CHILD PROTECTION IN ENGLAND

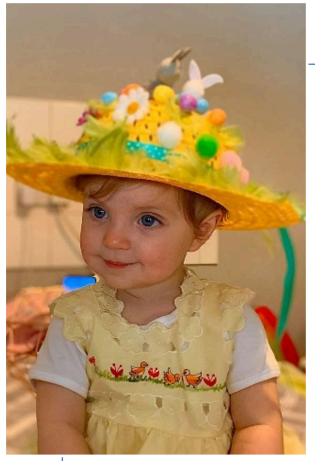
National review into the murders of Arthur Labinjo Hughes and Star Hobson 2022

Child Safeguarding Practice Review Panel

NCASP
NORTHUMBERLAND CHILDREN AND ADULTS SAFEGUARDING PARTNERSHIP

In memory of Arthur Labinjo-Hughes & Star Hobson

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 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.

What are the key practice issues?

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.

What are the key practice issues?

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.

What can we learn?

Key findings..

Weaknesses in information sharing and seeking within and between agencies

A lack of robust critical thinking, analysis and challenge within and between agencies, compounded by a failure to trigger statutory multi-agency child protection processes at several 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 optimum organisational conditions for undertaking this complex work.

These are not new issues – they recur across serious incidents in a number of areas, in rapid reviews and local child safeguarding practice reviews

Why do these issues persist?

Protecting children from abuse is intrinsically complex and challenging work

It requires great expertise in finding out what is happening in the intimate realm of family life

It involves intruding into very private spaces to evaluate and make professional judgements about parenting, the development and wellbeing of children, and whether a child or infant is experiencing harm

Outside of the family, child protection professionals must also address the complex issues of extra-familial harm, including child sexual and criminal exploitation

All child protection practice requires confidence, capability and the use of expert authority to make decisions about children's lives

At its heart, child protection practice requires excellent skill in blending 'care' and 'control' functions

This can only be achieved by building trusting relationships with parents and children whilst recognising that how things appear may not be the reality of a child's experience

What needs to change?

The review contends that 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

Redesigning child protection practice

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 appropriate expertise and skill undertaking 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

The review is recommending that Multi-Agency Child Protection Units – integrated and co-located multi-agency teams staffed by experienced child protection professionals – are established in every local authority area

The units would be responsible for:

- convening and leading strategy discussions
- carrying out section 47 child protection enquiries
- chairing child protection conferences
- overseeing, reviewing and supporting child protection plans
- recommending court applications
- advising other teams and agencies on child protection

The role of education in the local multi-agency safeguarding arrangements

For many vulnerable children, school is a place of safety and support

All educational settings are in a unique position to identify concerns early, to recognise when concerns are escalating, and to share key information with Children's Social Care

At present schools, colleges and other educational settings are referred to as 'relevant agencies' in local multi-agency safeguarding arrangements

The review recognises the involvement of schools, colleges and other education providers needs to be reconsidered and there must be full involvement of schools and education services at both the strategic and operational level

Recommendation for schools to become the fourth statutory partner

Key messages for Safeguarding Partners

Safeguarding Partners should assure themselves that:

CHILD PROTECTION ENQUIRIES

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

RESOURCES

- 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.

INFO SHARING

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

See: Info Sharing Protocol

ASSESSMENTS

- 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.

SUPPORTING PRACTICE

- 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.

Questions for you to reflect upon as a practitioner..

1. How do you work with other agencies to build a full picture of what is happening in a child's life?
2. What behavioural biases, e.g. confirmation bias, might impact upon your information sharing and seeking practice?
3. 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?
4. What assumptions might you hold relating to culture, ethnicity, gender and sexuality? In what ways might this affect your practice?
5. 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?
6. What opportunities do you have - formally or informally - to challenge decisions within your and other agencies and to consider different professionals' perspectives?