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

This CASPAR briefing summarises findings and recommendations from the national review into the murders of Arthur Labinjo-Hughes and Star Hobson, conducted by the Child Safeguarding Practice Review Panel.

June 2022

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. It brings together experts from different sectors including social care, policing and health to provide a multi-agency view on cases which raise issues that are complex, or of national importance.

› **Find out more about the case review process in England**

This review looks at the circumstances leading up to the deaths of Arthur Labinjo-Hughes and Star Hobson in 2020 and explores why the public services and systems designed to protect them were not able to do so.

Whilst undertaking the review, it was clear to the Panel that the experiences of Arthur and Star were not unusual. The review therefore considers wider issues and evidence from serious safeguarding incidents reviewed in the last three years. Based on these findings, the Panel sets out a number of local and national recommendations to improve the child protection system in England. This briefing summarises the national recommendations.

The review was initiated due to the severe level of harm experienced by Arthur, 6, and Star, 16 months, whilst public agencies were involved with their families. The Panel draws similarities between both cases.

Arthur and Star were both murdered 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.

Key findings

Core issues

The review identifies a set of core issues that hindered professional understanding of what was happening to the children in both cases. The Panel emphasises that these are not isolated issues; they feature regularly in serious case reviews and thematic practice reviews.

- 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 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.

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 and practice knowledge

In both cases, professionals did not have a clear understanding of what daily life was like for the children. The review identified a number of reasons for this.

- There was limited direct work with the families. For example, in Arthur's case, it was often the voice of his father that was heard by professionals rather than his own.
- There was a lack of reflection and further exploration into how the children and families presented themselves during visits.
- There were failures to talk with and listen to the views of wider family members. Different family members raised concerns about potential abuse with police and social care professionals on multiple occasions. However, despite family members knowing the children well, their voices were not heard.
- There were gaps in specialist skills around interrogating and analysing evidence; the versions of events given by parents were too readily accepted and photos provided by wider family members were not properly examined.
- In both cases, professionals were often kept at arm's length by those who were perpetrating abuse. For example, professionals were prevented from coming into contact with the child, or consent to share information was not provided.
- Practitioners' biases and assumptions impacted on how they assessed risks to the child and made decisions about their safety.
- The impact of the parents' own experiences on their ability to care for their children were not fully explored or understood.
- The risk posed by new partners was not fully considered. For example, a range of historic and current domestic abuse issues were present in both cases, but the risk posed to the child was not thoroughly explored.

Systems and processes

In both cases, a number of issues around how information was shared and used prevented professionals from building a full picture of what was happening in the child's life.

- In Arthur's case, photos of bruising received by the police were not passed to the multi-agency safeguarding hub (MASH). Also, background information

relating to his father's partner, who was later found to be the main perpetrator of the abuse, was not included in a screening ahead of a home visit.
- There was limited evidence of professionals trying to unpick concerns raised by family members.
- There were limited opportunities for professionals to consider information altogether and assess risks through use of wider strategy meetings.
- Opportunities for critical thinking and challenge between agencies were missed. For example, in Star's case, practitioners did not test their findings about domestic abuse with the specialist domestic abuse service, who may have been able to provide important challenge.
- The Panel identified instances of behavioural bias (behaviours that can influence the way that evidence is perceived or interpreted) which may have impacted information sharing between agencies. For example, in Star's case, professionals tended to interpret information based on its source (wider family members who supposedly made 'malicious' referrals) rather than its substance.

Leadership and culture

The Panel identified a 'weak line of sight' between leadership and frontline practice.

- Safeguarding partners did not have a clear enough understanding of child protection practice, which impacted the delivery of frontline services and caused staffing issues to remain unresolved.
- There was an 'absence of an agreed partnership and vision' which impacted the delivery of services and therefore outcomes for children.
- Opportunities for meaningful supervision and learning were limited in both cases and were not a constant feature of professional life for social work practitioners.

Wider service context

A number of wider service issues impacted risk assessment and decision making.

- **Workforce development in social care.**

  Acute issues with recruitment and retention of social work staff affected capacity to conduct sustained direct work with families.

- **Issues with funding levels, capacity and turnover in other services.**

  Significant increases in health visiting caseloads meant that in Star's case, a pre-birth family health needs assessment was not conducted. For Arthur, limited capacity in children's mental health services may have impacted

responses to his emotional and mental health needs. There was also a lack of a domestic abuse commissioning strategy in place.

- **Wider contextual factors**

  For example, the impact of the COVID-19 pandemic on child protection services affected both cases.

National recommendations

The Panel acknowledges that, whilst there were examples of good practice, it is clear that the core issues referred to at the beginning of this briefing are not unusual and appear in multiple serious incident reviews. Despite successive reviews and inquiries, these issues continue to recur. The Panel therefore advises that its recommendations be implemented at both a local and a national level.

The Panel makes one core recommendation, and eight further, more specific 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.

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

- 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.
- Reformed family help services that encourage multi-agency child protection units and wider family help teams to work together.

- Improved quality and consistency for multi-agency safeguarding hub (MASH) models across the country.

2. Establishing national multi-agency practice standards for child protection

- 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.

3. Strengthening local safeguarding partners to ensure proper co- ordination and involvement of all agencies

- 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.

4. Changes to multi-agency inspection to better understand local performance and drive improvement

- 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.

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

- 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.

6. A sharper performance focus and better co-ordination of child protection policy in central government

- Clearer, stronger leadership and support from central government departments for local multi-agency safeguarding arrangements. This should be achieved by establishing a national child protection board, bringing together all relevant central government departments, local government, the police, education, health representatives and others.

7. Using the potential of data to help professionals protect children

- The Secretary of State should convene a group of data and technological experts from a range of sectors, to look at how the use of data can be transformed to better protect children. The group should be chaired by a child protection expert and will report back on its findings at the end of each year.

8. Specific practice improvements in relation to domestic abuse

- Safeguarding partners working more effectively with and being committed to the commissioning of specialist domestic abuse services.
- Incorporating guidance around effective responses to domestic abuse into the new national child protection practice framework.
- Embedding domestic abuse training for practitioners across all safeguarding partners.

Key messages for all safeguarding partners

The Panel outlines practice issues that should be immediately addressed by safeguarding partners.

- 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.

References

Child Safeguarding Practice Review Panel (2022) **National review into the murders of Arthur Labinjo-Hughes and Star Hobson**. [Accessed 30/05/2022]. <https://www.gov.uk/government/publications/national-review-into-the-murders-of-arthur-labinjo-hughes-and-star-hobson>

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