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

This briefing aims to summarise the key learning points and recommendations from the Child Safeguarding Practice Review Panel’s national review into the murders of Arthur Labinjo-Hughes and Star Hobson. It outlines the main practice and systems issues that featured in Arthur and Star’s stories. It also sets out national recommendations for improving child protection across England.

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.

Read the full review report here: [National review into the murders of Arthur Labinjo-Hughes and Star Hobson](https://www.gov.uk/government/publications/national-review-into-the-murders-of-arthur-labinjo-hughes-and-star-hobson)

**About the national review**

Arthur Labinjo Hughes: Died 16 June 2020, aged six. Arthur was murdered by his father’s partner (Emma Tustin). His father, Thomas Hughes, was convicted of manslaughter.

Star Hobson: Died 22 Sept 2020, aged 16 months. Star was murdered by her mother’s partner (Savannah Brockhill). Her mother, Frankie Smith, was convicted of allowing her death.

The review was initiated due to the severe level of harm experienced by Arthur and Star, whilst public agencies were involved with their families. 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.

The review explores why the public services and systems designed to protect Arthur and Star were not able to do so. It also looks at wider issues and evidence from serious safeguarding incidents reviewed by the Panel in the last three years. Based on these findings, the review sets out a number of recommendations to improve the child protection system in England.

**Key Findings**

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 nationally.

* Weakness in information sharing and seeking, within and between agencies, no clear picture of what happening
* Family concerns not listened to and too much taken at face value
* Lack of robust critical thinking and challenge
* Failure to trigger statutory multi-agency CP processes
* Sharper specialist child protection skills and expertise
* Leaders ’ responsibilities to create conditions for this complex work.

**Key Practice Issues**

The Panel have set out in more detail the main practice issues that feature in Arthur and Star’s stories which resonate with findings from analyses of other serious safeguarding incident, for example, the Panel’s two annual reports (2018-19; 2020), the Panel’s thematic reviews, and the triennial analyses of serious incidents (Sidebotham et al., 2016; Brandon et al., 2020).

* **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.
* **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

**Questions that you might want to reflect upon as a Practitioner:**

Set out below are some questions that you might want to reflect upon as a practitioner either individually, as part of supervision, or as a group:

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

**Key messages for all Safeguarding Partners**

The report also sets out a few key messages for all Safeguarding Partners to reflect on:

All Safeguarding Partners should assure themselves that:

* Robust multi-agency strategy discussions are always being 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, Initial Child Protection Conferences.
* There are robust information sharing arrangements and protocols 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. Indeed, the Panel believes that the use of such language has many attendant risks and would therefore discourage its usage as a professional conclusion.

**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.

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

* + New operational framework for child protection investigations
	+ New multi-agency child protection units in every local authority
	+ Practitioners and managers under single management
	+ Multi-disciplinary make up
	+ Link to Care Review recommendations

Recommendation 2: Establishing National Multi-Agency Practice Standards for Child Protection.

Recommendation 3: Strengthening the local Safeguarding Partners to ensure proper co-ordination and involvement of all agencies.

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

Recommendation 5: A new role for the Child Safeguarding Practice Review Panel in driving practice improvement in Safeguarding Partners.

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

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

Recommendation 8: Specific practice improvements in relation to domestic abuse.

**References**

National Review <https://www.gov.uk/government/publications/national-review-into-the-murders-of-arthur-labinjo-hughes-and-star-hobson>

Community Care <https://www.communitycare.co.uk/2022/05/26/arthur-and-star-cases-show-need-for-expert-child-protection-units-finds-review/>

NSPCC <https://learning.nspcc.org.uk/research-resources/2022/national-review-murders-arthur-labinjo-hughes-star-hobson-caspar-briefing>

Child Safeguarding Practice Review Panel Webinar <https://youtu.be/SiR_dCc9o1I>