Workforce briefing

North Lincolnshire
CHILDREN'S MULTI-AGENCY RESILIENCE & SAFEGUARDING BOARD

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

Child Safeguarding Practice Review Panel: Published May 2022

Introduction

- Welcome from the presenters

- Safeguarding partners in North Lincolnshire
  - Matt Peach, Chief Superintendent and South Bank Commander, Humberside Police
  - Helen Davis, Director of Nursing and Quality, North Lincolnshire Health and Care Partnership
  - Ann-Marie Matson, Director of Children and Families, North Lincolnshire Council

- Children's MARS Board is made up of the three safeguarding partners, the Assistant Director for Education, NLC and the Lead Member for Children and Families who is a participatory observer. Other attendees are safeguarding partner representatives and subgroup chairs

- The safeguarding partners should:
  - take account of the findings from their own local reviews and from all national reviews
  - consider how identified improvements should be implemented locally
  - Consider the way in which organisations and agencies work together to safeguard and promote the welfare of children
  - so that the findings from these reviews make a real impact on improving outcomes for children

About the review

- Published in May 2022 by the Child Safeguarding Practice Review Panel (the Panel). Responsibility for how the system learns lessons from serious child safeguarding incidents lies at a national level with the Panel and at a local level with safeguarding partners

- This national Child Safeguarding Practice Review has superseded the two local areas reviews that will not be published

- The review looks at the circumstances leading up to the deaths of Arthur Labinjo-Hughes aged 6 and Star Hobson aged 16 months in 2020 and sets out recommendations and findings to protect children at risk of serious harm

- The review explores why the public services and systems designed to protect Arthur and Star were not able to do so

- Review team held conversations with professionals and engaged with family members

- The review also looks at wider issues and evidence from serious safeguarding incidents reviewed by the Panel in the last three years

About the review: Arthur's story

- Arthur was six years old when he died on 17 June 2020. He was living with his father Thomas Hughes, father's partner Emma Tustin, and her two children
- In February 2019, Arthur's mother was convicted of manslaughter and received a significant term of imprisonment. Following his mother's arrest, Arthur was cared for by his father
- In autumn 2019, Thomas had begun a relationship with Emma. Thomas and Arthur moved into Emma's home on 23 March 2020, when the UK entered the first period of national lockdown during the COVID-19 pandemic. Arthur was not attending school
- On 14 April, Arthur and his father stayed overnight at the paternal grandparents' house following a disagreement between Thomas and Emma. On 16 April, Thomas and Emma reconciled their differences. Thomas and Arthur returned to Emma's address, despite strongly expressed misgivings from the paternal grandparents, who were concerned about the return to what they saw as an abusive situation for Arthur. This was the last occasion that Arthur was seen by his wider family until the day of his death.
- Family members expressed their concerns and made contact with children's social care, the police, and Arthur's school.
- Evidence from video footage and text messages seen at the criminal proceedings. A total of 130 bruises were found on Arthur's body at the time of his death. Blood tests indicated very high levels of sodium, suggesting the possibility of salt poisoning, for which Emma was convicted.
- The explanations for Arthur's injuries given by Thomas and Emma were not considered plausible. They were arrested and subsequently charged with the offence of causing or allowing the death of a child. In court proceedings concluded on 1 December 2021, Emma was convicted of murder and Thomas of manslaughter

About the review: Star's story

- Star was born on 21 May 2019 and was 16 months old when she was murdered on 22 September 2020
- Star's mother Frankie Smith was 17 years old when she became pregnant. Star's father had been in care and was living in supported accommodation but remained in contact with his parents
- After her birth, Star had a somewhat unsettled life. Frankie's relationship with Star's father was "on and off" both during the pregnancy and immediately after her birth
- The relationship between Star's parents finally ended when Star was four months old but father had regular contact at his parents' home. Frankie met Savannah Brockhill around October 2019. We now know that Savannah had a history of domestic abuse with a previous partner
- Around February 2020, Frankie asked Star's great grandmother to look after her as she could not cope after Savannah had ended the relationship with her. In April 2020, without any prior warning or discussion, Frankie removed Star from their care at the point when the relationship with Savannah resumed. Frankie and Star moved back to live with Star's grandmother. On 3 July, Frankie moved into her own flat and Savannah remained a regular visitor to the home
- Wider family including grandparents, great grandparents, Star's father and other wider family and friends made contact with agencies due to noticing bruising and other marks on Star
- From early September 2020 it is clear that Frankie and Savannah acted to prevent professionals and family members from coming into contact with Star
- The final cause of Star's death was an abdominal haemorrhage caused by blunt force trauma. A post-mortem found evidence of a recent skull fracture, other fractures and multiple injuries commensurate with Star having been physically assaulted on numerous occasions in the weeks and months leading up to her death. Savannah was convicted of murder of 15 December 2021 and Frankie was convicted of causing or allowing her death

About the review

- Sets out a number of practice issues for safeguarding partners

- Sets out analysis of the systemic factors influencing child protection practice under four key domains:
  - Practice and practice knowledge
  - Systems and processes
  - Leadership and culture
  - Wider service context

- Based on these findings, the review sets out a number of recommendations to improve the child protection system in England

- The key recommendations from this report read across and are similar to some of those in the Independent Review of Children's Social Care which was published in May 2022

Systemic factors influencing child protection practice

The analysis in the report has been organised under the four key domains:

- Practice and practice knowledge
- Systems and processes
- Leadership and culture
- Wider service context

Systemic factors influencing child protection practice

Practice and practice knowledge

- **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, Star's mother and Savannah Brockhill, mother's partner, 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
- **Specialist skills and expertise for working with families whose engagement is reluctant or sporadic** - in Arthur and Star's stories, professionals were increasingly kept at arms length by the perpetrators. There were also signs of parental avoidance
- **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
- **Appropriate responses 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 Arthur's father's partner, Emma Tustin and her history of domestic abuse was not triangulated between agencies
- **Specialist skills and expertise for undertaking child protection investigations -** Child protection decision making is a highly skilled and intrinsically complicated activity. It involves extremely complex risk assessment in an ever-changing context, requiring analytical skill to collate and distil evidence forensically. There were gaps in such specialist skills particularly around interrogating and analysing evidence

Systemic factors influencing child protection practice

Systems and processes

- **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
- **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 discussions were not held prior to the home visit to see Arthur and before Star's child protection medical

Leadership and culture

- **Underpinning all factors, the need for leadership and management –** common to both Bradford and Solihull was a weak 'line of sight' to frontline practice by safeguarding partners

Wider service context

- **Effective risk assessment and decision making was affected by the wider service context** – e.g. workforce development and the capacity to conduct sustained direct work with families

Key messages for safeguarding partners

- 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

Key messages for safeguarding partners

- It is important for all safeguarding partners to recognise that when there is a high level of media and public scrutiny of children dying as a result of abuse, professional anxiety is raised and this can drive up risk averse practice in the system. This in turn can obscure those children who most need help. Increasing rates of child protection activity does not necessarily translate into effective child protection practice

- It is for all safeguarding partners to ensure that practitioners are well supported, have necessary expertise and that systems and processes are in place locally for identifying those children who need to be protected, whilst minimising any unnecessary intervention in family life

National recommendations

Arthur and Star's stories resonate with the other serious incidents reviewed by the Panel every year. As these issues keep recurring, the Panel are advocating that the approach to child protection practice should be strengthened at both local and national levels.

The Panel has set out recommendations at a national level focusing on the child protection system. The Panel use the term 'child protection' rather than 'safeguarding' intentionally, to mean what happens when there are concerns that a child might be being/or at risk of being significantly harmed. Child protection work would benefit from the wealth of knowledge and skill of multi-disciplinary and multi-agency practice.

The way the child protection system in England is designed currently does not give professionals the best possible opportunity of succeeding at the very difficult task of protecting children.

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.

National recommendations

What would this mean in my role?

- Child protection is core work for all children's social workers also a priority for any agency that works with children
- Whether you're a social worker, health visitor, paediatrician, GP, teacher, police officer or another practitioner working with children, you need to make difficult decisions every day which affect the lives of children and families
- Core child protection processes of investigating child protection concerns, child protection planning, implementation and reviewing are key points where **integrated multi-agency involvement and specialist child protection skills are critical**
- Star and Arthur's cases show the limitations of taking a single agency approach to investigating concerns when statutory multi-agency procedures were needed

National recommendations

Eight national recommendations are made:

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

Independent review of children's social care

About the review

- A once in a generation opportunity to transform the children's social care system and provide children with loving, safe and stable families
- Children, young people and families views and experiences all the way through
- Sets the tone and sets the purpose of children's social care
- Sets out the importance of relationships
- Principles which are all about 'love' and children being in their families
- Considers key things like poverty and inequality, domestic abuse, mental health, substance misuse and asylum
- Identifies 81 actions set against seven key domains:
  - A revolution in family help
  - A just and decisive child protection system
  - Unlocking the potential of family networks
  - Transforming care
  - The care experience
  - Realising the potential of the workforce
  - A system that is relentlessly focussed on children and families
- Has a five year strategic plan to make it happen

Key recommendations associated with the CP in England report

A revolution in family help

- Brings together early help and children in need into ’family help’
- Introduces **multi disciplinary family help teams**
- Focused on **‘neighbourhood’**
- Aims to keep more families safely together at home

A just and decisive child protection system

- Introduces the **expert child protection practitioner**
- Emphasises **the need for multi-agency contribution to MASH (locally know as IMAP)**
- Introduction of **Child Community Safety Plans for harm outside the family (ROTH)**

Responding to the national reports

Local response

- Communicating across the partnership to share key messages and raise awareness via workforce sessions, boards and partnership forums
- Benchmarking exercise undertaken to consider our current position in relation to the findings and learning from the report and to identify emerging actions
- Transformation discussions being held amongst senior leaders

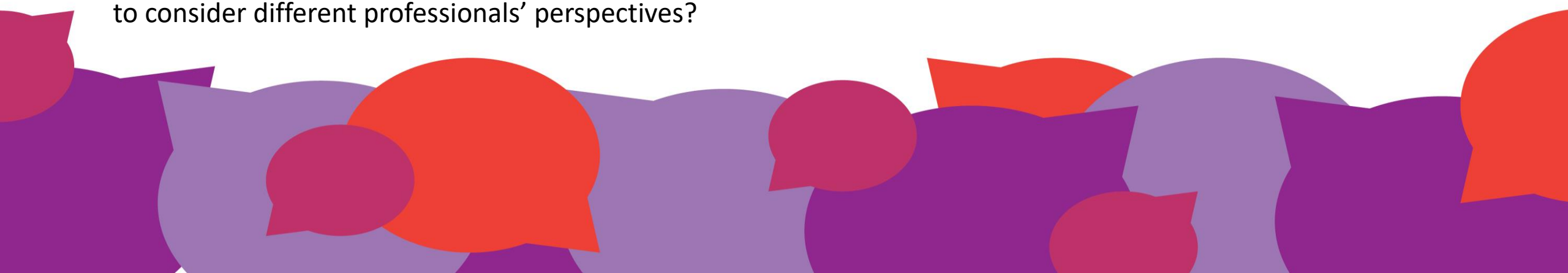
National response

- Cross ministerial group considering both reviews and their recommendations
- Anticipate government response by the end of the year

Questions for reflection

You may wish to reflect upon these 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?



Any questions or comments?

Further reading

[Child Protection in England: National review into the murders of Arthur Labinjo-Hughes and Star Hobson (2022) Child Safeguarding Practice Review Panel]

[Independent Review of Children's Social Care (2022) Josh MacAlister]

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