West of Berkshire LSCB Forum

Disguised Compliance
LSCBs – three LSCBs across the west of Berkshire. Role of the LSCB – there to ensure that all children & young people in the area are effectively and appropriately safeguarded by organisations and services working with them. We have a joint Learning & Development Sub-group, promoting learning across the area. The joint Case Review Group identified disguised compliance as a recurring feature in national Serious Case Reviews.
 Definition

The NSPCC defines disguised compliance as:

Disguised compliance involves parents giving the appearance of co-operating with child welfare agencies to avoid raising suspicions, to allay professional concerns and to delay or avoid professional intervention.

West Sussex SCR describes it as being ‘where parents defuse professionals attempts to make a more authoritative stance by making pre-emptive shows of cooperation. The family’s compliance was only temporary but was sufficient to persuade workers of their apparent willingness to be more open and therefore kept them at bay. Giving the illusion of cooperation by telling workers what they wanted to hear and selective engagement with professionals.'
Disguised Compliance and the Importance of Professional Curiosity

www.safeguardingchildreneea.co.uk/resources/sue-woolmore-talks-about-disguised-compliance-2/

www.safeguardingchildreneea.co.uk

Video clip by Sue Woolmore.

Highlights
• The need for professional curiosity
• Have conversations with colleagues or manager to unravel questions you have – to allow you to weigh up what you have seen and come to conclusions. Others may see it differently to you.
• Easy to focus on the needs of parents and loose sight of the child
• Vital to be curious about what life is like for the child.
What does disguised compliance look like in real life? Using the NSPCC Case Review Repository – 4 SCRs where disguised compliance was a predominant feature

Havering - 3 school age children in care of maternal grandfather and his wife – Chronic neglect, emotional and sexual abuse

Manchester – Child Z (2015)
Death of 9 month old left unattended in a bath with 20 month old sibling

Chester West and Chester – Child A (2016)
Serious head injury of primary school aged child

West Sussex – Child G (2013)
Death of 10 month old due to non-accidental head injury

Similarities:
- All 4 have neglect as a key feature
- Chester, Manchester – parents has history of childhood abuse
- In 2 cases the mums were very young. In West Sussex the Author felt that this manipulation was not deliberate but a feature of her inexperience. Both Mums kept professionals at a distance.

Missed appointments & appearing positive but not following through – Manchester: parents saying there would be improvement but no evidence this took place. West Sussex: Mum appeared positive about future involvement but then failed to attend

Occasional improvements – Chester: Parents made occasional improvements which led to over optimism of their parenting capacity and their motivation to change

Difficult to engage – Havering: Carers hostile to professionals and they denied any issues. Manchester: Young mum kept professionals at a distance. West Sussex: Professionals found it difficult to engage and build relationship with the mother, avoiding contact and deceptive in her responses

 Criticism of other professionals – West Sussex: Mother diverted attention by being critical of other professionals

Dominating meetings - Chester: Parents engaged in TAF meetings but appeared to dominate and manipulate the meetings by disputing points, using diversionary behaviour and feigning compliance with recommendations

Leading to misdirection – shifting focus away from the family, but more importantly, the child.
Ineffective information sharing – Havering: Number of moves between local boroughs which led to information being lost as not travelled with the family. Manchester: No multi-agency information sharing or meeting to discuss issues. Only single agency decisions, no joint decision making, which also enabled misdirection, gaps in information and analysis.

Record Keeping – Manchester: Neglect a clear feature but not identified before the incident – a cannabis factory was found in the house that had not been identified during previous professionals visits. Lack of historical information available/recorded – enabled parents to deny problems (historic or current) leading to misdirection, especially when using self reporting and disclosure tools which were then used by professionals to make judgements. Effective and informed assessments require access to and understanding of parental and family history.

Lack of clear plans – Havering: Not a formal ‘looked after’ arrangement and lack of clear plans meant it was problematic for professionals to prove disguised compliance, Carers felt professionals were not honest as they were not provided a clear outline of the expectations of them, Professionals felt carers were reluctant to accept advice but it was unclear how this was challenged. Chester: There had been no formal assessment of their parenting capacity to allow this to be measured. The TAF meetings had at first been useful to engage the parents but lost impact over time when higher level support/intervention seemed to be required. Professionals knew there was disguised compliance but were stuck how to proceed.
Multi-agency involvement – Manchester: Young mum with long term support from Family Nurse Partnership, Professionals were reassured that parents were engaging with support (FNP) which would resolve the issues, but in reality they were not really engaging.

Chester: Large number of professionals involved which may have inadvertently enable distraction and feigned compliance

Quality of supervision – Manchester: Identified clear need for effective supervision for professionals to talk through concerns. West Sussex: Quality of supervision was an issue – did it sufficiently challenge professionals in their attitudes, constantly asking if assumptions about a family are correct or founded in hard evidence. Did supervisors challenge practitioners regarding the level of improvement with the family and whether clear analysis of risk factors had been undertaken.

Has anyone spoken to child to find out their lived experience?
Does anyone understand what the child thinks?
Manchester – Child Z

There is clear evidence of misdirection occurring in the case. There was a belief that the parents were open to and willing to accept help and support. In reality, there was an underlying pattern of missed appointments, behaviour that did not put the children’s needs foremost (for example in mother self-discharging from hospital after the first birth), and a reliance on parents saying they would make required changes without enough evidence of what was actually achieved.

Some of this reflects a misplaced empathy with parents being seen to overcome a range of personal difficulties, possibly an over confidence in the ability of a particular model of working being able to overcome and deliver improved outcomes, some professionals being under significant workload pressures and competing demands, not enough organised collation of information that could have highlighted important historical information as well as identifying for example behaviour that was indicative of disguised compliance.
Working with Disguised Compliance

• Think of a time you have tried, or wanted to change something in your life (diet, quitting smoking, changes jobs etc)
• How did it go? Was it easy? What were the barriers? Excuses?
• Did anybody try to take charge of you?
• Did anybody else ‘known best for you’?
• What effects occurred as a result of any or all of these experiences?
Working with Disguised Compliance

1. What might Disguised Compliance look like in the work that you do?

2. What challenges to practice does Disguised Compliance raise? What are the risks?

3. What works well when addressing Disguised Compliance?
Question and answer session

Suggestions for future forum topics?
Networking and Close

LSCB websites:
www.readinglscb.org.uk
www.westberkslscb.org.uk
www.wokinghamlscb.org.uk

Child Protection Procedures online:
www.proceduresonline.com/berks/

NSPCC National Case Review Repository:
www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/national-case-review-repository