THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Briefing note for child protection professionals across England

This short briefing note aims to summarise the key learning points from the independent Child Safeguarding Practice Review Panel's national review into the murders of Arthur Labinjo-Hughes and Star Hobson. It outlines the main practice and systems issues that featured in Arthur and Star's stories, which professionals might want to reflect on. It also sets out national recommendations for improving child protection across England. Read the full review report here: National review into the murders of Arthur Labinjo-Hughes and Star Hobson - GOV.UK (www.gov.uk)

About the national review

Arthur Labinjo-Hughes, 6, and Star Hobson, 16 months, were both murdered in 2020 as a result of sustained abuse and neglect by their caregivers. Extraordinarily harrowing video footage and images of both Arthur and Star, during the final weeks and days of their lives, led to understandable questions about why children had experienced such gross abuse when they were seemingly in 'plain sight' of public agencies.

Therefore, a national review was initiated to understand what happened to these children during their short lives, how agencies acted to safeguard them and whether their tragic deaths are representative of wider, national issues.

What can we learn from Arthur and Star's deaths?

In analysing what happened to Arthur and Star and how public agencies responded, the review identified a set of issues which hindered professionals' understanding of what was happening to Arthur and Star. These are:

- Weaknesses in information sharing and seeking within and between agencies.
- A lack of robust critical thinking and challenge within and between agencies, compounded by a failure to trigger statutory multi-agency child protection processes at a number of key moments.
- A need for sharper specialist child protection skills and expertise, especially in relation to complex risk assessment and decision making; engaging reluctant parents; understanding the daily life of children; and domestic abuse.
- Underpinning all of the above, a need for leadership and management which has a powerful enabling impact on child protection practice and creates and protects the optimum organisational context for undertaking this complex activity.

These are not new issues – they recur across serious incidents in a number of local areas, which the Panel sees on a fortnightly basis in rapid reviews and local child safeguarding practice reviews.

What are the key practice issues that feature in Arthur and Star's stories?

We have set out in more detail the main practice issues that feature in Arthur and Star's stories which resonate with findings from analyses of other serious safeguarding incident, for example, the Panel's two annual reports (2018-19; 2020), the Panel's thematic reviews, and the triennial analyses of serious incidents (Sidebotham et al., 2016; Brandon et al., 2020).

- **Lack of timely and appropriate information sharing**, for example, photographs of bruising to Arthur were not shared with the MASH; and limited information seeking, for example, concerns raised by Arthur and Star's family members were not unpicked.

- **Evidence was not pieced together and considered in the round** e.g. for Star, each referral was treated as a different episode and the evidence was not looked at altogether.

- **Understanding what the child's daily life is like, where this might not be straightforward** with both Arthur and Star there was limited direct work. Additionally, the histories of those involved in their lives, e.g. Frankie Smith and Savannah Brockhill, were not looked into sufficiently.

- **Listening to the views of the wider family and those who know the child well** - in Arthur and Star's stories a significant gap was the failure to talk to and listen to wider family members.

- **Appropriate response to domestic abuse** - the impact of domestic abuse on Arthur and Star was not explored in depth; concerns about domestic abuse towards Star's mother were considered episodically and not investigated sufficiently; information about Emma Tustin's history of domestic abuse was not triangulated between agencies.

- **Working with diverse communities** – assumptions and biases relating to culture, ethnicity, gender and sexuality affected how practitioners understood Arthur and Star's daily experiences and risks to their safety.

- **Working with families whose engagement is reluctant and sporadic** – in Arthur and Star's stories, professionals were increasingly kept at arm's lengths by the perpetrators. There was also signs of parental avoidance.

- **Critical thinking and challenge** - there were missed opportunities for critical thinking and challenge within and between agencies and to consider information altogether e.g. Strategy Meetings were not held prior to the home visit to see Arthur and before Star's Child Protection Medical.

- **Leadership and culture** – common to both Bradford and Solihull was a weak 'line of sight' to frontline practice by Safeguarding Partners.

Questions that you might want to reflect upon as a practitioner:

We have set out below some questions that you might want to reflect upon as a practitioner either individually, as part of supervision, or as a group:

- How do you work with other agencies to build a full picture of what is happening in a child's life?

- What behavioural biases, e.g. confirmation bias, might impact upon your information sharing and seeking practice?

- Do you consistently speak to and listen to the views of family and friends who know a child well? What barriers can get in the way of you doing this?

- What assumptions might you hold relating to culture, ethnicity, gender and sexuality? In what ways might this affect your practice?

- What aspects of working with families whose engagement is reluctant and sporadic do you feel more/less confident with? What do you consider to be typical signs of parental avoidance?

- What opportunities do you have - formally or informally - to challenge decisions within your and other agencies and to consider different professionals' perspectives?

Key messages for all Safeguarding Partners:

The report also sets out a few key messages for all Safeguarding Partners to reflect on:

All Safeguarding Partners should assure themselves that:

- Robust multi-agency strategy discussions are always being held whenever it is suspected a child may be at risk of suffering significant harm.

- Sufficient resources are in place from across all agencies to allow for the necessary multi-agency engagement in child protection processes e.g., strategy discussions, section 47 enquiries, Initial Child Protection Conferences.

- There are robust information sharing arrangements and protocols in place across the Partnership.

- Referrals are not deemed malicious without a full and thorough multi-agency assessment, including talking with the referrer, and agreement with the appropriate manager. Indeed, the Panel believes that the use of such language has many attendant risks and would therefore discourage its usage as a professional conclusion.

How can we change nationally?

The review outlines that the way child protection work is undertaken currently is not benefitting from the wealth of knowledge and skill we hold about the benefits of multi-disciplinary and multi-agency practice. It recommends that we need:

- Fully integrated multi-agency investigation and decision making, end-to-end across the child protection process; embedded in both structures and cultures.

- Those with the greatest expertise and skill doing the most difficult child protection work.

- Leaders who know what it takes to deliver an excellent child protection response and can create the organisational context in which this can flourish. This includes prioritising child protection, ensuring the resources necessary to deliver the work are in place, and working tirelessly to remove barriers that get in the way.

Therefore, at the heart of the recommendations is a proposal for new Multi-Agency Child Protection Units – integrated and co-located multi-agency teams staffed by experienced child protection professionals – established in every local authority area.

What would this mean for my role?

Child protection is absolutely core work for all children's social workers. It is also a priority for any agency that works with children, especially police, health and schools. Whether you're a social worker or health visitor, teacher or GP, police officer or paediatrician, every day you need to make difficult decisions, often in a short time frame, which deeply affect the lives of children and families. The core child protection statutory processes – of investigating child protection concerns, child protection planning and implementation, and reviewing progress – are key points where integrated multi-agency involvement and specialist child protection skills are very critical.

Star and Arthur's deaths illustrate the limitations of taking a single agency approach to investigating concerns when statutory multi-agency procedures were needed.

The review proposes that the proposed new Multi Agency Child Protection Units would be organised and delivered at a local level. Multi-agency professionals would be employed by their 'home' agency but seconded into the child protection unit, bringing their agency function with them. It is expected that units would be hosted by the local authority to ensure smooth join-up with the rest of children's social care. The review outlines how these build on Multi-Agency Safeguarding Hubs.

It recommends that Government puts in place an 'early adopter' approach to roll out, where some areas are supported to implement the new model quickly as part of a first wave, with following waves learning from their implementation experience.

What are the other recommendations?

There are eight recommendations in total. They are:

- **Recommendation 1**: A new expert-led, multi-agency model for child protection investigation, planning, intervention, and review.
- **Recommendation 2**: Establishing National Multi-Agency Practice Standards for Child Protection.
- **Recommendation 3**: Strengthening the local Safeguarding Partners to ensure proper co-ordination and involvement of all agencies.
- **Recommendation 4**: Changes to multi-agency inspection to better understand local performance and drive improvement.
- **Recommendation 5**: A new role for the Child Safeguarding Practice Review Panel in driving practice improvement in Safeguarding Partners.
- **Recommendation 6**: A sharper performance focus and better co-ordination of child protection policy in central Government.
- **Recommendation 7**: Using the potential of data to help professionals protect children.
- **Recommendation 8**: Specific practice improvements in relation to domestic abuse