North Yorkshire
Safeguarding Children Partnership

7 point briefing

Child Protection in England : National review into the murders of Arthur Labinjo-Hughes and Star Hobson

April 2023

1 Provide a brief summary of the circumstances of the case

Arthur and Star were both killed in 2020 as a result of sustained abuse and neglect by their caregivers. Professionals and family members had previously thought their parents capable of providing good care to them. However, wider family members voiced multiple concerns and shared evidence of physical abuse with professionals prior to their deaths. There was also a history of domestic abuse in both cases.

Arthur Labinjo-Hughes was a little boy who loved playing cricket and football. He enjoyed school, had lots of friends, and was always laughing. Arthur died in Solihull aged six on 17th June 2020. His father's partner, Emma Tustin, was convicted on 1st December 2021 of his murder. Arthur's father, Thomas Hughes, was convicted of manslaughter. They are now both serving prison terms.

Star Hobson was an inquisitive toddler who loved to listen to music and would dance in her baby walker, laughing and giggling. Star died in Bradford aged 16 months on 22nd September 2020. Her mother's partner, Savannah Brockhill, was subsequently convicted of murder on 15th December 2021 and her mother, Frankie Smith, was convicted of causing or allowing her death. They too are now in prison.

2 Tasks and challenges to the case

The Child Safeguarding Practice Review Panel is an independent body who oversee all statutory case review activity

- Given the similarity of the cases, the severity of harm and the death of both children, and because they happened so close together, the Panel decided to undertake a national child safeguarding practice review
- The purpose of the review was to analyse the circumstances leading up to Arthur's and Star's deaths and to explore why the safeguarding processes designed to keep them safe failed
- The review identified that the experiences of Arthur and Star in their short lives were not unusual and therefore made a number of local and national recommendations.

3 Actions taken by agencies and professionals

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.

Alongside guidance on key practice issues and national recommendations the report also sets out Key Messages for safeguarding partners to reflect on:

All safeguarding partners should assure themselves that:

- Robust multi-agency strategy discussions are always be 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 and initial child protection conferences).
- Robust information sharing arrangements and protocols are 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. Referrals should also not be described as malicious in professional conclusions, due to the risks associated with this language.

4 Responses to the actions undertaken

Following the publication of the Child Protection in England document, a summary paper was circulated to statutory partners. The paper focused on the local recommendations for Solihull (p49) and Bradford (p79) based on Arthur and Star's stories.

It was agreed by partners than by examining these recommendations and reflecting on them through a North Yorkshire lens, it would give partners an in-depth assessment of North Yorkshire practice and enable us to thoroughly reflect on the partnership recommendations that were highlighted in the report (see above).

Statutory partners were asked to look though the local recommendations and ascertain whether they felt assured or not assured that as a partnership those recommendations were being met.

- Where partners felt assured, they were asked to provide evidence why they felt this was the case.
- Where partners were not assured actions were identified.

The recommendations were then taken to a wider partnership event to gather further information and evidence.

5 Outcome of the case

A task and finish group comprising of members from across the partnership was formed to collate the findings of the work to present to wider partners and share learning and resources with professionals based on those findings.

These findings are cumulated on the NYSCP partnership webpage. The information will also be discussed at a partnership webinar/leaning event which will be recorded and made available across the partnership.

6 Learning points that have arisen

The work of the task and finish group have identified a series of learning themes from the accumulation of partnership discussion.

Key learning and resources from each theme will be added to the NYSCP webpage.

- Domestic abuse
- Information sharing and seeking between professionals
- Professional curiosity & challenge
- Strength in relationship practice model – whole family/think family approach
- Mental Health support (including the impact of Adult Mental Health on children)
- Guidance for allegations of non-accidental bruising in children.

7 Additional resources

Full Report: https://www.gov.uk/government/publications/national-review-into-the-murders-of-arthur-labinjo-hughes-and-star-hobson

The Child Safeguarding Practice Review Panel: Briefing note for child protection professionals across England: ALH_SH_Practitioner_Resource_FINAL.pdf

CASPAR briefing: Summary of the national review into the murders of Arthur Labinjo-Hughes and Star Hobson (nspcc.org.uk)