Summary of the National Review into the Murders of Arthur Labinjo-Hughes and Star Hobson

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Arthur and Star

- 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.

Background to the Review

- The Child Safeguarding Practice Review Panel (the Panel) is an independent body set up to identify, commission and oversee reviews of serious child safeguarding cases in England.

- This national review was initiated in the context of widespread public distress about the circumstances of the deaths of these children that followed the conclusion of the two murder trials. Understandable questions were asked about why children had experienced such gross abuse and suffering when they were seemingly in ‘plain sight’ of public agencies.

- It is also very important to acknowledge that Arthur and Star both died during the COVID19 pandemic. Therefore the Panel sought to understand, as far as it is possible, whether the circumstances of this global crisis affected Arthur and Star, their families and the response of professionals to what was happening in their lives.

- Whilst undertaking the review, it was clear to the Panel that some of the issues that were identified were not unique to the experiences of Arthur and Star. The review therefore considered wider issues and evidence from serious safeguarding incidents reviewed in the last three years.

Arthur’s Lived Experience

Arthur's mother arrested
Olivia Labinjo-Halcrow arrested for Domestic Murder of Gary Cunningham. Arthur moves in full time with Thomas Hughes. A Children in Need assessment by Birmingham Children’s Trust (BCT) concluded with no further action. Arthur’s father was assessed to be a ‘protective factor’ for him.

Grandparents raise concerns about bruising
Paternal grandparents voice growing concerns about bruising with Solihull Emergency Duty Team (EDT). EDT call police that evening relaying grandparents concerns. Police deny request for a ‘Safe and Well’ visit based on their observation of Arthur the previous day.

Social work team check on Arthur
Following paternal grandparent’s concern, the MASH send social workers to check on Arthur. Social workers report that Arthur and Emma’s son are willing to show bruises – no safeguarding concerns were identified. An offer of ‘Life Story’ work is made.

Police receive photos of bruising
Photographs of bruising are sent to the police by Arthur's uncle. They are received by the police but never sent onto the MASH.

MASH receive photos of bruising
Family members continue to express their concerns to Children’s Social Care, the police, and Arthur’s school. The photos of bruising are passed onto the MASH by maternal grandmother on April 24th. End of April No further investigation It was decided that no further investigation was needed in relation to the family’s concerns about bruising.

Emergency services called
Emergency Services called as Arthur is suffering Cardiac Arrest after sustaining a severe head injury. He dies the next day.

The Conclusions

- Professionals had only a limited understanding of what daily life was like for Arthur.
- Professionals did not always hear Arthur's voice. Arthur's voice was often mediated by his father in contact with professionals
- Thomas Hughes was seen from the very first assessment in 2019 as a protective father. Whilst this was a reasonable judgement at that time, this framing was never subsequently challenged by any professional when circumstances changed and when evidence to the contrary – such as reports from Thomas' own family that they were not sure he would protect Arthur – was available.
- There was never proper consideration given to the risks to Arthur arising from the move to live with Emma Tustin
- Arthur's wider family members were not listened to, despite their many attempts to get agencies to look into what might be happening to Arthur.
- The response to concerns about bruising to Arthur was undermined by the lack of a multi-agency strategy discussion, which should always be triggered when there are allegations about the suspected abuse of children.
- The West Midlands Child Protection Procedures did not include practice guidance in relation to allegations of the physical abuse of a child.
- Our conclusion is that a pivotal dynamic underpinning many of these practice issues was a systemic flaw in the quality of multi-agency working. There was an overreliance on single agency processes with superficial joint working and joint decision making. Robust multi-agency working is critical to the challenging work of uncovering what is really happening to children who are being abused.

Star’s Lived Experience

Concerns of domestic abuse and bruising
Following concerns by a family friend, a social worker visited Star. The assessment was completed which included 3 visits. There were no obvious concerns noted or observed during the visits and the decision was made that the main issue was housing for Frankie and Star.

Referral to Children's Social Care
Star's maternal great-grandmother made a referral to Children's Social Care in Bradford. The next day a social work team made an unannounced visit to Savannah's household and were content that Star was safe and well. It was concluded that the referral was malicious.

Father submits photos of bruising
Star’s father submits more photos of Star to the MASH with concerns over Star’s treatment by Savannah. Child Protection Medical is arranged after Police talk with family. CP medical finds no points of concern and concludes that the bruising to Star was most likely to be accidental and consistent with parents account.

Video of Star with bruises emerges
A video of Star with bruises on her face is exchanged between family members and some close adults on social media. The video is sent to the police. Police attempt a visit but Frankie and Savannah report that they are in Scotland with Star.

Maternal family contact the Integrated Front Door

Star’s maternal great grandfather contacted the Integrated Front Door (IFD) stating he had a video of bruising to Star. He was asked to send it by email but was unable to do so. A social worker contacted Frankie. Frankie said that she had already contacted her previous social worker to say that Star had bruised herself falling downstairs. There is no record of such a contact. As a result, a home visit was deferred until 4th September.

Star dies

There was no further contact with professionals between 5th and 22nd September, when Star passed away after sustaining multiple injuries inflicted by Savannah

The Conclusions

- Professionals had only a limited understanding of what daily life was like for Star, beyond a superficial assessment from “one off” visits, which did not build on any historic information known by each agency.
- Decision making in the Integrated Front Door reflected management priorities to respond to a high volume of referrals and ensure throughput of cases.
- Assessments did not explore the family context and interaction between family members, most specifically in relation to concerns raised about how Star was being treated
- Star’s wider family members were not listened to.
- Domestic abuse between Savannah and Frankie was cited by referrers to children’s social care in January and May 2020 but this was not assessed in the respective single agency assessments.
- Assessments within children’s social care were not fit for purpose and did not enable the identification of risks to Star and a plan for mitigating those risks.
- The responses to the referrals with concerns about Star were significantly weakened by the lack of formal multi-agency child protection processes, especially strategy discussions and consideration of whether Section 47 enquiries should be initiated.
- In 2020, Bradford children’s social care service was a service in turmoil, where professionals were working in conditions that made high quality decision making very difficult to achieve
- The volume of work and significant problems with workforce stability and experience, at every level, meant assessments and work with Star and her family were too superficial and did not rigorously address the repeated concerns expressed by different family members.
- There were undoubtedly multiple fault lines in multi and individual agency practice arrangements in Bradford in 2020, some of which are unique to that area.

Core Issues

The review also highlights two important factors currently impacting the child protection system in England:

- Multi-agency arrangements for protecting children are more fractured and fragmented than they should be.
- There has been insufficient attention to, and investment in, securing the specialist multi-agency expertise required for undertaking investigations and responses to significant harm from abuse and neglect. The review then goes on to look at more detailed findings.

Practice & Practice Knowledge

- Understanding what the child's daily life is like, where this might not be straightforward
- Listening to the views of the wider family and those who know the child well
- Specialist skills and expertise for working with families whose engagement is reluctant or sporadic
- Working with diverse communities
- Appropriate responses to domestic abuse
- Specialist skills and expertise for undertaking child protection investigations

Systems and Process

- Appropriate information sharing and seeking, which can be impacted by behavioural biases
  - Diffusion of responsibility
  - Source bias
  - Confirmation bias
  - Risk aversion
- Critical thinking and challenge within and between agencies
- Leadership and culture
- Wider service context
  - workforce development
  - funding levels and the strategic use of funding to invest in family support services
  - the impact of wider socio-economic factors and matching priorities to resources.

Key Findings

Fundamental issues with practice:

- Weaknesses in seeking, sharing and acting on information from multiple sources.
- 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 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 these issues is the need for leaders to have a powerful enabling impact on child protection practice, creating and protecting the organisational conditions needed to undertake this complex work.

National Recommendations

Core recommendation: *develop a new approach to undertaking child protection work*

Fully integrated, multi-agency investigation and decision making should take place throughout the entire child protection process.

Only those with the appropriate expertise and skills should undertake child protection work.

Leaders should be able to deliver excellent child protection responses and create the right organisational context to make this happen

A new expert-led, multi-agency model for child protection investigation, planning, intervention, & review

Multi-Agency Child Protection Units to deliver excellent practice.	The development of a new operational framework for undertaking child protection investigations, including planning, delivery and review of children who are at risk of significant harm.
	The introduction of new multi-agency child protection units in every local authority, led by expert child protection social workers.
	Membership of the unit to include as a minimum representatives from the police, health services, education, and children and adult mental health.
	Links between “family help” teams and multi-agency child protection units and the multiagency safeguarding hub “MASH”

Establishing National Multi-Agency Practice Standards for Child Protection

These standards must be truly multi-agency in their nature and speak to all local Safeguarding Partners.

Evidence-based guidance that can be followed by professionals from different backgrounds working with children and families in a child protection context.

The public should also have access to this information so they know what to expect from the child protection process and how to challenge when standards are not met.

Strengthening Local Safeguarding Partners to Ensure Proper Co-ordination & Involvement of all Agencies

Protecting children from abuse and neglect is a multi-agency endeavour. When things go wrong, a lack of co-ordination across agencies is often a key issue.

Ensuring proper involvement and oversight by all agencies, particularly schools, colleges and other education providers.

Agreeing a shared set of values, systems and processes for all involved agencies.

Providing greater clarity on the role and function of safeguarding partners.

Improved leadership development to support safeguarding partners.

Changes to multi-agency inspection to better understand local performance & drive improvement

Inspectorates draw up proposals for a more genuinely integrated and comprehensive model of multi-agency inspection, adequately resourced by all partners, and integrated into the ongoing work of each inspectorate.

Multi-agency inspection should play a stronger role in ensuring all areas are held to account for their multi-agency partnership working.

Inspectorates should firstly undertake an initial thematic review of multi-agency arrangements in a number of areas. A more integrated and comprehensive model of multi-agency inspection should then be developed and integrated into the ongoing work of each inspectorate.

A new role for the Child Safeguarding Practice Review Panel in driving practice improvement in safeguarding partners

National peer support capability for Safeguarding Partners is developed

The Panel should facilitate greater sharing of learning and insights across safeguarding partners by developing a national peer support capability for safeguarding partners, which will help to disseminate learning and provide more practical, hands-on support.

This role goes beyond learning from when things go wrong to capturing the best practice that protects the most vulnerable children

A sharper performance focus and better co-ordination of child protection policy in central Government

The establishment of a national Child Protection Board, bringing together all relevant central Government departments, local Government, the police, education and health representatives and others.	To oversee performance in the child protection system, spotting emerging issues, ensuring the delivery of reforms, and acting as the escalation route for issues which need resolving at the national level
	To develop a set of national operational standards for multi-agency child protection work; and
	To oversee and ensure delivery of multi-agency child protection units in all local authorities.

Using the potential of data to help professionals protect children

Insight into areas where learning from other sectors could be used to improve child protection responses across the country.

There is huge scope for better use of data and technological solutions in child protection and a need to ‘upgrade’ the digital landscape and innovate within it; but

Any innovation needs to be done with the user (practitioner) and families in mind – thinking about how best to support practitioners to do their job rather than trying to replace professional judgement.

Specific Practice Improvements in Relation to Domestic Abuse

Improvements must be made in developing the specialist skill and expertise of staff, and in information sharing between agencies.	Safeguarding Partners to improve how they work with specialist domestic abuse services by establishing stronger working relationships and clear information sharing protocols.
	Safeguarding Partners must be committed to, and fully invested in, the commissioning of DA services and ensure all staff have a robust understanding of what the DA support offer is in their area.
	Appropriate responses to domestic abuse should feature clearly in the new National Child Protection Practice Framework and training should be embedded across all Safeguarding Partners for all practitioners to ensure they provide a domestic abuse informed response.

Next steps for Trafford

- Development day with Trafford Strategic Safeguarding Partnership (TSSP) focusing on the National Review, Care Review and the Solihull JTAI
- Launch of the TSSP Safeguarding Priorities 22-25 held in October 2022
- Multiagency Quality Assurance Framework which focuses on practice, decision making and management oversight