Sandwell Children's Safeguarding Partnership

Please visit our website for more information and for learning from local reviews: https://www.sandwellcsp.org.uk/

The review identified and summarised the key learning points for frontline professionals across all agencies: DOWNLOAD HERE

Webinar slides and recording: National review into the murders of Arthur Labinjo-Hughes and Star Hobson. Five webinars have been released about the national review into the murders of Arthur Labinjo-Hughes and Star Hobson. We would like to encourage everyone to watch the recording HERE and download a summary of the key issues discussed HERE

National Review Briefing

- The Child Safeguarding Practice Review Panel is an independent body who oversee all statutory case review activity
- Given the similarity of the cases, the severity of harm and the death of both children, and because they happened so close together, the panel decided to undertake a national safeguarding practice review
- The purpose of the review was to analyse the circumstances leading up to Arthur's and Star's deaths and to explore why the safeguarding processes designed to keep them safe, failed
- The review identified that the experiences of Arthur and Star in their short lives were not unusual and therefore made a number of local and national recommendations

Link to the National review into the murders of Arthur Labinjo-Hughes and Star Hobson - GOV.UK (www.gov.uk)

Arthur

- Arthur was just six years old when he died in June 2020 as a result of injuries sustained from abuse by his father's partner
- Prior to his death no significant concerns had been raised by professionals. His mother was imprisoned in 2019 for the manslaughter of her partner and Arthur lived with his father
- In 2019 Arthur's father began a relationship with Emma Tustin
- Arthur's grandparents contacted services with concerns about bruising to Arthur
- On 16 June 2020 emergency services attended the family home and found Arthur with bruising. He later died of his injuries

Key Findings

- Professionals only had a limited understanding of what daily life was like for Arthur and his voice was not heard
- Arthur's father was seen as a protective factor, and this view did not change because too many assessments relied on his view
- no proper consideration was given about the risks to Arthur arising from the move to live with Emma Tustin
- Arthur's wider family were not listened to
- Child protection procedures did not include practice guidance about allegations of physical abuse
- The lack of multi-agency strategy discussion undermined the response to concerns about bruising to Arthur
- Joint working and joint decision making were both very poor which led to poor assessments and ineffective multi-agency working

Key National Recommendations

ESTABLISH
- A national expert led model for child protection
- National multi-agency practice standards for child protection

STRENGHTEN
- Local safeguarding partnerships to ensure better coordination and involvement of agencies
- Sharper performance focus and better coordination of child protection policy in central Government
- Using the potential data to help professionals protect children
- Specific practice improvements in relation to domestic abuse

CHANGE
- To inspections to better understand local performance
- A new role for the National Panel to drive practice improvement

Star

- Star was just 16 months old when she was murdered by her mother's partner in September 2020. Her mother began a relationship with Savannah Brockhill in October 2019. Savannah was a known perpetrator of domestic abuse
- Concerns were raised by professionals in January 2020 about the relationship and physical chastisement of Star. The case was closed
- Family members described Star as looking sad and depressed and made a referral to children's social care. another referral followed in response to a video showing Star with bruising
- Star's mother and Savannah acted to prevent professionals from seeing Star
- At the time of her death Star had numerous injuries including a fracture to her skull

Key Findings

- Professionals only had a limited understanding of what daily life was like for Star
- Decision making reflected the volume of activity rather than information sharing
- Assessments did not explore the family context
- Star's wider family members were not listened to
- Children's social care was beset with structural and workforce issues
  - Domestic abuse was not considered as part of single assessments and therefore was not understood
  - Assessments within children's social care were not fit for purpose and did not enable the identification of risks to Star
  - The response to referrals were weakened by a lack of formal processes, particularly strategy discussions