BRIEFING NOTE

Child Protection in England:

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

See: full report / press release

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.

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, CCTV footage showed that Arthur had been forced to stand to attention alone in the hallway of the house for most of the day, without water. He was made to sleep downstairs on a hard floor without a mattress. This was the pattern of Arthur's life for many weeks before his death, with no contact from family members or friends, and out of the sight of children's social care, school, and other public services.

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.

Photographs taken show a sad child with many bruises on her legs, arms and face a stark contrast to earlier photos of the happy child taken by her extended family. CCTV footage, when Star was in the sole care of Savannah, showed the child being physically assaulted by Savannah with 20 separate blows to the head and body recorded over a period of two hours.

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.

The review sets out recommendations and findings for national government and local safeguarding partners to protect children at risk of serious harm. It examines the circumstances leading up to the deaths of Arthur and Star and considers whether their murders reflect wider national issues in child protection.

ARTHUR

In Arthur's case, the panel found that professionals in Solihull had only a limited understanding of what life was like for him, did not always hear his voice, did not challenge their initial framing of his father, Thomas, as protective, and did not take the concerns of his wider family seriously.

It said children's social care's failure to convene a multi-agency strategy discussion in April 2016, after Arthur's paternal grandmother reported bruising that she felt may have been carried out by his stepmother, Emma Tustin, was not appropriate and undermined agencies' response. Overall, the review found a "*systemic flaw in the quality of multi-agency working",* with "*an overreliance on single agency processes with superficial joint working and joint decision making*".

The local recommendations for Safeguarding Partners in Solihull, where Arthur lived, include:

ensuring that all assessments undertaken by agencies draw on information and analysis from all relevant professionals, wider family members or other significant adults who try and speak on behalf of the child

reviewing the partnership Multi-Agency Safeguarding Hub arrangements to ensure a more "Think Family" approach

reviewing and commissioning strategies to ensure practitioners know how to respond to incidents of domestic abuse and understand the risks to children of prisoners

STAR

The panel found a number of similar findings in the case of Star. It said that professionals in Bradford had limited understanding what life was like for her, did not listen to wider family members and that the responses to safeguarding referrals "*were significantly weakened by the lack of formal multi-agency child protection processes*".

In addition, it found an inadequate response to concerns of domestic abuse towards Smith from Brockhill and that assessments by children's social care "*were not fit for purpose*", at a time of "*turmoil*" within Bradford's children's social care service, in 2020.

The local recommendations for Safeguarding Partners in Bradford, where Star lived, include:

agreeing clear expectations regarding risk assessment and decision making and ensuring these are understood by all agencies

reviewing, developing and commissioning a comprehensive early help offer which can be accessed before, during and after the completion of any child and family assessment by children's social care

reviewing and commissioning domestic abuse services to guide the response of practitioners and ensure there is a robust understanding of what the domestic abuse support offer is in Bradford

The panel (which is also responsible for analysing serious child protection incidents reported by councils) said that what happened to Arthur and Star were not isolated incidents and their deaths reflected wider problems in child protection practice.

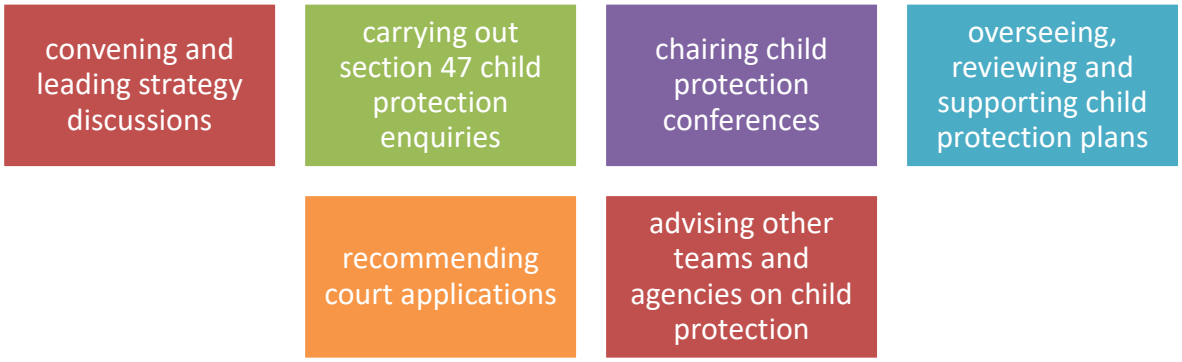
It identified **two key lessons** from the cases and its wider learning from safeguarding concerns:

1. Multi-agency arrangements for safeguarding children are too fragmented, with inadequate information sharing making it "extremely difficult" to build and maintain an accurate picture of what life is like for the child.

2. 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".

Among a number of recommendations made, the review called for the **creation of dedicated multi-agency child protection teams,** in every area, to investigate allegations of serious harm to children. These teams will be based within local authorities but made up of secondees from the police and health as well as social workers.

The units would be responsible for:



The panel said this arrangement would ensure fully integrated multi-agency decision making throughout the child protection process, delivered by those with the appropriate skill and expertise.

Panel chair Annie Hudson said: "At the moment, each professional who comes into contact with a child holds one piece of the jigsaw of what is happening in a child's life. Our proposed reforms would bring together experts from social work, police and health into one team so that they can have a better picture of what is happening to a child, listening carefully to relatives' concerns and taking necessary actions to protect children."

The panel backed the recommendation of the Independent Review of Children's Social Care, in its final report (published on 23rd May) to establish the role of expert child protection practitioners, obtained in future by passing a five-year assessed early career framework.

It also accepted the care review's proposal that such expert practitioners co-work cases with family help teams to avoid fragmentation. Under the care review's blueprint, these teams will have been working to support the family prior to child protection processes being initiated – but the panel stressed that the child protection units should have decision-making authority in such cases.

Unit police and health representatives would need to be well-connected to their employing agencies and maintain their professional development to ensure they could co-ordinate the involvement of their professional colleagues in cases, enabling effective multi-agency working.

The panel's other recommendations were for the government to:

Establish national multi-agency practice standards for child protection, capturing the best available evidence of what works when working with children and families.

Set up a national child protection board involving representatives from central government departments, local government, the police and health, to ensure greater co-ordination of child protection policy and performance management.

Strengthen local multi-agency safeguarding partnerships, in line with the recommendations of the care review, to address issues including lack of senior representation, inadequate oversight of practice and problems agreeing funding levels.

Increase the role of multi-agency inspection in holding partnerships to account, strategically and operationally, potentially reducing the number of single-agency inspections as a result.

Fund peer support for safeguarding partners, overseen by the panel itself, in order to share learning.

Convene a task group to improve the way data is used by professionals to better protect children.

Promote the way safeguarding partners work with domestic abuse services and ensure professionals in their areas have adequate knowledge of the topic. The panel itself will produce a practice briefing this summer on safeguarding children in families where there is domestic abuse.

Key messages for all Safeguarding Partners

The panel identified a set of practice issues which **all Safeguarding Partners across the country** should immediately assure themselves are being dealt with effectively in their area.

All 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.

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.

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.