Norfolk Safeguarding Adults Board

Norfolk Safeguarding Adults Board

Professional Curiosity Guidance

FINAL
27 September 2018

Issue Number	1 – FINAL
Document Owner	Norfolk Safeguarding Adults Board
Date Approved	SEPTEMBER 2018
Date Published on NSAB website	27 SEPTEMBER 2018
Review Date	SEPTEMBER 2019 or sooner if required

Professional curiosity

Key Points

- Have empathy and hear the voice of the person.
- Know the factors that are barriers to professional curiosity and take steps to reduce them.
- Be courageous and ask difficult questions.
- Think the unthinkable; believe the unbelievable
- Consider how you can articulate 'intuition' into an evidenced, professional view and discuss 'gut feelings' with other professionals.

Introduction

Professional curiosity is an emerging theme in the SARs and other reviews completed in Norfolk, and this finding is reflected nationally. It has long been recognised as an important concept in Children's Services, but is equally relevant to work with adults.

What is professional curiosity?

Professional curiosity is the capacity and communication skill to explore and understand what is happening with an individual or family. It is about enquiring deeper and using proactive questioning and challenge. It is about understanding one's own responsibility and knowing when to act, rather than making assumptions or taking things at face value.

Barriers to professional curiosity

It is important to note that when a lack of professional curiosity is cited as a factor in a tragic incident, this does not automatically mean that blame should be apportioned. It is widely recognised that there are many barriers to being professionally curious. Some of the barriers to professionally curious practice are set out below.

- ***Disguised compliance***

  A family member or carer gives the appearance of co-operating with Social Services to avoid raising suspicions, to allay professional concerns and ultimately to reduce professional involvement. We need to establish the facts and gather evidence about what is actually happening. We need to focus on outcomes rather than processes to ensure we remain person centred.

- ***The 'rule of optimism'***

  Risk enablement is about a strengths-based approach, but this does not mean that new or escalating risks should not be treated seriously. The '**rule of optimism'** is a well-known dynamic in which professionals can tend to rationalise away new or escalating risks despite clear evidence to the contrary.

- ***Accumulating risk – seeing the whole picture***
  Reviews repeatedly demonstrate that professionals tend to respond to each situation or new risk discretely, rather than assessing the new information within the context of the whole person, or looking at the cumulative effect of a series of incidents and information.

- ***Normalisation***
  This refers to social processes through which ideas and actions come to be seen as 'normal' and become taken-for-granted or 'natural' in everyday life. Because they are seen as 'normal' they cease to be questioned and are therefore not recognised as potential risks or assessed as such.

- ***Professional deference***
  Workers who have most contact with the individual are in a good position to recognise when the risks to the person are escalating. However, there can be a tendency to defer to the opinion of a 'higher status' professional who has limited contact with the person but who views the risk as less significant. *Be confident in your own judgement and always outline your observations and concerns to other professionals, be courageous and challenge their opinion of risk if it varies from your own*. Escalate ongoing concerns through your manager and use the Managing Professional Difficulties procedure.

- ***Confirmation bias***
  This is when we look for evidence that supports or confirms our pre-held view, and ignores contrary information that refutes them. It occurs when we filter out potentially useful facts and opinions that don't coincide with our preconceived ideas.

- ***'Knowing but not knowing'***
  This is about having a sense that something is not right but not knowing exactly what, so it is difficult to grasp the problem and take action.

- ***Confidence in managing tension***
  Disagreement, disruption and aggression from families or others, can undermine confidence and divert meetings away from topics the practitioner wants to explore and back to the family's own agenda.

- ***Dealing with uncertainty***
  Contested accounts, vague or retracted disclosures, deception and inconclusive medical evidence are common in safeguarding practice. Practitioners are often presented with concerns which are impossible to substantiate. In such situations, 'there is a temptation to discount concerns that cannot be proved'.

A person-centred approach requires practitioners to remain mindful of the original concern and be professionally curious.

- ‘Unsubstantiated’ concerns and inconclusive medical evidence should not lead to case closure without further assessment
- Retracted allegations still need to be investigated wherever possible.
- The use of risk assessment tools can reduce uncertainty, but they are not a substitute for professional judgement. Results need to be collated with observations and other sources of information
- Social care practitioners are responsible for triangulating information such as, seeking independent confirmation of information, and weighing up information from a range of practitioners, particularly when there are differing accounts and considering different theories and research to understand the situation.

- ***Other barriers to professional curiosity***
  Poor supervision, complexity and pressure of work, changes of case worker leading to repeatedly ‘starting again’ in casework, closing cases too quickly, fixed thinking/preconceived ideas and values, and a lack of openness to new knowledge are also barriers to a professionally curious approach.

Why professional curiosity is important: learning from Safeguarding Adults and Case Reviews

SAR Group referral

A referral was received from a residential care provider indicating a person had been pushed by another resident, with no injury sustained. At face value, the incident appears to be low risk, with management by the care provider recommended, and the safeguarding threshold for a s42 enquiry not reached. However, a check of the records of the perpetrator, person who was pushed, and the care provider, indicated a history of one off incidents by the perpetrator on both the current ‘victim’ and other residents. A record check revealed the ‘victim’ had been assaulted multiple times by both the perpetrator and other residents, which called into question assurances from the provider that the situation was being managed.
A check on the provider’s record revealed a history of quality assurance and safeguarding concerns.

These things escalate the risk to the individual who is the subject of the latest safeguarding concern. Checking case history and making links between what may initially appear to be unrelated incidents, would be a demonstration of professional curiosity and identification of ‘**cumulative’ or ‘accumulating’ risk**.

Mrs BB
The Safeguarding Adults Review (Dec 2016) for Mrs BB, was completed in Norfolk. Mrs BB was an older woman with dementia who was walking with increasing frequency around the town, and to visit her husband in his care home. Mrs BB regularly became lost. She would ask for lifts and for help to cross the road and the Police regularly returned her to her home, but these incidents were not reported to ASSD. Her walking was seen as 'normal' for her, and was not put in the context of her holistic situation i.e. having a diagnosis of dementia, the number of times she had become lost, the risks to her of 'wandering' in the town. This is an example of '**normalisation'**.

Adult H
This SAR was carried out by Nottinghamshire Safeguarding Adults Board. Adult H, aged 21, has a diagnosis of Spina Bifida and Hydrocephalus. A safeguarding adult referral was made by the ambulance service following severe burns. Adult H suffered 14% skin loss and chronic wounds indicative of urine burns. Adult H's transition to adult care showed minimal multi agency working. There was insufficient focus on non-attendance at medical appointments. The family's lack of engagement disabled the safeguarding process repeatedly with no escalation by professionals. Adult H was consistently seen with her mother, hence lack of her own voice was evident.

Recommendations include a review of transfer between children's and adult's services. Creation of a multi-agency self-neglect policy and a multi-agency escalation policy. Guidance to be provided on working within the context of service refusal. This case is an example of '**disguised compliance'** by family members.

Matthew Bates and Gary Lewis
Two men aged 30 and 63 respectively, with profound learning disabilities, cerebral palsy and osteoporosis, both resident in the same care home in West Sussex, both admitted to hospital and found to have suffered fractures to a femur. An assumption was made that the injuries were due to a moving and handling issue and no safeguarding referral was raised. The SAR concluded that the circumstances of these injuries and the Consultant's statement, should have led to police being contacted directly by the hospital. Had the injuries occurred to two children, the author had no doubt that police would have been contacted very early on. This case demonstrates how the approach to injuries inflicted on vulnerable adults still has a different more cautious approach, leaving adults at risk.

At an early stage moving and handling was the emerging explanation, and this was never strongly challenged. ***'Confirmation basis'*** appears to have reduced professional curiosity leading to the lack of consideration of other possibilities.

Beryl Simpson

Beryl Simpson (not her real name), aged 82 years, lived with her daughter aged 62 years, in a house that Beryl owned in Kent. On 6 December 2016, following concerns raised by Kent County Council Adult Social Care & Health (ASCH) about Beryl's welfare, officers from Kent Police used their power under Section 17 of the Police and Criminal Evidence Act 1984 to enter the house. They found Beryl in a very poor state of health; she was emaciated and malnourished. Her daughter was also present in the house, which was in poor repair.

There was no working toilet, it was cold and there was evidence of long term extreme hoarding. After Beryl's condition was stabilised by paramedics, she was taken to Hospital. Despite intensive treatment she died in hospital on 15 December 2016.

The SAR concluded that:

> *'the fundamental issue in this review is that organisations did not have any contact with Beryl in the last four and a half years of her life. While it is accepted that it will always be challenging to support people who decline help, there seems to have been a lack of what has become known as 'professional curiosity' about Beryl's condition.*
>
> *There is little evidence that, when contact was made in the initial stages with Beryl and Margaret, and latterly with Margaret, any questions were asked about Beryl's health and wellbeing. It went further than Margaret being permitted to speak for Beryl; she was not asked about Beryl. There was no evidence that Beryl lacked the mental capacity to make decisions for herself; more effort should have been made to speak to her.'*

Developing skills in professional curiosity

The following is based on guidance issued by the Norfolk Safeguarding Children's Board about removing the barriers to professional curiosity:

- Be flexible and open-minded, not taking everything at face value. Check your own emotional state and attitudes. Leave time to prepare yourself for managing risk and uncertainty and processing the impact it has on you.
- ***Think the unthinkable; believe the unbelievable. Consider how you can articulate 'intuition' into an evidenced, professional view.***
- Use your communication skills: review records, record accurately, check facts and feedback to the people you are working with and for. Never assume and be wary of assumptions already made.
- Use case history and explore information from the person themselves, the family, friends and neighbours, as well as other professionals (triangulation).
- Pay as much attention to how people look and behave as to what they say.

- Actively seek full engagement. If you need more support to engage the person or their family, think about who in the network can help you. Consider calling a multiagency meeting to bring in support from colleagues in other agencies.
- Take responsibility for the safeguarding role you play, however large or small, in the life of the person in front of you.

Professional curiosity is likely to flourish when practitioners:

- Attend good quality training to help them develop.
- Have access to good management support and supervision.
- Have empathy ('walk in the shoes') of the person to consider the situation from their lived experience.
- Remain diligent in working with the person and their family/network, developing professional relationships to understand what has happened and its impact on all involved.
- Always try to see the person separately.
- Listen to people who speak on behalf of the person and who have important knowledge about them.
- Be alert to those who prevent professionals from seeing or listening to the person.
- Do not rely on the opinion of only one person, wherever possible.
- Have an analytical and reflective approach.
- Develop the skills and knowledge to hold difficult conversations.

Holding difficult conversations and challenging

Tackling disagreements or hostility, raising concerns or challenge, and giving information that will not be well received are recognised as hard things to do.

The following are some tips on how to have difficult conversations.

- Planning in advance to ensure there will be time to cover the essential elements of the conversation.
- Keeping the agenda focused on the topics you need to discuss. Being clear and unambiguous.
- Having courage and focusing on the needs of the service user.
- Being non-confrontational and non-blaming, and sticking to the facts.
- Having evidence to back up what you say. Ensuring decision-making is justifiable and transparent.
- Showing empathy, consideration and compassion – being real and honest.
- Demonstrating congruence ie making sure tone, body language and content of speech are consistent.

- Acknowledging 'gut feelings', sharing these with other professionals, and seeking evidence.
- Understanding the elements and indicators of behavioural change.
- Holding a healthy scepticism.
- Understanding the complexities of disguised compliance.
- Applying professional judgement.

Never be concerned about asking the obvious question, and share concerns with colleagues and managers. A 'fresh pair of eyes' looking at a case can help practitioners and organisations to maintain a clear focus on good practice and risk assessment, and develop a critical mindset.

How managers can support professionally curious practice

Managers can maximise opportunities for professionally curious practice to flourish by:

- Playing 'devil's advocate' – asking 'what if?' questions to challenge and support practitioners to think more widely around cases. Question whether outcomes have improved for the person and evidence for this.
- Present alternative hypotheses about what could be happening.
- Provide opportunities for group supervision which can help stimulate debate and curious questioning, and allow practitioners to learn from one another's experiences. The issues considered in one case may be reflected in other cases for other team members.
- Present cases from the perspective of other family members or professionals.
- Ask practitioners what led them to arrive at their conclusion and support them to think through the evidence.

- Monitor workloads and encourage practitioners to talk about, and support them to address issues of stress or pressure. Support practitioners to recognise when they are tired and need a fresh pair of eyes on a case.

Further information

The 'Managing professional difficulties' multiagency procedure is available on the NSAB website. This sets out guidance for challenging other professionals/managing a challenge from another professional, and a process for escalation and decision-making.

The multiagency 'Complex case guidance' is published on the NSAB website. This covers the process for involving other agencies in difficult cases.

Further material on professional curiosity is contained on the Manchester children/adult board website:

https://www.manchestersafeguardingboards.co.uk/resource/professional-curiosity-resources-practitioners/

Brighton and Hove Safeguarding Children's Board have published a useful newsletter about professional curiosity. It is aimed at professionals working with children, but the content is equally applicable to practitioners working with adults. A copy is embedded below:

B&H-LSAB-Professional-Curiosity-Bulle

St Thomas' Training run a course for multiagency professionals on Learning from Safeguarding Adults Reviews. This course has a strong emphasis on professional curiosity. The course details can be found on the St Thomas' Training website.

The Norfolk Safeguarding Children's Board runs a course on Professional Curiosity and Challenge. This is focused on working with children but covers skills transferable to working in professionally curious way with adults. This can be booked via the NSCB website.

The Safeguarding Adult Reviews referenced above can be found at these links:

Mrs BB
Adult H
Matthew Bates and Gary Lewis
Beryl Simpson

END

27 September 2018