practice from the reports on serious cases.

4. Methods

We tendered successfully for the commissions for the four studies that are the main source of data for this paper. The final periodic review of SCRs and the review of the history of SCRs were commissioned by the Department for Education (DfE). The two annual reviews of LCSPRs were commissioned by the national Child Safeguarding Practice Review Panel (CSPR Panel). Research ethics approval for each of the studies was given by the School of Social Work at the University of East Anglia.

The core research questions and tasks specified by the funders for the three studies of recently-completed reviews were broadly the same: 1. to distil the common themes and trends across the reports; 2. to provide an understanding of the key issues and challenges for practitioners and agencies, including the root causes of systemic strengths and vulnerabilities; and 3. to draw out implications of the analysis for policy makers and practitioners. These objectives required a mixed methods approach, using quantitative data from the reports to give a statistical picture of the children's and families' circumstances and characteristics; and qualitative data from close analysis of a sample of cases, and from focus group discussions with local practitioners and managers. Full details of the methodology and the statistical information are in the research reports, the qualitative analysis provides the data for this paper. For the historical overview, the task was to give an account of changes and continuities in policy and practice over time, and draw out the messages for policy and practice in the future. Curiosity and challenge were not specified as subjects for analysis in any of the studies; rather, their significance, complexity and ultimate insufficiency became apparent as we analysed the data. Intrigued and inspired by that, we have taken the analysis further in this paper.

Study 1: The review of 2017–19 SCRs (Dickens et al., 2022a). There was a total of 235 reviews relating to a serious incident that had occurred between April 2017 and September 2019, for which 166 completed reports were available (most were supplied to us by the DfE, along with the initial notification details; we tracked down 11 of the reports ourselves). The main reasons for reports not being available were delays in completion, often attributed to ongoing criminal investigations, or that they had not been published, primarily due to concerns about the impact on surviving family members.

All the initial notifications and reports were read by at least one member of the research team. A template was used to record key information and a case summary. From this we were able to undertake the quantitative analysis, using *SPSS* software, on matters such as the ages and gender of the children, their backgrounds, the nature of the abuse that led to the SCR, the family circumstances, and the geographical location.

We also purposively selected 49 cases for in-depth qualitative analysis, focusing on four topics: the problem of neglect, the challenges of professional practice, the task of listening to the voice of the child, and the issue of intra-familial child sexual abuse (CSA). We used thematic analysis (Boyatzis 1998), with the aid of *NVivo* software. The first three themes were chosen because they have been perennial issues throughout the history of SCRs, so there was value in looking at them as the process came to an end. Intrafamilial CSA was investigated at the suggestion of the DfE advisory panel, as a key area of challenge that had not been an explicit focus in previous overviews (see Garstang et al., 2023). We used the case summaries to select the cases. Most were selected because they fitted with more than one of themes (e.g. neglect *and* intrafamilial CSA); some had elements of all four. We ensured that the selected cases had a balance of different age groups, ethnicities, gender, death or serious harm, and regions of the country.

We also held two online 'knowledge exchange events' with local child safeguarding professionals to explore how the reviewing of serious cases and the practices they reflect have changed over time, and the messages to take forward to the new LCSPR system (these also served to inform Study 2). The events took place in January and February 2022 and were organised and hosted for us by *Research in Practice* (RiP). They sent invitations to agencies in their network, and almost a hundred people attended over the two events. Participants came from a wide range of professional roles, including local authority senior managers, safeguarding advisers and social workers; managers and chairs of local child safeguarding partnerships; specialist nurses, midwives and doctors; police officers and independent reviewers. The main professional groups in attendance were from social work and health. Attendees were divided into smaller groups to facilitate their discussions on three issues: the key changes in practice over time, the ongoing challenges both for practice and for reviews, and what impact SCRs have had in their area. The main points in their conversations were written up in real time on

online 'jamboards' (a digital whiteboard).

Study 2: The overview of the history of SCRs (Dickens et al., 2022b). This was based on a thematic analysis of the nine periodic reviews, and other relevant publications such as the Laming, Munro and Wood reports (cited earlier).

Studies 3 and 4: The two LCSPR reviews. The 2020 review reported on 33 LCSPRs, all that were available at the time (Dickens et al., 2021) and the 2021 review on 84, all those that had been completed and submitted to the CSPR Panel in the calendar year 2021 (Dickens et al., 2022c). This gave 117 LCSPRs from a total of 372 that had been initiated since the system was established in 2018. This is just 31%, although we could not expect any that were initiated in the second half of 2021, because they have six months to be completed. We also have to make allowance for the impact of the Covid-19 pandemic over these years.

Under the new system, all serious cases should have a rapid review, even if they do not proceed to an LCSPR. In Study 3 we looked at a sample of 135 rapid reviews completed between January and December 2020 (approximately 25%). In Study 4 we were supplied with the relevant rapid reviews and serious incident notification (SIN) forms for the 84 reports, if available.

As with the SCR studies, we used a mixed methods approach – a statistical picture of the key features, and an in-depth qualitative analysis to identify and explore key themes. Given the relatively small number of reports in Study 3, we used them all in the qualitative analysis. For Study 4, we took a purposive sample of 20 cases, selected to give a variety of cases broadly reflective of the whole cohort. Also, in order to address an additional question about the implementation of recommendations and their impact, we used these 20 reviews plus four from the 2020 cohort, which gave them longer to have achieved impact. For this element we conducted a review of the relevant partnership websites, an online survey (completed by 22 of the partnerships), and an online focus group involving a representative from each of the responding partnerships (i.e. 22 senior safeguarding professionals were invited and attended).

For all the studies we received excellent support from the funders in terms of supplying the local reviews, facilitating our work and commenting astutely and constructively on our draft reports. For the SCR studies we benefited from the insights of an advisory panel established by the DfE, and for the LCSPR studies from meetings with the CSPR Panel.

The four studies were conducted separately, but the shared themes became apparent as we analysed the data. We pull them together in this paper, analysing the concepts of curiosity and challenge in more depth than would have been appropriate in the commissioned research reports. We focus on the implications for practice, arguing that they are best understood within wider contexts of communication and courage, and beyond that an understanding of the limits of state intervention in private and family life in a liberal democratic society (Dingwall et al. 1983).

5. Findings

Three broad areas where shortcomings in practice were commonly identified in the reviews concerned: 1. the quality of assessments, 2. inter-agency working and information sharing and 3. knowing the children and understanding their experiences. These themes are often highlighted when cases hit the news headlines, and it is important to address them; but it is also important to appreciate that they are at a very high level of abstraction, and the precise features, reasons and circumstances vary notably from case to case. We address them in turn, drawing out the messages about professional curiosity and challenge.

5.1. Poor assessments

The criticisms of assessments have two major angles – inadequate information gathering and analysis at the 'front door', when cases first come to attention, and reluctance or inability to revise assessments in the light of new information. (Both of these issues have also been explored in detail in the CSPR Panel's national review of two child death cases which hit the news headlines in late 2021, the abuse and murders of Arthur Labinjo-Hughes and Star Hobson: CSPR Panel 2022a.).

A significant gap in many assessments was not taking proper account of the family's racial and cultural heritage. The first of the periodic reviews commented on assessments that did not address the child and family's ability to speak and understand English, their knowledge and understanding of available services, the impact of racism, and the significance of cultural or religious practices (Sinclair and Bullock 2002: 19). This continues over the SCR period (see also Bernard and Harris, 2018) and we found it still happening in the 2021 LCSPRs. One example involved a severely disabled boy from an Asian family. The review was asked to consider how well the culture of the family was understood and taken into account in assessment and planning, and concludes that 'few attempts were made and minimal progress achieved in understanding the reality of [the family's] day to day life'. The boy's mother is only mentioned once in all the case records the reviewer saw. She did not speak English well, and contact with the family was through the father. The review says that 'a little more professional curiosity' was needed to explore her experiences of caring for the boy, but does not go further into why this was lacking, the suitability of local services or the availability of interpreters. There were two other cases involving Asian families where the main contact was with the father and very limited efforts were made to speak directly with the mother, and no interpreters engaged to help with this.

There was also evidence of cases sometimes being closed even though very little, if anything, had changed and the children still being at risk. In one example, a family did not allow their children's allegations of sexual abuse to be investigated, which resulted in 'No Further Action' decisions from agencies. There was a sense in some reports of agencies 'giving up' in the face of parents' or young people's resistance, but the reasons for this particular decision were not explored in the report. This suggests that the review itself showed a lack of curiosity and challenge, although we have to be cautious because we only have the written report and do not know what other discussions may have taken place.

Reviews often link the notions of professional curiosity and challenge, and see their absence as a key factor in poor assessments and weak engagement with families, as in this comment from one of the 2017–19 SCRs:

> *Much of what happened in the life of [the child] was accepted without explanation or taken at face value. Apparently rational explanations were not queried or challenged rigorously, and there is limited evidence of curiosity about what his life at home was like.*

However, effective challenge is a complex and subtle matter. This is well illustrated in one of the 2021 LCSPRs. The child's mother was experiencing domestic abuse and drinking heavily. Her child was taken into care but later returned to her. She was interviewed by the author of the LCSPR and said that 'accepting that you were wrong is the most difficult thing'. She captures the dilemmas by saying that practitioners should have been 'softer' but also 'more persistent' with her, and that:

> *… persistence might have been the only thing that could have encouraged her to behave and think differently at the time but she isn't really sure whether this would have prevented what happened …. She thinks that she should have been 'forced' to engage with the domestic abuse service but she also recognises that people can't be 'forced' to do these things.*

Her comment shows that challenge requires skill, subtlety and often patience if it is to be effective and constructive. The way that the terms are used in the reviews often suggests that practitioners should adopt a more inquisitorial and confrontational approach in their work with families, but the risk is that this could easily become counter-productive, alienating families. Welfare intervention is normally built on (more or

less) voluntary cooperation from the families, with overtly coercive action such as court proceedings only as a last resort (Dingwall et al. 1983). Confrontational challenge jeopardises that delicate balance. One review did identify the way that curiosity and challenge could be conceptualised more constructively, as foundation stones for effective, helping relationships:

> … *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.*

Set against that admirable ambition was the reality of heavy workloads and resource shortages. The issue was powerfully illustrated in one SCR concerning the death of a 5-week-old infant. The midwife undertaking the postnatal discharge visit had eight visits to complete that day with 15 minutes allocated to each of them. Within that timeframe, there are profound limitations to the degree of relationship-building, professional curiosity and constructive challenge that can be achieved.

5.2. Inter-agency working and information sharing

'Inter-agency working' and 'information sharing' are at the heart of the multi-agency child protection system, and a wide variety of issues are contained within these broad headings. There may be breakdowns in information exchange between services within the same agency, between different agencies within a local authority area, or when families move to new areas. Information exchange may be thwarted by unreliable or cumbersome IT systems, so that it is not entered properly or read, or systems that do not 'speak' to one another, so it is lost. Equally, a practitioner may not convey important information to another agency because they are not aware of its potential significance for the others, or information may be received but not properly understood. Specialist and medical diagnoses are notable examples of the latter. An example from one of the 2017–19 SCRs was that information about a young person's health diagnosis was shared between the relevant agencies, but its significance for that young person was not appreciated. The condition prevented her from taking part in various activities and sports from which she derived enjoyment, relationships and meaning, and sadly she took her own life. Similarly, another SCR found that:

> … *lots of information was exchanged, but was not shared, interrogated or its importance properly understood… Multi-agency work requires staff to be alert to their own 'professional cultures, languages and knowledge base' and to be ready to 'translate' this to other professionals.*

There is therefore an important distinction between information exchange and effective communication. Communication will often be better achieved if relevant practitioners have a discussion about new information or case transfers, as well as the written report, so that information is more accurately understood and its implications fully appreciated.

Effectively negotiating and managing the working arrangements with other agencies is seen as a core element of authoritative practice (Brandon et al. 2020: 109), but the reviews often identify lack of curiosity and challenge as reasons for shortcomings in inter-agency working. Differences of opinion were often left unresolved, particularly in relation to the level of risk and the threshold for cases being taken on by the local authority children's social care department. This was particularly the case for teachers or health workers making referrals or requests for a service, although there were also examples in the reverse direction. The issue of increasingly high thresholds for services in all agencies came up in the focus groups, and the risks of children being overlooked if they did not meet the threshold (Dickens et al., 2022a: 110). Several reviews commented how the experience of having referrals and requests to other agencies rejected, sometimes without explanation or feedback, could leave professionals feeling powerless. This meant that referrals or requests were less likely to be made in the future, and decisions less likely to be questioned.

There are many other reasons why professionals in all disciplines might not raise challenges even when they may have grounds to do so. Professional hierarchies can come into play – that is, staff may be reluctant to use escalation processes if it means challenging senior or more 'expert' colleagues. An example from the 2017–19 SCRs is a case of suspected Fabricated or Induced Illness (FII). Here, the child had been prescribed a high dose of addictive medication for an unusually long period. The child's GP, the pharmacist and other professionals had expressed reservations about this but did not feel able to challenge it or escalate their concerns because the medication had been prescribed by a specialist paediatrician.

A further factor that could lie behind a lack of inter-professional challenge was a mutual recognition of the pressures that all local services were facing, in terms of workforce capacity, caseloads and reduced funding. As one SCR put it, there was often 'an implicit understanding between agencies as to the pressures they were under'. This meant that practitioners were sometimes reluctant to challenge decisions they felt to be unsafe or inappropriate in relation to the child; or in some cases, it led to a decision not to refer at all.

Participants in the online focus groups emphasised the obstacles to good practice posed by heavy workloads, high staff turnover and sickness rates, and limited resources. One view was that 'staff know what they should be doing, but can't' (Dickens et al., 2022a: 111), although it was also thought that given the large numbers of newly qualified, inexperienced workers, some might not be confident about what they should be doing even if they knew it from their training. Good guidance and support for new staff is essential. Another issue that came up was the relationship between national policy, including funding, and local action: one participant observed that 'some key themes repeat locally because it's not addressed at the national level' (Dickens et al., 2022c: 59).

5.3. Not knowing the children and understanding their experiences

The third major area of criticism was of not getting to know the children and insufficient curiosity about their daily experiences. Trusting relationships between children and professionals are held to be a vital key to effective safeguarding, but limited resources can lead to organisational practices that make it difficult for professionals to offer relationship-based work – for example, frequent changes of worker, large caseloads, and incident-based work with cases being closed and reopened rather than held long-term.

The 2017–19 overview found many instances where children were not seen on their own, or where parents limited and controlled access to children – examples of allowing contact but controlling it are keeping the door open to the room where a social worker was talking with the child, or making the child tell them afterwards what was talked about. Two young people who had been sexually abused by kinship foster carers spoke to the SCR author and one of them said:

> *We used to have to be so careful as the family were in the room. We never got offered to be seen alone – maybe we should just have been taken. Social workers could have taken us out, they just used to sit us down at home. … Everything you said to the social worker got repeated back to the carers anyway.*

The review comments that:

> *Requests to see children alone should be made in a child focused and creative way and case notes should include the reasons given if a child refuses to see a social worker away from their carer.*

Practitioners did not always challenge parents about seeing children alone. There are many possible reasons for this. The dilemmas were highlighted in one review where practitioners felt compromised

between maintaining a relationship with the parents which allowed them at least *some* access to the children, and challenging the parents which tended to result in access being withdrawn. It is unlikely to be easy to speak to a child alone in the face of parental hostility, but the reviewer concludes:

> *Children's own voices, experiences, wishes and feelings should be the drivers to decision making. Where access to those children is being (however subtly) controlled, concerns should be heightened.*

Another reason is that professionals may feel intimidated or afraid, as one of the 2017–19 SCRs demonstrated powerfully. The family had made threats to professionals' lives and had actively pursued neighbours who provided evidence against them. As a result, professionals were concerned for their own and others' safety. Within this context of fear, they withdrew from the family and avoided asking challenging questions about the children's welfare. The children were not routinely seen alone and professionals were reluctant to explore the reasons for the children's, at times obvious, distress.

An important clue to what children are experiencing is their behaviour, and this may well be the primary way through which they express their feelings, rather than speech. There are many reasons why children may not be able to say, or choose not to say, what is happening to them. These include not recognising the situation as being abusive or neglectful, not having a trusted person to tell, and fear of what may happen if they do (Cossar et al. 2019). It is therefore vital that practitioners are alert to recognise and respond to behavioural signs, but there were many instances in the 2017–19 SCRs of this not happening. One of the siblings in the case mentioned earlier told the SCR author:

> *I totally changed [after the sexual abuse started], they never asked about the change in the way I dressed, changes in my eating. I started to self-harm. No one looked between the lines. No one took me away from the house. I had counselling for self-harm, and I kept myself to myself.*

This SCR considers the lack of professional curiosity shown by practitioners in all the agencies involved, referring to the paper by Burton and Revell (2018). It concludes that professionals need to take responsibility for their own practice, but that the opportunities for critical reflection and rigorous supervision were limited, thus affecting their ability to demonstrate curiosity.

6. Discussion: re-envisaging professional curiosity and challenge

When one reads the reports on these distressing cases, it is easy to become angry and despairing about the mistakes and missed opportunities to protect the children, so the calls for greater curiosity and challenge can have a powerful appeal. They seem obvious solutions to obvious problems. However, they are deceptively simple and need to be understood within their wider practice and socio-legal contexts. If this is done, then refreshed understandings of the terms might help to move policy and practice forward more constructively.

First, we have to be aware of the dangers (not only the benefits) of hindsight. We can see the tensions if we look back to an earlier quotation: 'Apparently rational explanations were not queried or challenged rigorously…'. But if they appeared rational, it is not clear why they should have been challenged at the time. There is a legal and societal requirement to be proportionate, as well as the resource implications of investigating every explanation including the rational ones. On the other hand, there certainly were cases where there was clearly the need and basis for a more probing response at the time. This poses a perplexing puzzle: given the high-profile nature of the work, the direct risks to the children, the career risks to the individual worker and the reputational risks to the agency, why weren't those extra questions asked?

All too often the reviews do not explore this. The lack of professional curiosity or challenge is given as an explanation for the shortcomings, the 'answer' to the problem – whereas it should only be a stepping-stone to the next question 'why wasn't professional curiosity used?', or 'why wasn't there challenge to the other professionals, or to the parents?'. This would open up more complex and nuanced dimensions, about the organisational context, workloads, training and supervision, the emotional demands of the work and the wider socio-legal and political ambiguities of state intervention in family life (e.g. to support parents *and* safeguard children, to intervene swiftly *and* to give people time to change).

This ambiguous context is reflected in calls for change in the opposite direction to the messages from SCRs and LCSPRs, for practice to be *less* sceptical and interrogative – for practitioners to start from a position of trust and work with families to empower them, rather than starting with scepticism, however 'healthy'. The view is captured in a speech given in January 2021 by the government-appointed chief social worker for England, Isabelle Trowler, who is also a member of the national CSPR Panel (reported by Blackwell 2021). She was talking about a review of children's social care in England that had just been launched by the government (since published: MacAlister 2022), saying that it opened the chance of a 'completely new offer' for children and families:

> *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?*

The messages from the reviews are that practitioners *do* often start from a position of trust – in fact, in many cases misplaced trust, too readily accepting of what they are told. The competing viewpoints highlight the profound complexity of the work, being expected to think the best of people and the worst.

The rather inquisitorial meanings of curiosity and challenge that are usually used in the reviews sit awkwardly with concepts of relationship-based and strengths-based practice. Such approaches have become popular as ways of offering help to families, not only investigations of risk. They emphasise the importance of building effective alliances with families and young people, working with them rather than on them, keeping them at the centre of decision-making and supporting them to make positive changes in their lives. ('Signs of Safety' has become an internationally prominent model of this approach, and was being used 'in some form' by two-thirds of local authorities in England in 2020: Baginsky et al. 2020: 7.) There is certainly a place within this for challenging poor parenting or harmful behaviour, because not engaging with these difficult issues would itself be unhelpful and even dishonest; but effective challenge is done with sensitivity and respect, within the context of a strong professional helping relationship (for a thoughtful discussion see Ruch et al. 2018). A positive step forward would be to reframe curiosity and challenge so that they are not seen solely as tools for child protection work, but also – and primarily – as an approach to helping families, as argued in one of the SCRs quoted earlier (using 'significant and authentic relationships' to help bring about change). The example of the mother who thought that practitioners should have been 'softer' and yet 'more persistent' with her indicates how much skill and support is required to strike the right balance.

Developing the necessary skills and providing the right support requires an understanding of the complex psychological, practical and organisational factors that make this difficult. Setting curiosity and challenge within wider frames of communication and courage could be a productive route.

Good communication lies at the heart of effective relationships with parents and other professionals; this is much more than 'information sharing' but about listening and observing, asking questions in ways that enable people to answer, reflecting and analysing, explaining clearly, using different settings and methods to assist understanding, giving reasons for decisions and why requests might be turned down. In pressured situations it can be the hardest thing to do, and professionals have to be willing to accept challenge as well as give it ('Communication and co-operation prove most difficult to achieve when they are most needed': Woodhouse and Pengelley 1991: 3). It is therefore important to

recognise the emotional as well as practical demands that might impair communication. Feelings of anxiety, uncertainty, fear and threat can shut down the ability of professionals to think and question, reducing their capacity for professional curiosity, reflection and openness to new ideas and information. Understanding curiosity and challenge within the broader and more reciprocal frame of communication, and what facilitates or constricts it, would help to address these dimensions.

Courage is the other element to add. Some of the families and young people with whom social workers, health visitors, midwives, teachers and police officers engage can be violent and intimidating (and see Hunt et al., 2016, Ferguson et al. 2021), especially those who had become entrapped in drug dealing and other criminal activity. Safeguarding professionals often undertake visits to people's houses alone, with an element of unpredictability about the situation they will encounter. This can sometimes require notable courage, although it is essential not to be foolhardy. Agencies have a responsibility to ensure the physical and psychological safety of their staff, for example through joint-visiting protocols and giving time and support to discuss and process the powerful emotions that can be evoked (Dickens et al., 2022a: 71).

Courage is not only required to deal with fear of aggression and physical harm. There are many other dimensions. Other professionals can sometimes be intimidating too, and as we have discussed professional hierarchies can come into play. It can require bravery and persistence to challenge senior managers in one's own or other agencies. Furthermore, in a context where agencies and individual professionals are likely to be criticised so heavily when things are seen to have gone wrong, it can take courage to trust families; again, it is essential not to confuse this with a lack of due care. Trust has to well-grounded, in careful assessments, good knowledge of the children, and effective support for them and their families. It can also require courage to engage with children and young people and discover what they have experienced. Behind the perceived lack of professional curiosity there may be dread and avoidance of hearing about children's pain and distress, and the emotional and practical impact that will have (Ferguson 2017).

There is another side to courage that is crucial to bear in mind. It is not only required of practitioners, but it can take great courage for parents and children to tell professionals about what is happening in their lives. Parents and carers may fear that their family will be broken up and their children removed; children and young people may be afraid of that too, or that they will not be believed, or they will be punished for saying, or that nothing will happen. Young people who are being criminally exploited may fear reprisals from others in those networks if they tell of their predicament, as was shown in several reviews of such cases (and see CSPR Panel 2020). Reviews also show the benefits of an effective relationship with a trusted professional to help families and children speak out. It turns out that courage is reciprocal too: if professionals can be courageous to engage with families and children, this creates a chance for them to respond.

Two further points arise. First, none of the attributes we have been discussing – curiosity, readiness to challenge, skilful communication and courage – should be seen as innate characteristics that practitioners either do or do not have, but as elements of an overarching professional approach that can be nurtured and used effectively if they have proper support. Second, that although nearly all the SCRs and LCSPRs referred to the involvement of practitioners in the review process (e.g. through practitioner events, surveys, interviews), the learning about their thoughts and feelings was not often clear in the reports (Dickens et al., 2022c: 45). More explicit consideration of the lived experience of doing the work and the emotions it evokes, such as uncertainty, stress, relief, hope, sadness and sometimes fear, would be a useful improvement and help reviews get beneath the clichés of lack of professional curiosity and challenge.

6.1. Limitations

There are of course limitations to what we can say about child safeguarding practice from studying these local reviews. First, they are based on the worst cases, and we should be cautious about treating them as representative of all practice. The reviewers have the luxury of hindsight, whereas practitioners at the time are operating with incomplete knowledge, under great pressure of workloads and conflicting expectations. It is complex work, often dependent on the work of others, and situations can change quickly. Having said that, many of the reviews identify elements of good practice as well as shortcomings, and the cases are not entirely out of the ordinary as other research, reviews and inspections find similar problems in the quality of assessments, information exchange and knowing the children.

Second, although we had all the SCRs and LCSPRs that had been completed within our timeframes, there was a substantial number that were not available because they had not been finished. We had more than two-thirds of the possible 2017–19 SCRs, but less than a third of the possible 2020 and 2021 LCSPRs. We can be confident in our analysis of the SCRs given that we also had the eight previous periodic reports to draw on and our findings are consistent with them. However the point of the move to LCSPRs was to introduce a new way of doing the reviews, and although most of the LCSPRs we saw still resembled SCRs there were signs of some change over the two years. It may be that when more LCSPRs are completed, there will be deeper analysis than the clichés of curiosity and challenge. This will need to be subject of a further study.

Third, our analysis draws mainly on the written documents and these may not capture all the discussions, debate and learning that took place. Furthermore, the local reviews do not say what happened subsequently, whether the recommendations were accepted and how the lessons were, or were not, put into practice. Our online focus groups with local safeguarding leaders and the survey in Study 4 were designed to give a picture of these aspects. They showed the determined work that goes on at local level to spread the messages and make the required changes; but the discussions also highlighted the difficulties, such as heavy workloads and high staff turnover, and that many of the changes require action at national level, such as clear guidance, effective support and sufficient resourcing for the agencies. A larger, longitudinal study of the processes of commissioning, conducting and then responding to a local review would be invaluable.

7. Recommendations

We draw recommendations to improve learning and practice in four broad areas. First, as just noted, an in-depth study of the real-life working of case reviews would be beneficial. This should investigate the decision-making and actions of the participants from the initial identification of the death/serious harm, the 'behind-the-scenes' learning, and the post-review actions (e.g. any procedural changes, training, inter-agency links and so on) and evaluate these. Second, for review authors, we suggest that they use the ready-made terms of curiosity and challenge with restraint, and always as a springboard to asking 'why?', not as the solution. Third, for the local agencies and managers involved in this difficult work, it is essential to give staff the structure and support to build their confidence and skills in communicating effectively and courageously with children, parents and other professionals. This means clear guidelines, good supervision, creative training and a local culture that is open-minded and curious about itself as well as about the families and children it supports. Finally, for national government, the message is that it is crucial to support and fund child welfare services properly so that practitioners have the time and resources to build effective relationships with families and children, balancing skilful curiosity, astute but sensitive challenge and flexible, high-quality assistance. The 2021–22 review of children's social care in England, mentioned earlier, called for additional funding of £2.6 billion over the following four years to 'reset' the system to a more proactive and preventive model (MacAlister 2022: 229); the government's response was to offer £200 million over the next two years for a range of pilot projects (DfE 2023). The expressed aim is to 'lay the foundations for

whole system reform', but the response is clear that what happens after that will depend on where children's services stand compared to other priorities for funding and amending legislation. If only small change is offered, little change can be expected.

8. Conclusion

This paper has drawn on the findings from four studies of local reviews in England into cases where children have been killed or seriously harmed because of abuse or neglect. These were the final periodic overview of serious case reviews (SCRs) (incident date between April 2017 and September 2019), and a longer history of SCRs going back to 1998, and the first two annual reviews of local child safeguarding practice reviews (LCSPRs) (reports completed in the calendar years 2020 and 2021). It has identified three recurring themes, to do with the quality of assessments, inter-agency collaboration and understanding the children's views and experiences. The paper has focused on two of the reasons frequently given in reviews for poor practice that leaves children at risk of harm – a lack of professional curiosity and the absence of challenge to parents/carers and other professionals. Our analysis shows the need for a more practically grounded and theoretically nuanced understanding of these concepts, and the reasons why they may or may not be put into practice. We have suggested that locating curiosity and challenge within wider frames of communication and courage would help with this, together with a keener awareness of the political and socio-legal tensions around state intervention in private and family life that make this such a complex field of work. We have made specific recommendations regarding future research, authorship style, practice in local agencies and national government policy. Moving beyond curiosity and challenge is essential if lessons really are to be learned and positive change achieved.

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CRediT authorship contribution statement

Jonathan Dickens: Conceptualization, Methodology, Writing – original draft, Writing – review & editing, Supervision, Project administration, Funding acquisition. **Laura Cook:** Conceptualization, Formal analysis, Investigation, Writing – review & editing. **Jeanette Cossar:** Conceptualization, Formal analysis, Investigation, Writing – review & editing. **Cynthia Okpokiri:** Conceptualization, Formal analysis, Investigation, Writing – review & editing. **Julie Taylor:** Conceptualization, Methodology, Investigation, Writing – review & editing, Supervision, Project administration. **Joanna Garstang:** Conceptualization, Methodology, Formal analysis, Investigation, Writing – review & editing.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

Quotations from reviews are taken from reports that have been published and are available on the NSPCC national case review repository. Other material is confidential.

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