

Professional curiosity

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## What do we mean by ‘professional curiosity’?

Professional curiosity is a combination of looking, listening, asking direct questions, checking out and reflecting on information received. It means not taking a single source of information and accepting it at face value. It means testing out your professional hypothesis and, making sure you do not go into a situation with an unconscious bias or developing one. It means triangulating information from different sources to gain a better understanding of person/family/household functioning which, in turn, helps to make predictions about what is likely to happen in the future. It means seeing past the obvious and initial presentation of the person/family/child/young person.

Similar terminology has been used in some areas and is known as ‘respectful uncertainty’ (Laming 2003). This means that professionals must remain sceptical of the explanations, justifications, or apologies they may hear. In other words, professionals should think the unthinkable and be respectfully curious.

This is not a new approach and does not mean extra work.

## Why is it important in working with people, children and their families?

Learning from case reviews, both nationally and locally, shows that responding to presenting issues in isolation and a lack of professional curiosity can lead to missed opportunities to identify less obvious indicators of vulnerability or significant harm, and we know that in the worst circumstances this has resulted in death or serious abuse.

## Is exercising professional curiosity easy and straight forward?

Not always. Especially with those people who demonstrate disguised compliance or coercive control. People / Families can appear to be engaging with professionals but are not able or willing to change because of an intervention. Or certain family members are unable through fear to be open and honest about the family dynamics. It is with these people (domestic units/living arrangements) and families that professionals need to exercise most curiosity. It is acknowledged that this is not always straightforward, and the use of supportive supervision may be important for workers / staff to reflect on individual situations and encourage that professional curiosity in these situations.

## What is disguised compliance?

This can occur when individuals want to draw professional’s attention away from possible harm. It is often a theme in Adult Safeguarding Review and ChildrenCase Reviews. Disguised compliance can often prevent, or delay understanding of the severity of harm and can cause situation to drift.

For example:

* There may be no significant change despite significant input from professionals.
* The individuals account may differ from that of other household members / parents/carers.
* Little effort into making agreed changes work.
* People / family and household members predominantly focus on their or other issues to distract professionals from what is happening.
* Behaviours may distract professionals from focussing on the child or adult.

## What can you do about it?

* Question your own assumptions about how people and family’s function and guard against over optimism. Sometimes practitioners are over optimistic about progress and ability to care for the child / adult or their promises to engage with services. Rationalising behaviour is also common – for example failure to engage with services as a matter of choice rather than non-compliance.
* Observe what is being said but also remember to look for non-verbal cues e.g. body language and carer and cared for interactions.
* Keep detailed records and build up a chronology - this will help with looking for patterns of noncompliance.
* Look at previous records to identify patterns of behaviour/engagement, including our partnerships experience of behaviours and engagement. Remember that previous history is the best predictor of future behaviour, are we the best agency to facilitate the engagement.
* Recognise how your own feelings (for example tiredness, feeling rushed or illness) might impact on the view of a child/ person or family on a given day.
* Be willing to have less than ‘comfortable’ interactions with people / families when this is necessary.
* Address any professional anxiety about how hostile or resistant people / families might react to being asked direct or difficult questions – get support if needed.
* Remain open minded and expect the unexpected, utilising all your senses including gut feeling, and you may only have one piece of the ‘jigsaw.’
* Seek guidance from safeguarding leads.
* Appreciate that respectful scepticism and challenge are healthy – it is ok to question what you are told.
* Ensure you can recognise disguised compliance.
* Understand the impact of coercive control on the behaviour and responses of family members.
* Understand the cumulative impact, multiple or combined risk factors, e.g., domestic abuse, drug/alcohol misuse, mental health (previously referred to as ‘toxic mix’)
* Ensure that your practice is reflective and that you have access to good quality supervision (encouragement to refer ‘If it doesn’t feel right, it probably isn’t right!’)
* As a supervisor – ensure you are asking curious questions, drawing the practitioners thought processes and analysis of the case into a realm of curiosity and respectful scepticism.
* Linking in with other professionals / services to share and explore information, discussing information with other professionals who knows the person / child / family who may share the same concerns and feelings. (focusing on evidence/fact/responses as opposed to solely on assumption/opinion) effectively rationalising why you have raised concerns and more importantly what you have done around these concerns (who they have spoken to, raised it with)

## Keep the focus.

* Remain focused at all times.
* Look to uncover the reality of the circumstances talk to the child (ren) / adult. What is it like to be a person or adult living in that household?
* When an important appointment (s) is / are missed (e.g. with health providers, employment, education) remember that this may not be a choice.

Appointments not attended are potential missed opportunity to engage in support that is required to meet their needs. We need to consider the impact on the person of them missing their appointment and what it could mean to their life. Please follow your services ‘was not brought’ / none attendance / engagement policy and consider the level of risk / urgency when doing this. (Key trigger and requires further research, whether this was intentional, measures taken to negate any risk of missed appointment, history of attendance, impact of missing appointment (concealing children or adults at risk of abuse from professionals))

* Checking the information, you have been given to corroborate, if you are told there is an extensive network such as friends and or, family members, have you investigated to check and recorded the outcome. (who else needs to know this information, has this been shared)

## Some example questions to ask yourself?

Looking

* Is there anything about what I am seeing in my interaction with this person (people) / family which prompts questions or makes me feel uneasy or concerned?
* Am I observing behaviour which is indicative of a safeguarding concern (abuse or neglect etc).
* Does what I am seeing support or contradict what I am being told?

Listening

* Am I being told anything which requires further clarification?
* Am I concerned about what I am hearing people / family members saying to each other?
* Is someone trying to tell me something but finding it difficult to express themselves? If so, how can I help them to do so?

Asking

* Are there direct questions which I could ask in my direct contact with this person (people) / family which will provide more information about the vulnerability of person / family members?

Consideration

* The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged sixteen and over living in England and Wales who are unable to make all or some decisions for themselves.
* Is there any reason to doubt the person ability/ capacity to make decisions regarding their care and support needs, including their safety? Is this because of an impairment of the mind or brain?
* Do I need to share my concerns and seek support from relevant professionals?
* For more information - [Mental Capacity Act 2005 at a glance | SCIE](https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance)

## Assessment example questions.

* How do members of your family deal with conflict?
* How do adults / children in the household respond to stress?
* What arrangements are in place for people (person) to access pre-school setting/education/ further education/ability to work?
* Who are the professionals working with person (People) / members of your family?
* What is it like to be (name) living in this family/household? What is a typical day like for you?
* Who is this with you at this appointment?
* Who is living with you?
* Why are you not at pre-school/school/education/employment?
* What is the first thing you think of when you get up in the morning and/or the last thing you think of before you go to sleep?
* When were you last happy?
* Do you feel safe?
* What do you look forward to?
* Are there people who regularly visit your home apart from those who live there?
* Are you in fear of the consequences of doing something, or not doing something?
* “I’m curious, tell me more about that …”
* “I’m wondering…”
* “I’ve noticed…and I’m wondering why?”
* “I get the feeling… would I be right?”

## Am I colluding.

* Am I colluding to avoid conflict i.e. taking the word of a family member rather than speaking to the child or adult at risk?
* Am I minimising negative information to avoid provoking a reaction?
* Am I hesitant to share my concerns to avoid confrontation?
* Am I keeping my concerns to myself or am I sharing them with my Line Manager / Safeguarding?
* Am I focusing on the family needs not the needs of the child or adult at risk?

## Checking out.

* Do I know what other professionals are involved with this person and or their family?
* Have other professionals observed what I have seen?
* Are professionals being told the same or different things, or do explanations from family members change over time or according to who you ask?
* Check out assessments of professionals for example, ‘they have capacity,’ ‘they have an LD’ are there documented assessments to support this?
* Are other professionals concerned? If so, what action has been taken so far and is there anything else which should or could be done by me or anyone else? are professionally challenging to each other, or have we accepted the status quo.
* Do I need a Multi-Disciplinary Team (MDT) meeting? (Something which professionals may feel is insignificant could create a bigger picture, so understanding the value of everyone’s contribution)

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