



Understanding and using professional curiosity and challenge: messages from local reviews of serious child abuse cases

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Introduction: local reviews

- The current system of local multi-agency reviews was introduced in 2018-19, replacing serious case reviews, which had started in 1988.
- LAs must notify the child safeguarding practice review panel of every death/incident of serious harm where abuse or neglect is known or suspected, and undertake a 'rapid review'. If this shows a need for further learning, local partnerships may commission an LCSPR.
- The team from UEA and Birmingham undertook the final periodic overview of SCRs (2017-19), a history of SCRs (1998-2019) and the first two annual reviews of LCSPRs (2020 and 2021).

THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Annual review of local child safeguarding practice reviews

December 2022

**Jonathan Dickens, Julie Taylor,
Laura Cook, Joanna Garstang,
Nutmeg Hallett, Cynthia Okpokiri
and Julia Rimmer**

SCR materials free to access at <https://scr.researchinpractice.org.uk/>

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Serious Case Reviews

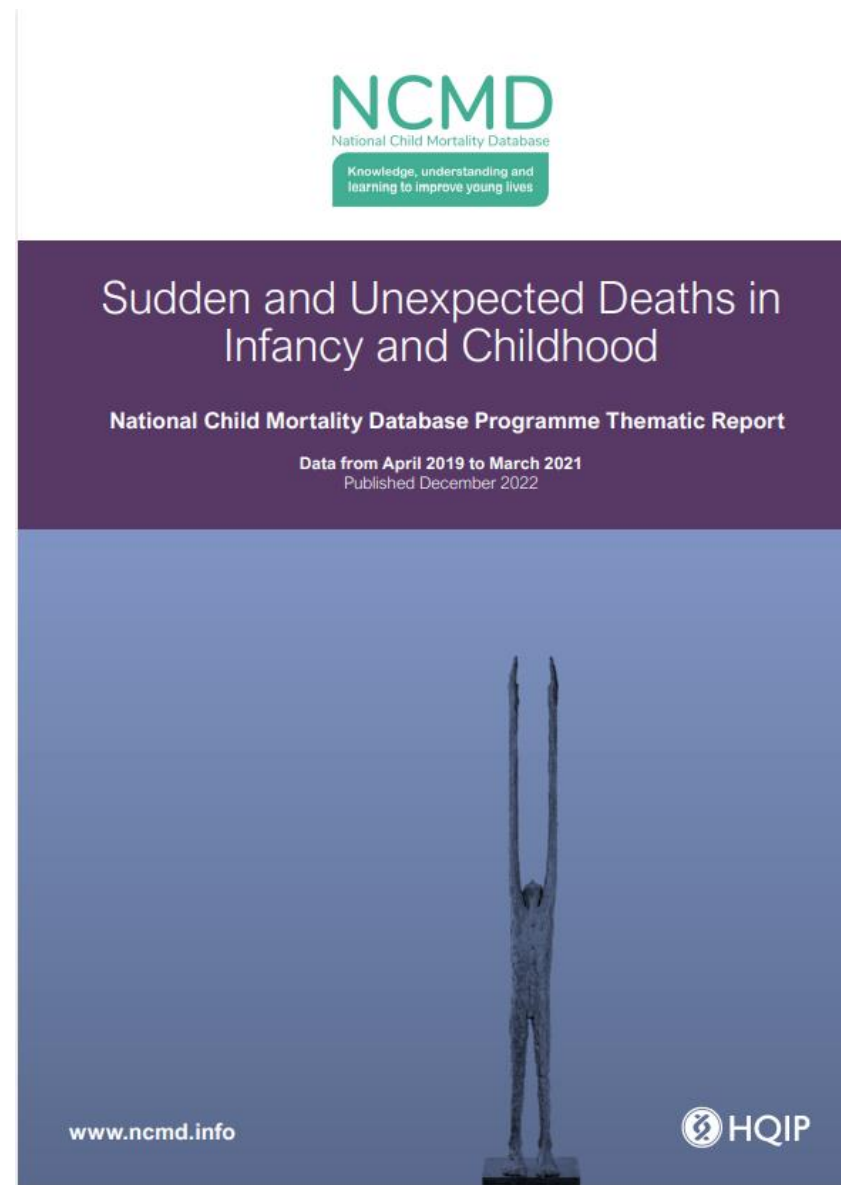
This site includes resources and reports from Triennial and Biennial Analyses of Serious Case Review reports (1998-2019) to support professional learning.

[Learning for the future: Final analysis of serious case reviews 2017-2019](#) analyses 235 serious case reviews (SCRs) relating to incidents between April 2017 and September 2019. This is the ninth and final periodic analysis, covering the period before SCRs were replaced by Local Child Safeguarding Practice Reviews (LCSRs). A separate report: [Serious case reviews 1998-2019: Continuities, changes and challenges](#) has been published alongside the 2017-2019 report.

Risk factors for SUDI

Sudden unexpected deaths of babies under 1, are strongly associated with neighbourhood deprivation, poor housing, low birthweight, prematurity, larger families, young maternal age, smoking during pregnancy, parental smoking, parental mental ill-health, drug and alcohol misuse, households with domestic violence, hazardous co-sleeping.

NCMD 2022



Preventing SUDI

Many of the risk factors for SUDI overlap with those for child abuse and neglect. SUDI is one of the largest types of case notified to the CSPR Panel (but these are a small proportion of all SUDI cases). The Panel commissioned a national thematic review of SUDI in 2019:

'SUDI prevention has all the hallmarks of other safeguarding work and should be understood as such ... it needs to be embedded within respectful and authoritative relationship-based safeguarding practice.' (CSPRP 2020, p. 4)

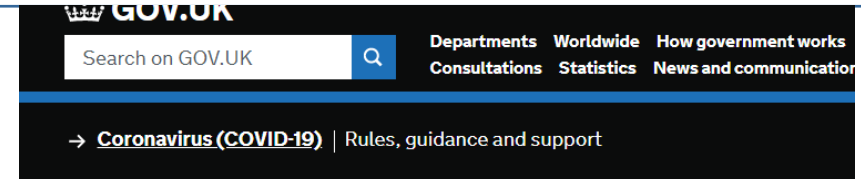
**Out of routine:
A review of sudden
unexpected death
in infancy (SUDI)
in families where
the children are
considered at risk of
significant harm**

Final report

July 2020

Curiosity and challenge: background

- A longstanding criticism of practitioners is that they did not demonstrate ‘professional curiosity’ or ‘challenge’ – these have become clichés – but we need to think more carefully about *what* they mean and *why* they may not happen.
- A key moment for ‘professional curiosity’ was the Laming report (2003) on Victoria Climbié – ‘respectful uncertainty’. It has evolved from keeping an ‘open mind’ to a more sceptical, investigative mentality.



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Independent report

The Victoria Climbié Inquiry: report of an inquiry by Lord Laming

This document contains the following information: The Victoria Climbié Inquiry: report of an inquiry by Lord Laming.

From: [Victoria Climbié Inquiry](#)

Published 28 January 2003

Documents



[The Victoria Climbié Inquiry: report of an inquiry by Lord Laming](#)

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- ‘Challenge’ also has a long history, and its focus has evolved: from the work itself being seen as challenging, some children’s behaviour being challenging, acting on the lessons of SCRs being challenging, to being ready to challenge other professionals and then to challenge parents.
- A key moment for professional challenge was the 'Baby Peter' case – the second SCR (2009) emphasised the need for ‘authoritative practice’.

Independent report

Haringey serious case reviews: child A

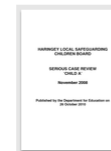
The first and second serious case review reports commissioned by Haringey local safeguarding children board relating to Peter Connelly.

From: [Department for Education](#)

Published 1 November 2008

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Documents



[Haringey local safeguarding children board: first serious case review - child A](#)

PDF, 1.37 MB, 135 pages



[Haringey local safeguarding children board: second serious case review - child A](#)

PDF, 413 KB, 74 pages

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What are the criticisms about professional curiosity?

- A lack of following up observations, not asking questions, not putting two and two together, not being open to new info – e.g. about parents’ drug use, about the behaviour of adolescents, the reasons for non-engagement, children’s views and experiences, 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.
- *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.*
- *Professionals lost sight of the domestic abuse and violence that had been reported and became focused on the housing situation; the view being that if the family had secure and appropriate housing then “everything would be all right”.*

What are the criticisms about professional challenge?

- Not asking questions of other professionals and parents/carers about things that are unclear, contradictory or you don't agree with; not using escalation procedures; not setting out clear expectations and holding families to them; accepting explanations at face value (e.g. reasons for missed appointments); accepting superficial compliance.
- *... 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.*
- *...The review identified many examples when practitioners should have escalated their concerns and been more critically challenging of decisions made by others that impacted on [the child's] safety and wellbeing.*

On the other hand

- ‘Chief social worker for children and families Isabelle Trowler said the care review [2021-22] 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?” (Jan 2021)



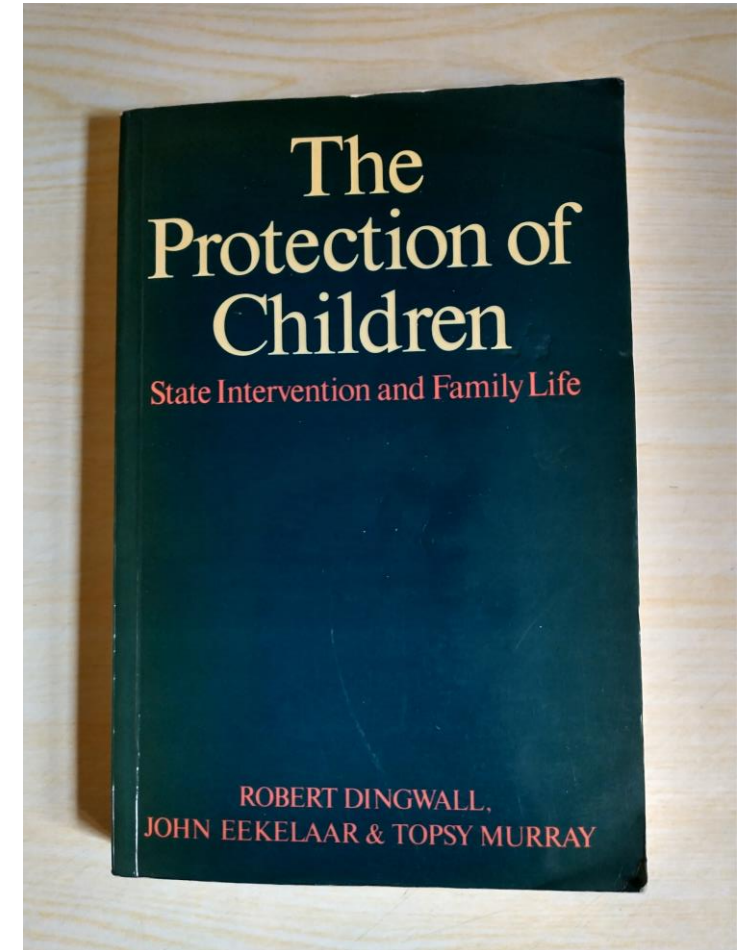
The screenshot shows the top of a webpage from CommunityCare. The logo is at the top left, with the tagline 'The heart of your social care career'. To the right are navigation links: 'Jobs/Careers', 'Inform', 'Events', and 'E-newsletters'. The main article title is 'Care review offers chance for 'completely new offer for children and families', says chief social worker'. Below the title is a sub-headline: 'Isabelle Trowler says review provides opportunity to move away from system that leaves "too many families feeling persecuted and unsupported" to one that "recognises the strengths of families and communities"'. The author is 'Alice Blackwell on January 29, 2021 in Children'. A photo of Isabelle Trowler is shown below the text. On the right side of the page, there are several small logos and icons, including 'Con li BDC, L', 'Essex Cou', and 'Com jc You'.

Complex and subtle work

- *... in many of these cases the families have experienced significant poverty which appears to inhibit professionals from being assertive in their interactions with parents, meaning they do not respond to clear risks to children.*
- Need to take proper account of the family's race, ethnicity, culture: *'... few attempts were made and minimal progress achieved in understanding the reality of [the family's] day to day life.'*
- A mother interviewed for the review thought 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.'*

Why ought we to be curious about professional curiosity and challenge?

- 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 often don't do it themselves! They have become clichés that hinder analysis
- Recognise the ambiguities and subtlety of professional curiosity and challenge



‘Child protection raises complex moral and political issues which have no one right technical solution. Practitioners are asked to solve problems every day that philosophers have argued about for the last two thousand years and will probably debate for the next two thousand ... What matters is that we should not disguise this and pretend it is all a matter of finding better checklists or new models of psychopathology – technical fixes when the proper decision is a decision about what constitutes a good society. How many children should be allowed to perish in order to defend the autonomy of families and the basis of the liberal state? How much freedom is a child’s life worth?’

Dingwall, Eekelaar and Murray (1983: 244) *The Protection of Children*

But curiosity and challenge do have an important place – they don't have to be inquisitorial, but they do need clear thinking and persistence!

- *....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.*
- So they ARE compatible with 'relationship-based practice' – being helpful and honest – it may not be easy, but this is an important message – staff may need help to put it into practice!

Making the most of curiosity and challenge

- *Recognise the complexity and subtlety of professional curiosity and challenge – support your staff to develop and apply the skills!*
- *Be curious about yourselves/your own organisation, and open to accept challenge to your agency and yourselves!*
- *Be astute about the wider context – national policy and legislation, budgets, inspections, scandals, the availability (or not) of services, the socio-political balances of state intervention and family autonomy.*


Putting curiosity and challenge into practice, effectively

- Kindly
- Observe
- Ask
- Listen
- Assess and act





Outline

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Children and Youth Services Review



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

[Jonathan Dickens^a](#)  , [Laura Cook^a](#)  , [Jeanette Cossar^a](#)  , [Cynthia Okpokiri^a](#)  ,
[Julie Taylor^b](#)  , [Joanna Garstang^c](#)  

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Highlights

- Learning the lessons from serious child abuse cases can prevent harm in future.
- Lack of 'professional curiosity' and 'challenge' are inadequate explanations.
- More productive understandings for practice would be communication and courage.
- Awareness of the ambiguous policy context is also essential.
- Well supported staff and properly resourced services are vital.

<https://doi-org/10.1016/j.childyouth.2023.107081>



ORIGINAL ARTICLE | [Open Access](#) |

Tackling the 'normalisation of neglect': Messages from child protection reviews in England

Julie Taylor , Jonathan Dickens, Joanna Garstang, Laura Cook, Nutmeg Hallett, Eleanor Molloy

First published: 12 July 2023 | <https://doi.org/10.1002/car.2841>

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Abstract

Despite a history of critique, concentrated discussion and improved assessment processes, neglect continues to be a major challenge for child protection services. This paper draws on findings from a government-commissioned analysis of 'serious case reviews' (SCRs) in England, arising from incidents of serious child abuse in 2017–2019. There were 235 cases, for which 166 final reports were available. Alongside a quantitative analysis of the whole cohort, we undertook an in-depth qualitative analysis of 12 cases involving neglect. A key challenge in responding to neglect in its different forms is that it can be so widespread amongst families that practitioners no longer notice its severity or chronicity – it becomes normalised. In this paper we explore two dimensions of the 'paradox of neglect' where it seems to be everywhere and nowhere simultaneously. The first is that neglect is so closely bound up with the prevalence of poverty that little action is taken to address it. The second is that the overwhelming nature of neglect can blind practitioners to other forms of maltreatment that may also be present within a family. Practitioners, now more than ever, need to recognise the dimensions of this paradox to protect children from neglect.

<https://doi.org/10.1002/car.2841>

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