### WSCB 12th Annual Conference:
Professional Curiosity & Respectful Uncertainty.

‘Professional curiosity’ is the term used to describe the questions we ask ourselves about what is going on for families and children below the surface. Our interactions with service users should always be respectful and honest. However we know that for lots of reasons families tell us things that aren’t true. Being curious about the likelihood of what you are being told by families, and testing it out when you aren’t confident or convinced about something is what has come to be known as ‘respectful uncertainty.’

We chose these two concepts for our conference this year because they are themes that keep cropping up in our case reviews, and it is clear that professionals often find it difficult to be curious and uncertain about what is going on in family life, or feel that it is wrong to ‘disbelieve’ what parents and carers tell them. We are all responsible for safeguarding children and promoting their wellbeing, and to do this effectively we need to understand what their lives are really like.

The conference this year provided delegates with an opportunity to reflect on some real life scenarios and encouraged practitioners to look beneath the surface—‘lifting the mask’. Geese Theatre Company opened the conference with an engaging and dynamic production, interspersed with questions to enable reflection on practice in Warwickshire.

Sarah Harris, Principal Social Worker, provided valuable insight and practice experience on the use of supervision to promote professional curiosity.

Lorraine Harris (CSE operations Team Manager), Sarah Gallagher (Childrens’ liaison Manager) and Edryd Coleman (Missing Team Manager) provided members of the conference with a valuable insight of the return home interview and the role professional curiosity has within this.

The conference concluded with Dr Peter Sidebotham delivering important messages from our serious and local case reviews, encouraging practitioners to think about preventative and protective actions we can take, emphasising the need for us all to “get smarter” about understanding cumulative risk.

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### BITE SIZE PIECES

1. Find out who the adults are that are accessing services for a child.
   - Is it the person I was expecting?
   - If not what does this tell me?

2. If a pattern of problematic behaviour is well established, don’t be too quick to believe that it has really changed.

3. Notice your own discomfort about working with an adult or visiting their home, and wonder what it is like for the children who live there.

4. Notice patterns, or changes in longstanding patterns, and try to find out what is behind them.

5. Professional colleagues sometimes abuse children. If you see or hear things that seem odd, don’t dismiss them just because of the role of the person concerned.

6. When you are aware that parents/carers are having difficulty in some areas of their life, (such as financial, health, offending behaviour) consider that this could be having an impact on the lived experience of their children.
THINK FAMILY

A single agency review requested by WSCB has continued to demonstrate the importance of ALL organisations applying a think family approach to their practice. Working Together (2015) clearly sets out “when staff are providing services to adults they should ask whether there are children in the family and consider whether the children need help or protections from harm” (pg 59). This review was undertaken following an apparent suicide attempt by a father which threatened the lives of his two children.

This review again demonstrates the important role professional curiosity has to play in practice. Research and statutory guidance tells us that children may be at greater risk of harm in families where mental health problems exist. In responding to this crisis unfortunately assumptions were made based on face value information available to the agencies undertaking their assessment. Services responded appropriately to the presenting medical needs of the adult male and continued to treat him as an adult male, failing to ask questions about other family members, including children.

The visiting service to the home identified children were present but in their assessment had viewed the children as being protective factors, and were not aware that the issues around contact with his children were also the catalyst to the incident. Whilst good practice was demonstrated in assessing the father’s mental health the triangulation of this information in assessing the risk of harm to the children or their needs did not take place. Subsequently at the point of closure the children were assessed as a protective factor which influenced decision making for ongoing care, but the assessment did not take into consideration the age of the children and their dependency on their father which could have potentially increased distress and therefore risk.

LIFTING THE MASK

WSCB special cases sub-committee holds responsibility for having oversight of relevant single agency reviews to enable wider learning to be identified and shared. These reviews, often referred to as critical incident reviews, analyse the incident, identify learning and note recommendations for improvement as well as sighting good practice in the overall report.

Special Cases had sight of a critical incident review undertaken following an attempted suicide of a young person who had been receiving multi-agency intervention over a period of time. The review identified that whilst the young person had been involved with a number of services since the age of 13yrs, interventions only addressed the presenting concerns and failed to address underlying causes to the behaviours. The review highlights how silo working contributed to the lack of a coordinated response in the assessment and management of the young persons needs.

The review also identified similar learning to other local and serious case reviews; identifying how an unwillingness or reluctance to engage in services can provide opportunity for services to withdraw. Responding to the reluctance or refusal of a parent to engage can often divert professionals attention away from the needs of the child/children. Dr. Peter Sidebotham illustrated this at the WSCB conference. Reluctance to engage is likely to be the choice of the parent and not the child’s choice.

“Lack of engagement by the family should, if anything, heighten concerns and should not prompt closure of a case without a thorough appraisal of any ongoing risks to children in the family”. For example, a child not attending a medical appointment is likely to be recorded as ‘did not attend’ when the reality is the child ‘was not brought’. A simple shift in language in itself can enable practitioners to exercise their professional curiosity and push us to ‘lift the mask’ and ask more questions.

WSCB Training Courses:

14th & 15th June— Effective Child Protection & Core Group Planning.

12th July—Emotional abuse and case management

15th July—Child Sexual Exploitation—Responsibilities, Reporting and Responding to CSE.

Register a place—https://warwickshire.learningpool.com/login/index.php