Child Protection in England

The National Review following the deaths of Arthur Labinjo-Hughes and Star Hobson

Safety agreement

- Self care
- Impact

Who are Arthur and Star?

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.

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.

Background to Review

- Both Children's Partnerships had begun local CSPRs
- These were both ended and replaced with a National Review commissioned by the National Panel
- The aim is not to apportion blame but to understand how and why the public services and systems designed to protect them were not able to do so.
- Arthur and Star's families made unique and crucial contributions to this report

Key issues identified

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 a number of 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.

Two important factors

The review contends that multi-agency arrangements for protecting children are fractured and fragmented.

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.

Overarching recommendations for system change

- 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
- National Multi-Agency Practice Standards
- A new Ministerial group is created to oversee the implementation of these new arrangements

Reflection: your initial thoughts

Four key themes identified

- Listening to families
- Lived experience/ day in the life of a child
- Domestic abuse impact
- Professional curiosity and over optimism

Theme for Learning One

Listening to Families

Listening to Families

Arthur

- 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

Who shared his voice

- Arthur's Paternal grandparents, Paternal Uncle and Maternal Grandmother all shared concerns regarding Arthur having bruises with Police and Childrens Social Care and their concerns that he was being abused.

Star

- Photographs as part of the police investigation show a sad child with many bruises on her legs, arms and face. These photographs are in stark contrast to earlier photos of the happy child taken by her extended family. Following her death there was evidence that Star had been physically assaulted on numerous occasions

Who shared her voice

- Star's Great Grandmother and Grandfather , shared concerns regarding her care as did her father and Uncle when she had bruises to her body and face.

Arthur’s Story

Challenging Our Own and Others Assumptions

- Contacts by family members viewed as malicious or was it unsubstantiated .
- Agencies not sure what to do with photographs- how to store and share, worry that images of the right child.
- Not enough weight given to what the images were showing- Children who are mobile do bruise, fall and fight but question the need for a CP medical. What about underlying injuries and injuries seen by others.
- Paediatric view not sought or multiagency strategy held to consider causes or Think the Unthinkable. Multiagency approach strengthens information sharing and safety planning.
- Professional Optimism- Arthur had been exposed to past trauma, His father stated he had concerns regarding his behaviour. CAMHS services reviewed him and acknowledge trauma, but were parent led and saw father as protective factor in his care as he was providing stability for Arthur since he left his mothers care, who was in prison. Arthur behaviour was linked to past trauma with no exploration of what could be happening for him at the time.

How can we listen Better….

- A Think Family Approach- Gathering information from those who knew the children. Rather than viewing information from relatives/neighbours the community as malicious, viewing it as unsubstantiated and in need of exploration.
- Documenting names of family members, new partners ,changes in partners, who cares for the child. Do they bring support and safety or harm and risk. What is know about them. Who is in the room when you visit. Asking- who are you. What involvement do you have with the child.
- Use Family Trees Genograms across agencies with a willingness to share what you know if you are concerned.
- Be professionally curious, What is the childs behaviour trying to tell you. Think- What do you see when you look at me- The Child? How does my world around me affect me? What is my daily lived experience? Arthur and Star had both lived with extended family members at times, what was this loss like for them when ties were cut and contact stopped?
- Consider as a partnership- Past, Present and Potential Harm and the unthinkable rather than accepting immediate solutions.

Theme for learning Two

The Day in the Life of a Child

‘Professionals had only a limited understanding of what daily life was like for Star, beyond a superficial assessment from “one off” visits, which did not build on any historic information known by each agency. Star experienced a high level of disruption due to constant moves throughout her short life. No professionals understood this. The fact that she may have been experiencing serious and systematic physical and emotional abuse was never really considered and addressed.’

What can we learn from Arthur and Stars Experiences?

- There was limited direct work with the families.
- There was a lack of reflection and further exploration into how the children and families presented themselves during visits.
- 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.

When do we get it right?

- When we focus on children and actively listen to what their words and behaviour tell us in a variety of environments.
- When we observe children and analyse what this tells us and use this to underpin our decision making.
- When we ensure that we consider what daily life is like for the children we work with- healthy challenge when this is not clear.
- When we seek information for a variety of sources to consider what children's day looks like not just take information from family at face value.
- When we look at what each child has experienced in their lifetime and consider what it might tell us about their needs.

What practical action can we take

- Always spend time observing children when you visit them and spend time with them, even non mobile and non verbal children can tell us how they feel!
- Direct work about daily life can be really illuminating – use of toys, worksheets.
- Make it clear to parents/carers that you will spend time with their child and that this is a key part of you assessing their needs.
- Be curious about what the child's day looks like- if this is unclear think about why? Is this because we need more information or is the child "hidden" in parental interactions.
- Check out with other professionals what they have observed about the child- does it fit with what you have seen/heard. If there are differences, what is your hypothesis about this?
- If parents are reticent for you to spend time with their child- be curious with them about why, explore with other agencies what this means.

People look for flamingos when sparrows are all around them


If your eyes are opened,
you'll see the things
worth seeing.
~ Rumi ~

What went wrong for Arthur and Star?

- Recognition
- Referral
- Responses
- Responsibility

Theme for Learning Three

Domestic Abuse

'Ensure practitioners know how to respond to incidents of domestic abuse and have a clear understanding of coercive and controlling behaviour, including female perpetrators and as well as the impact of domestic abuse on children'

Domestic Abuse: What went wrong?

- The biological parents of both Arthur and Star were not fully aware of their new partners previous Domestic Abuse history.
- In Star's case a safeguarding referral was made to Children Social Care by a local Domestic Abuse Provider, however Savannah Brockhill was not named on that referral.
- At the time Star and Arthur who were living in households where there was Domestic Abuse would not have been classified as 'Victims'.
- Extended family expressed concerns about both Child Abuse and Domestic Abuse, yet these concerns were dismissed.

Facts & Statistics on Domestic Abuse

Living in a home where Domestic Abuse happens can have a serious impact on a child or young person's physical and mental wellbeing as well as their behaviour, which can last into adulthood.

1 in 5 children under the age of 18 will have lived with an adult perpetrating Domestic Abuse during some point in their childhood (Refuge Stats)

Data from 2020 (WomensAid) suggests children and young people make up more than half of those who live in a refuge

Domestic Abuse was a factor in over 40% of Child Safeguarding Practice Reviews (2021)

Children who witness domestic abuse between parents may also be at greater risk of being violent in their future relationships

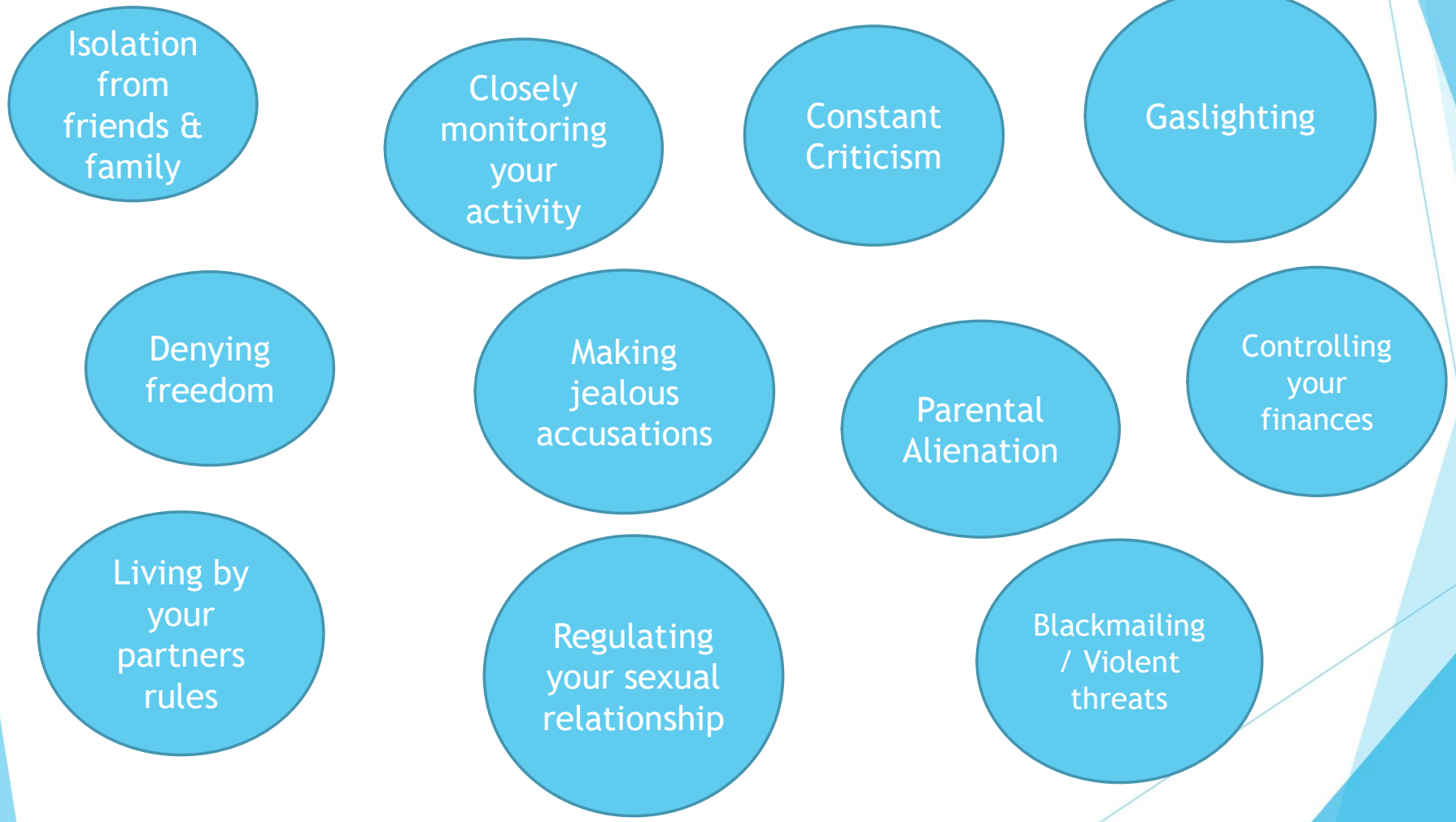
There were reports 11,436 reports of DA made to A&S Police in Bristol up until end of 2021.

Across Avon and Somerset Police as a force, Domestic Abuse makes up about 20% of all recorded crimes

New Legislation: Domestic Abuse Act 2021

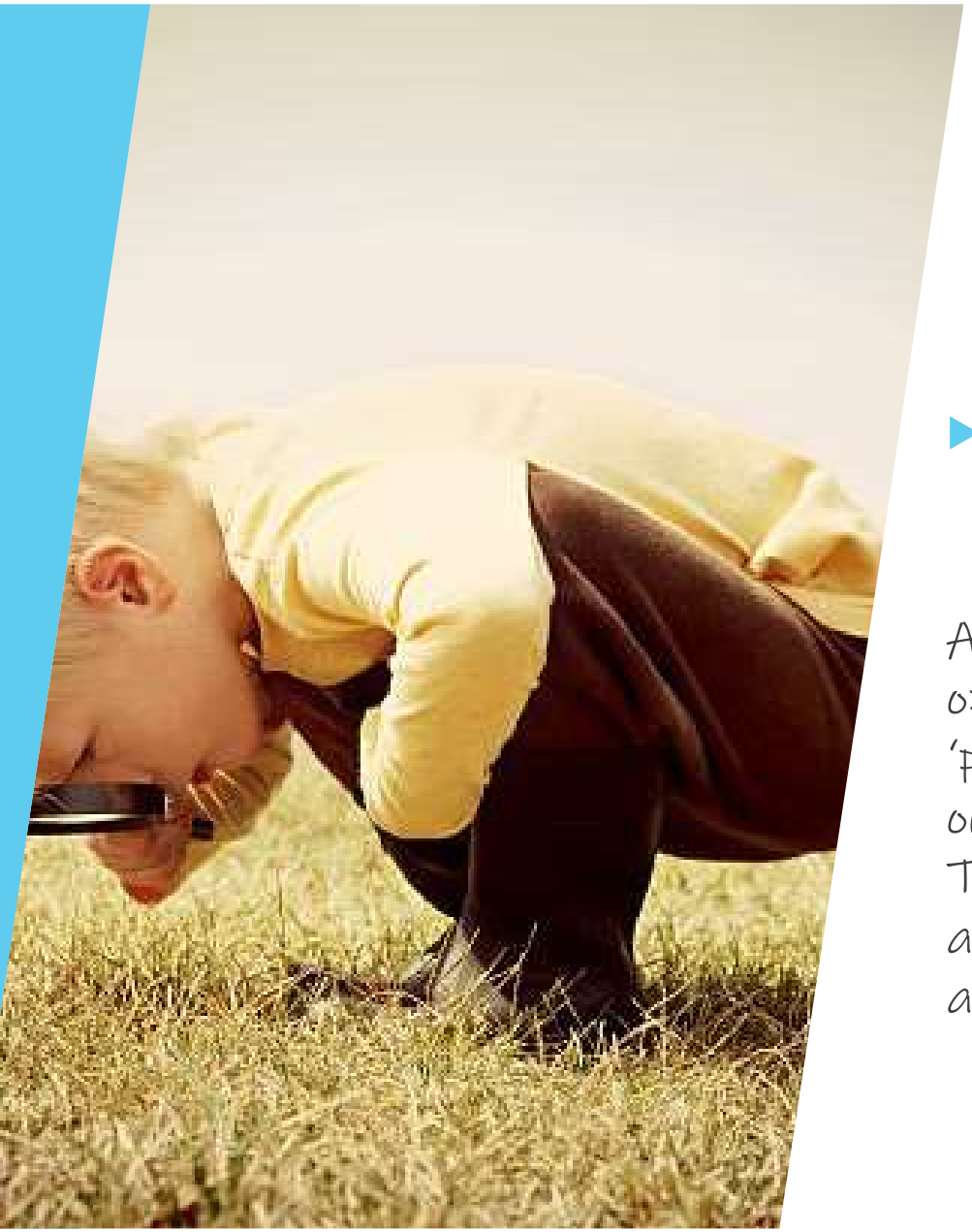
- The new statutory definition of domestic abuse, emphases that domestic abuse is not just physical violence, but can also be emotional, controlling or coercive, and economic abuse. It also extends the controlling or coercive behaviour offence to cover post-separation abuse.
- For the first time, following the passing of the Domestic Abuse Act 2021 Children who live in a home where domestic abuse takes place are now being recognised as victims in their own right rather than just witnesses. This change gives them more rights and should ensure locally commissioned services consider and address the needs of the child/ren in addition to the adult victim.
- The law will provide a new Domestic Abuse Protection Notice and Domestic Abuse Protection Order
- Places the guidance supporting the Domestic Violence Disclosure Scheme ("Clare's law") on a statutory footing.

Coercive & Controlling Behaviours



What can we as Practitioners do differently?

- Consider utilising the Domestic Violence Disclosure Scheme (DVDS), whether this be encouraging an individual to pursue an application, or submitting one on their behalf.
- Be ‘professionally curious’ & ask questions which glean further information
- Ensure full & accurate information gets included on inter-agency referral forms
- Use the online reporting tool to report a Crime or Intelligence which doesn’t require an emergency response Report | Avon and Somerset Police
- MARAC Referral for High Risk Cases
- Keep up our own CPD & Training around Domestic Abuse
- Language Matters- In Bristol we want to change the language to enable a more conscious and trauma-informed approach for Victims of domestic abuse and sexual violence.



Theme for Learning Four

- Professional Optimism & Curiosity

Assessments were often overly optimistic and lacking 'professional curiosity' in testing out parental self-reporting. They were too parent-focused and not always considering all adults in the household

What is Professional Curiosity?

- Professional curiosity is the capacity and communication skill to explore and understand what is happening with an individual or family.
- It requires you to not accept things at face value, to be inquisitive and not make assumptions.
- You need to ‘think outside the box’ and consider people’s circumstances holistically.
- It is about enquiring more deeply, using proactive questioning and challenge
- Curious professionals engage with individuals and families through visits, conversations, observations and asking relevant questions to gather historical and current information.

What skills are needed to exercise professional curiosity?

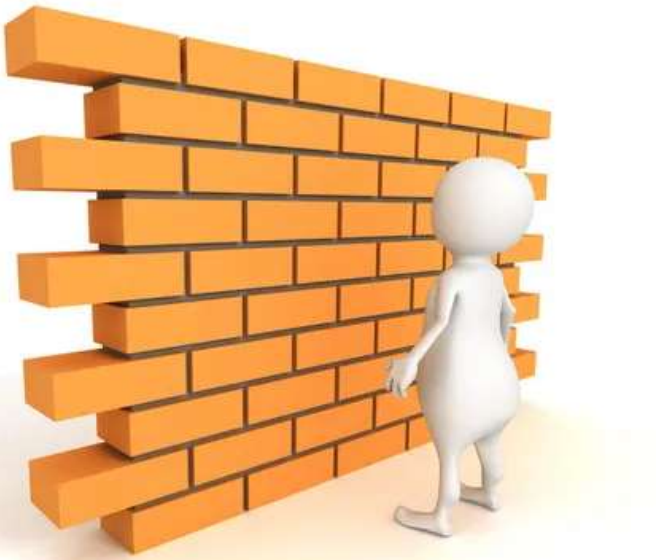
LOOK

LISTEN

ASK

CHECK OUT

What gets in the way of professional curiosity?



Professional curiosity is likely to flourish when practitioners:

- Are able to 'walk in the shoes' of the person and consider the situation from their lived experience
- See the child/family in a range of settings, alone and in the context of their family
- Are not reliant on a singular view – be that of a family or member of the network around the child
- Understand the cumulative impact or multiple or combined risk factors eg: trigger trio and think about gathering information within this context
- Have an analytical and reflective approach to their work and the information they gather from a range of sources
- Have good management support and good quality supervision
- Have skills, confidence and knowledge to hold difficult conversations and are happy to raise concerns and challenge information appropriately
- Appreciate that respectful scepticism/nosiness and challenge are healthy; questioning what you are told is ok as long as you do it in a respectful way.

- Build relationships and spend time getting to know the child, family and network
- Question your own assumptions about how families function
- Don't be overly optimistic, healthy scepticism is good
- Be willing to have challenging conversations (with professionals and the family)
- Expect the unexpected, think the unthinkable, believe the unbelievable
- DEAL - *"I need to point out something that you may not be aware of… **D**escribe – I need to point out that every time I ask a question, you interrupt me **E**xplain – this makes it difficult to progress matters – and will take me much longer to finish….**A**ction-please do not interrupt, please allow me to finish my Question – I'll do the same for you **L**ikely – if you keep interrupting me …I'll have no other option than to end the meeting"*
- EARS – Elicit, amplify, reflect, start over
- Understand history to consider cumulative impact or combined risk factors – chronologies are key to helping this
- Articulate your intuition into an evidence based professional view

Bristol assurance for recommendations

- Co-located MASH hub with increased targeted participation in Child Protection strategies due to technology.
- Staffed specialist provisions.
- Support for staff in their skills and expertise.
- Specialist Child Protection Unit within Avon and Somerset Police
- Information sharing agreements
- Professional curiosity

Where can I find out more?

You can read the full report here

The NSPCC have produced a helpful summary – read it here