Questions for Hypothesising and Reviewing Hypotheses

The intention is that these questions are used as triggers to help practitioners reflect on whether they have explored all possible hypotheses during an assessment and have explained this thoroughly in their assessment report.

1. **Hypothesising at the Early Stage of Involvement**

- Can you develop some hypotheses - at least four? (More if you can - keep them broad, not just single-incident based ones.)
- What knowledge and information are the hypotheses based on (for example, theory, research, observation, assumptions, information given, hearsay)?
- What actions could you take to test out your hypotheses?
- Can you construct an action plan for testing them, with timescales identifying the methods you will use?
- Who will be involved in gathering information to test out your hypotheses?
- How will you seek evidence to disprove (disconfirm) your hypotheses?
- What will you use to help you decide how to weight the value of different hypotheses?

2. **Reviewing hypotheses Mid-Way through on Assessment**

- Have you been able to test out all of the original hypotheses
- Are you satisfied that you have tested the hypotheses rigorously and you haven't simply sought out information to confirm your original hypotheses?
- Of the original hypotheses, which have you discarded and why?
- Have any new hypotheses emerged?
- What methods are you going to use to test out the new hypotheses?

3. **Evaluating hypotheses Towards the End of the Assessment**

- Are you satisfied that you have tested all the available hypotheses sufficiently rigorously?
- Are you able to demonstrate, in your assessment report, the methods you have used to test out the hypotheses and why you have discarded or retained each one?
- Are there some hypotheses that you have not been able to test out because of the unavailability of sufficient information or lack of time or access to key people?
- lf so, are further enquiries indicated beyond the point of this assessment?
- lf so, what form do you recommend these should take?

Hypothesising exemplar

Hypotheses	**Methods for Testing Hypotheses**
Domestic violence	Ask each parent. Alone. Physical evidence? Talk to older children. Check with Police and CSC, check other agencies, investigate previous relationships, talk to extended family
Overlay is a possibility	Check the sleeping arrangements, temperature of the room, parent's understanding. Parent's capacity for rational actions at all times
The parents' histories are affecting their parenting	Take a full history from parents, grandparents and check out facts with agencies where possible
Some other possible hypotheses:	
There is likely drug/alcohol abuse	Ask parents. Ask others. Check for involvement with substance misuse services. Check with police. Check with grandparents/ neighbours. Use the SCODA assessment framework.
There might be attachment issues for this baby	Careful assessment of parents' understanding of baby's needs. Do they understand the baby as having separate needs? Do they respond consistently to expressions of need? Use Fahlberg checklists.
Neglect might be happening	Check baby's physical presentation. Check food and hygiene in the home. Check stimulation for baby. Use graded care profile.
Mum is depressed (post-natal depression?)	Use Edinburgh scale (HV), use DOH adult wellbeing scale or other similar. Ask mum. Liaise with other agencies
Financial difficulties. impact of poverty	Talk to parents. Look at financial information, check benefits take-up / entitlement etc
On the run from CP Plan in another authority	Check with agencies and authorities

Professional Dangerousness

Key examples of professional dangerousness

1. Rule of optimism: Professionals tend to want to believe that all is well for the child. Even when the indicators of abuse are visible there is a tendency to explain them away and be convinced that the child is safe. This is a form of denial and probably the most common form of dangerous practice. In one case the social worker saw the child looking sick but afterwards saw her with the family on an outing. He allowed himself to believe the latter to be proof of the child's safety and thought his original concerns to be unfounded.

2. The Stockholm syndrome: This theory is based on hostage situations where the people taken hostage begin to identify with the cause of the terrorists. It is a survival mechanism common in child abuse cases. Sometimes a parent or abuser is powerful ' and intimidating, perhaps critical of professionals and the worker will begin to see the adult's point of view rather than the child's. It is one way that the worker feels safe at the expense of the vulnerable child.

3. Professional accommodation syndrome: The worker may mirror the child's retraction of abuse, deny the reality of the abuse and be keen to be persuaded that any allegation by the child must be suppressed. Any other possible reason for the abuse will tend to become accepted in preference to considering the possibility that abuse has occurred.

4. Exaggeration of hierarchy: Adults of low status who report abuse may not be heard or taken seriously even though they may be close to the child e.g. neighbours, friends or a nursery worker. A psychiatrist, lawyer or paediatrician will probably get their important opinions heard more readily by other professionals. In one child abuse scandal the cook in the children's home had a wealth of information about the child abuse taking place but was not interviewed by the inquiry.

5. Concrete solutions: Professionals respond swiftly to abuse situations with practical solutions such as housing, washing machines, or money rather than by investigating and attempting to verify the alleged abuse.

6. Assessment paralysis: Sometimes professionals feel helpless and incapacitated. It might be thought that change is hard to achieve because the family have always lived in an abusive way and it is just their way of life. Chronic neglect and inter-generational sexual abuse are often ignored because of this attitude.

7. Stereotyping: Professionals may make assumptions about how families bring up their children. These may include cultural stereotypes. In one case the stereotype of the black grandmother being able to cope with every situation falsely portrayed her as a protector of the child against a powerful and abusive adult within the family.

8. False compliance: Parents may be able to convince professionals that they are cooperating to protect the child but in fact a skilled practitioner who can analyse parental behaviour will be open to considering the possibility of them being abusive.

Professionals may become enmeshed with the family and be so collusive with the carers that they do not see the needs of the child.

9. Omnipotence: Professionals believe that they know the best interests of the child and will not revisit their perceptions in the light of new evidence.

10.Closure: Families may shut out professionals. Calls go unanswered, appointments are missed, curtains are closed and doors locked. Child deaths from abuse are often preceded by closure. This dynamic may be mirrored by professionals avoiding contact with the family.

11.Role confusion: Professionals may be unclear about tasks and assume that someone else is responsible for protecting the child. In child protection everyone has prime responsibility for the safety of the child. Clarity of decisions is essential. In one case a health visitor said she would see the baby and the social worker assumed that the health visitor was visiting the home. Instead, she was seeing the baby at the clinic and no-one saw the appalling conditions in the home.

12. Children unheard or parent and carers unheard: Every child abuse inquiry highlights the central importance of listening to the child. Although children do find it hard to speak of abuse it has been shown that prior to a child's tragic death they have often forewarned someone in authority about the risk. Similarly prior to fatally harming a child, carers often raise the alarm by telling a professional that they are afraid of hurting the child or they cannot cope.

13. Information which is emotional, recent and vivid takes precedence over the old: Inquiries inevitably demonstrate that there was, among agencies, a great deal of knowledge and understanding about actual or potential harm to the child. New information must be examined in the context of prior facts, The importance of chronologies to allow analysis cannot be over emphasised. This information must be transferred as a family moves between authorities. This is sometimes referred to as **The Start Again Syndrome** which prevents practitioners from having a clear understanding of a case based on past information (Brandon et al., 2008: 11).

14. Non-compliance with statutory procedures: Inquiries commonly report that legislation, policy and practice are sound but that professionals did not comply with their implementation. When child protection procedures are in place such as conferences and strategy meetings, children generally become safe. Formal procedures allow for collation and analysis of all available information.

15. Unsafe Practices: Professional is unclear about Safe Working Practices. Examples could be using their own home as a venue to meet the child, giving children gifts based on favouritism, using personal ‘e’ / ‘online’ spaces or mobile phones to contact children, discussing their own sexual relationships, having inappropriate physical contact (eg ‘Horseplay’) or visiting a child’s house unannounced to see the child alone, not recording contacts, not letting managers know when another member of staff does not follow procedures.