

Child Protection in England

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

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Foreword

There was palpable public shock just before Christmas 2021 when the unimaginably horrific deaths from abuse suffered by Arthur Labinjo-Hughes and Star Hobson became known. We will never know what their respective lives were really like in the weeks and months leading up to their murders. What we must do is attempt to understand how and why the public services and systems designed to protect them were not able to do so. That is the primary purpose of this review, which has been undertaken by the national independent Child Safeguarding Practice Review Panel (the Panel).

In carrying out this review, we have sought to make sense of what happened to Arthur and Star, recognising the uniqueness of their individual lives, so that we can consider what we might do differently in the future.

Arthur and Star's families have made unique and crucial contributions to this report, and it is very important that everyone respects their rights to privacy. Too often their concerns were disregarded and not taken sufficiently seriously. We have drawn on their insights to inform proposals about how national child protection systems could better protect children in the future. In that way, the lives of Arthur and Star can become, in the words of a family member, a 'footprint' in making the changes that are needed.

This report asserts that the child protection system must be strengthened, both locally and nationally. We think that there is too much inconsistency and ambiguity in child protection practice in England. This does not serve children, their families or practitioners well. That does not mean that the child protection system is 'broken'; indeed there is good evidence that, every day, many thousands of children are protected from harm by conscientious, committed and capable social workers, police officers, health, educational and many other professionals.

However, current arrangements for this difficult work are not consistently supportive or sophisticated enough to ensure the very best practice. There is a need for a clearer and sharper focus on protecting children from significant harm across England's diverse geographical and social communities. Professionals working in child protection must have the very best and right expertise for making the very difficult decisions that they must make.

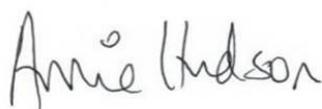
Despite the intentions of recent reforms (and most recently the [Children and Social Work Act 2017](#)), multi-agency safeguarding arrangements are not yet fit for purpose everywhere. This results too often in blurred strategic and operational responsibilities, creating fault lines in practice arrangements. This has major consequences for the ability of practitioners across different agencies to work together skilfully and purposively to protect children.

There needs to be much greater focus on creating the optimum conditions and environment for what is very complex and high-risk decision making. The perennial problems of sharing, seeking and using information about a child and a family persist. This must be tackled. We cannot afford to revisit these problems again and again; new approaches are required.

This review is focussed on Arthur and Star. Yet we know from our extensive evidence base spanning all serious safeguarding incidents over the last three years that many of the issues identified during the course of this review are frequently seen in practice more broadly across England. Our proposal for how we change the way child protection practice is undertaken extends out towards the serious risks faced by some children and young people outside their homes, and beyond that to serious online harm.

We hope that this review also provides a window of opportunity to enhance public understanding about the realities of child protection. All those professionally entrusted with protecting children must be held to public account, and this must be based on knowledge of the complexities involved.

We want this report to prompt considered, honest and careful reflection on what changes we must all make to better protect children in England. It is the responsibility of national and local leaders to take all necessary steps to strengthen and better support the very best child protection practice. We owe this to the families of Arthur and Star. Indeed, every family in England deserves nothing less.



Annie Hudson

Chair, Child Safeguarding Practice Review Panel

Overview

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.

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. Understandable questions were asked about why children had experienced such gross abuse and suffering when they were seemingly in 'plain sight' of public agencies. The extraordinarily harrowing video footage and images of both Arthur and Star, during the final weeks and days of their lives, no doubt contributed to questions being asked about how well children are protected in England.

The review has sought to keep the unique and distinctive lives and experiences of Arthur and Star at its heart. The point of this review is to evaluate the role of agencies. We can never know or understand why the perpetrators of these terrible crimes did what they did. Instead, we have to ask how agencies acted to protect Star and Arthur, and what factors enabled or limited their ability to do so, so we can identify improvements for the future. Arthur and Star were killed by people who should have been caring for them and loving them. The perpetrators, and they alone, are responsible for what happened. That inescapable fact cannot and should not be obscured by any of this review's findings and conclusions.

It is also very important to acknowledge that Arthur and Star both died during the COVID-19 pandemic. We have therefore sought to understand, as far as it is possible, whether the circumstances of this global crisis affected Arthur and Star, their families and the response of professionals to what was happening in their lives.

There has been a determination amongst those who have contributed to this review to make sure that significant change follows from the learning about the circumstances of Arthur and Star's deaths. This is important to members of Arthur and Star's respective

families as well as to the professionals who were directly affected by the extraordinary tragedy of what happened.

The death or serious injury of a child as a result of abuse at the hands of their parents or their parents' partners is relatively exceptional but the fact that it is an unusual event should not detract from our collective responsibility to make sense of what happened, to learn and to secure the improvements that may be required. There are obvious hazards in recommending major policy or system changes on the basis of what happened to one or two individual children. It has been vital therefore to triangulate the Panel's analysis with a wider evidence base, including the reviews of the many serious safeguarding incidents considered every year by the Panel.

What went wrong?

In analysing what happened to Arthur and Star and how public agencies responded, we have identified a set of issues which hindered professionals' understanding of what was happening to Arthur and Star. These are:

- 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.

These are not new issues; they recur across the reviews of serious incidents that the Panel sees on a fortnightly basis. They come up in all analyses of serious case reviews and thematic practice reviews; and they have featured in all previous inquiries into child deaths.

Why do these issues persist?

Protecting children from abuse is intrinsically complex and challenging work. It requires great expertise in finding out what is happening in the intimate realm of family life. It involves intruding into very private spaces to evaluate and make professional judgements about parenting, the development and wellbeing of children, and whether a child or infant is experiencing harm. Outside of the family, child protection professionals must also

address the complex issues of extra-familial harm, including child sexual and criminal exploitation. All child protection practice requires confidence, capability and the use of expert authority to make decisions about children's lives, recognising that these will have enduring and life shaping consequences. These involve, for example, initiating court-led decisions that a child should be removed from their parents, or deciding that the best thing for a child is to remain safely with their parents, even where this involves managing complex ongoing risk.

At its heart, child protection practice requires consummate skill in blending 'care' and 'control' functions, helping families to protect children. This can only be achieved by building trusting relationships with parents and children whilst recognising that how things appear may not be the reality of a child's experience. It also involves a well-honed ability to understand diverse and different communities, being able to reflect on how biases and cultural assumptions about, for example, ethnicity or sexual orientation, may shape judgements and decisions.

It is important to recognise at the outset that what happened to Arthur and Star was difficult to predict and understand. Arthur and Star were surrounded by loving extended families who were looking out for them. Professionals and family members had previously thought their parents capable of providing good care to them.

This complexity is a central feature of child protection work. It is what we are asking child protection professionals to cut through, to get to the truth of what life is like for children. It is our contention that the way the child protection system in England is designed currently does not give professionals the best possible opportunity of succeeding at this very difficult task.

What needs to change?

This review has highlighted two important factors about child protection in England.

The review contends that **multi-agency arrangements for protecting children are more fractured and fragmented** than they should be.

Despite the best intentions of reforms, the design of multi-agency child protection arrangements is sometimes inhibiting professionals from having a clear, accurate and contemporaneous picture of what is happening to a child and their family. The child's story is often held by multiple people in multiple places, the detail of which is constantly evolving. This means that it can be extremely difficult to build and maintain an accurate sense of what life is actually like for a child, without a forensic focus held by a consistent set of multi-disciplinary professionals who are charged with pulling together the disparate parts of the jigsaw of a child's life.

Whilst we have a well-embedded concept of partnership working across agencies, enshrined in statutory guidance ([Working Together to Safeguard Children 2018](#)), in practice, the key ingredients of effective operational delivery are not hard wired into our current arrangements. Trust, shared values, and identity are crucial behavioural factors in frictionless sharing of information between professionals. The current reliance on quickly pulling together a team from across overstretched agencies to think and act together to protect a child every time child protection processes are triggered is certainly inefficient and often ineffective.

Lord Laming described to us how, during his inquiry into the death of Victoria Climbié (2003), many professionals reflected on how they would have acted differently: ‘if only I’d known’. Arthur and Star’s stories tragically illustrate how critical information from multiple sources becomes rapidly fragmented leading to a partial and siloed understanding of children’s experiences and lives. Our recommendations seek to address these issues.

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.

There is value in the concept of safeguarding being ‘everyone’s business’ but its meaning has become too broad and elastic. As a consequence, there has been distraction and drift away from the need to make sure that those investigating and responding to abuse and neglect have the right specialist expertise. A stronger focus on the specialist skills required to work with this relatively small but extremely vulnerable group of children should lead to more clearly differentiated responses to concerns about abuse and neglect.

Redesigning child protection practice

We believe that the way that we approach child protection in this country needs to change fundamentally. The importance of effective ‘multi-agency working’ has been emphasised for many decades. But it is still not yet achieving the impact that it must have. There are examples of excellent multi-agency practice, but too often we see critical, life changing decisions being taken for children by children’s social care alone or with only superficial and partial involvement of other agencies. We need to see genuinely joint, challenging, rigorous decision making every time there are concerns that a child may be suffering significant harm.

Progress has been made in recent years. The Multi-Agency Safeguarding Hub (MASH) model has led to more accurate assessment of risk and need at the ‘front door’ of child protection, when it has been implemented well (Home Office, 2014). The reforms in the Children and Social Work Act 2017 established genuinely joint multi-agency accountability for safeguarding for the first time. Practice frameworks such as Family Safeguarding

Hertfordshire have shown us the great value of bringing highly skilled, multi-agency professionals together into a single team with a shared vision and purpose (Department for Education, 2017a).

But promising approaches are implemented patchily across the country. It does take time to build the evidence but once that is sufficiently strong, incremental changes are no longer enough. The way child protection work is undertaken currently is not benefitting from the wealth of knowledge and skill we hold about the benefits of multi-disciplinary and multi-agency practice, bringing the functions and expertise from multiple partner agencies to work together in a cohesive whole. Therefore, in all areas across the country, we need:

- Fully integrated multi-agency investigation and decision making, end-to-end across the child protection process; embedded in both structures and cultures.
- Those with the appropriate expertise and skill undertaking child protection work.
- Leaders who know what it takes to deliver an excellent child protection response and can create the organisational context in which this can flourish. This includes prioritising child protection, ensuring the resources necessary to deliver the work are in place, and working tirelessly to remove barriers – for example around IT systems – that get in the way.

Therefore, at the heart of our recommendations is a proposal for a new approach to undertaking child protection work.

We are recommending that **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.

These teams will be staffed by professionals with the highest levels of child protection expertise and experience and will see the key child protection agencies of the police, health and social care working together seamlessly as a single team. This does not mean that the highest levels of child protection expertise are not also held elsewhere, for example, by those overseeing the practice of those working with children in need. It does mean though, that there would be a consistent and highly skilled group of multi-disciplinary professionals leading statutory child protection practice in every local area.

Our other recommendations are rooted in enabling the proposed new Multi-Agency Child Protection Units to deliver excellent practice. The most important enabler of excellent practice is, of course, leadership. This is most pertinent in a multi-agency context where professionals are reliant on the right authorising environment – the right multi-agency budgets, priorities, protocols, values and systems – being in place. Therefore, we have put forward proposals for strengthened multi-agency leadership and accountability, and for

better multi-agency co-ordination and system oversight from central government. We have also recommended that new National Multi-Agency Practice Standards are developed for child protection, to help deliver consistently good practice across the country. Local area child protection practice across all agencies should be substantially and frequently inspected to ensure these national standards are met.

Delivering high quality child protection services to communities in rural Northumberland will be different to what is needed in urban Newham or Nottingham. However, roles and responsibilities for child protection need to be clearer nationally and locally. Central government must take a clear leadership role, with other stakeholders, for setting and overseeing implementation of child protection. We are therefore recommending that a new Ministerial group is created to oversee the implementation of these new arrangements. Child protection is a major public concern and should be matched by sufficient and sustained political leadership across all relevant Government Departments.

Review approach

The Education Secretary's [oral statement to Parliament](#) following Arthur's murder announced that the Panel would undertake this national review.

The Panel is part of the relatively new safeguarding architecture ushered in by the Children and Social Work Act 2017. The Panel's primary role is to oversee the national system of learning from serious incidents where children have died or been seriously harmed in the context of abuse and neglect, and to recommend ways in which policy or practice should change in response. The Panel has a unique perspective on the quality and effectiveness of safeguarding and child protection practice in England; its evidence base of over 1,500 reviews of serious incidents since its inception in 2018, alongside a range of thematic reviews that it has commissioned, positions it well to discern and analyse patterns in practice involving both intra and extra-familial harm to children.¹

The Panel's focus on the most serious incidents of abuse and neglect means that it has a very specific perspective examining situations where something has gone drastically, and sometimes fatally, wrong for children. The national system of rapid reviews and local child safeguarding practice reviews (LCSPRs) has generated much robust learning about how safeguarding systems should change or improve though there is much more to be done to ensure that change and improvements are sustained and consistently delivered.

We are rightly focussed on child protection systems and practice and have not sought to attribute individual blame or responsibility, though we have necessarily examined in considerable detail why professionals behaved in the way they did and what the consequences of each decision may have been for Arthur and Star. Our aim has been to identify a set of recommendations that will support – rather than get in the way of – the

¹ [Research and statistics - GOV.UK \(www.gov.uk\)](#)

professional behaviours and organisational conditions needed to engender high quality decisions for children.

This review is reporting just after the publication of the [independent review of children's social care in England](#) led by Josh MacAlister. Its terms of reference were to look at the whole system of support, safeguarding, protection and care, and the child's journey into and out of that system, including relevant aspects of preventative services provided as part of early help. The lens for our review is different in that it has focussed specifically on multi-agency child protection practice. While both reviews have worked independently of each other, we have shared pertinent information and the Government should consider the findings in the round to take forward comprehensive recommendations to improve the lives of children and families.

Methodology

Following the Secretary of State for Education's announcement that the Panel would undertake a national review, the [terms of reference](#) were published and a methodology was agreed.

The methodology has been adapted as the Panel and review team have gathered information, spoken to those involved and worked with the Safeguarding Partners in Bradford and Solihull to ensure the national review builds on what was learned locally. The review method was not to undertake two local child safeguarding practice reviews but to apply the learning from the deaths of these two children to the national system.

Key working principles for this review have been:

- The Panel has drawn on its unique and independent national role to analyse robustly and objectively the effectiveness and quality of child protection systems, processes, policy and professional behaviours.
- It has ensured that its analysis and recommendations are based on clear and robust evidence, drawing upon Panel evidence alongside that from other sources including research.
- It has involved key organisations and representative bodies at relevant points of the review to 'test' hypotheses and emerging findings. This includes appropriate engagement with the independent review of children's social care.
- There has been a particular focus on analysing child protection's perennial problems (e.g., risk assessment and decision making, information sharing and seeking). This is to help bring about change that will reduce risk and better protect children.
- The review has focussed on child protection systems and practice. It has considered individual practice within that context; this is in order to learn from practice issues rather than to assign blame.

The Panel has used a systems framework to understand the factors that underpin effective risk management and decision making; these factors are leadership and culture, systems and processes, practice and practice knowledge and the wider service context.

It is important to emphasise also that this review does not supersede or replace any complaints, disciplinary or other processes relating to individual professionals. Any such processes are a matter for other bodies, including employers.

Phase 1

Chronology: All the information, case notes, records and witness statements were gathered and analysed to form a chronology of Arthur and Star's lives. This work included the material accrued through the local reviews undertaken in Solihull and Bradford. The Panel is particularly grateful to family members and professionals who contributed to both processes.

Significant events and 'Key Practice Episodes': The chronology analysis identified significant events that happened to Arthur and Star pre-birth, during their lives and that impacted on their deaths. These were then analysed in detail to understand the role of all agencies and are referred to as 'Key Practice Episodes'.

Phase 2

Interviews and reflective conversations: The Panel and their reviewers conducted just under 80 interviews with professionals across Bradford, Birmingham and Solihull. This phase of the work was completed on the following basis:

- All participants were invited through a letter from the Panel chair. The meetings were largely held on Teams over video conferencing. Brief notes were made to capture reflections and better understand what factors in the work environment supported or hindered practice.
- The conversation included structured and unstructured questioning. Prepared questions focussed on key practice episodes that were relevant to each participant.
- Discussions sought to seek clarity over what happened and why but also to invite wider reflections about the practice environment and context.
- The conversations were undertaken by an experienced reviewer and a Panel member. A member of the secretariat attended to take notes.
- Consideration was given to ethical issues when preparing for and undertaking the conversations; including when consent was required.

Reflections of family members: The Panel approached, either directly, or through other family members, Arthur and Star's relatives to offer a conversation about what had happened. Not everyone responded or felt able to speak to the Panel. Some had already spoken to local reviewers and the report has drawn on those conversations.

We conducted the majority of these in person except where circumstances did not allow. We are very appreciative not only of the engagement of family members in such difficult circumstances but also of the insights they brought and which have added a great deal to our learning and understanding about child protection practice.

Interviews with perpetrators: The Panel approached the individuals who have been imprisoned as a result of Arthur and Star's murders respectively. Thomas Hughes and Emma Tustin declined to be interviewed. Frankie Smith and Savannah Brockhill were interviewed.

Interviews with professionals: The Panel spoke to practitioners and other professionals, some involved in the lives of Arthur and Star, and others with roles in local services, to understand what happened and identify underlying wider influences on local practice. More than 65 interviews took place with professionals involved. This covered around 100 personal perspectives of practitioners, managers and leaders.

Safeguarding Partners - visiting the localities: The Panel chair and lead reviewer visited Solihull and Bradford to meet with leaders and staff across agencies. These visits allowed the reviewer to understand more about the working environment for professionals. As part of the visits, the Panel also visited local offices and Arthur's school.

Other Panel reviews: The Panel has seen over 1,500 rapid reviews of serious incidents since its inception. This evidence base offers considerable learning and recommendations. The Panel's previous and ongoing reviews, including its published reports, were also drawn upon.

Wider evidence and data: The learning from serious incidents provides a robust basis for recommending improvement but the Panel has also drawn upon relevant national and international research and other studies. Where appropriate, inspectorate reports have also been considered. The collection and analysis of data has informed our understanding of local and national child protection contexts. The Panel has exchanged relevant information about emerging learning with the independent review of children's social care.

Risk assessment and decision making review: The Panel previously commissioned work to review incidents that feature poor management of risk and decision making. This included an analysis of 30 rapid reviews of circumstances where a child has died or been seriously injured in the context of abuse and neglect, to establish some of the factors behind effective and strong child protection practice. This work has been an important input to the review and evidenced further some of the factors that can inhibit strong practice. We have drawn upon this systems framework to help provide a clear foundation for the review's analysis and recommendations.

Thematic review of domestic abuse: The Panel commissioned a thematic review of multi-agency child safeguarding and domestic abuse. The learning from that report has fed

into this report and the findings are aligned. The Panel will publish a practice briefing on safeguarding children in families where there is domestic abuse in Summer 2022, this will include more specific recommendations.

Behavioural insights and Challenge Group: Understanding the culture and context in which practitioners make highly complex decisions under pressure has been a consideration of the review. To get underneath this, the Panel has considered how decisions are made in other high-risk environments which involve multiple institutions/ organisations to see if there are lessons in behavioural science which could inform the Panel's hypotheses and recommendations. The Panel commissioned the Behavioural Insights Team (BIT) to carry out research focussed on how behavioural science might inform decision making and information sharing in child protection practice. It also convened a group of leading researchers and thinkers from outside of the world of child protection to consider different ways of tackling some of the systemic issues in the English child protection system.

Stakeholder engagement: The Panel has developed and tested out its hypotheses and recommendations with a range of stakeholders. This has included the chairs of previous national reviews of child protection, key stakeholders from local government, charity, policing and health sectors, as well as with individuals of significance in related fields. A full list of these stakeholders can be found in Appendix A.

Phase 3

Recommendations and report development: This brought together key lines of enquiry, findings from the chronology and interviews, wider research and data and learning from the wider system. In this phase we tested hypotheses and recommendations with a range of people, including sector bodies and leaders, and with relevant central government departments to complete the final report for publication. The draft report was checked for factual accuracy by Solihull and Bradford Safeguarding Partners.

Arthur's Story

This chapter provides a short overview of Arthur's life and the involvement of key agencies with him and his family. In the overview, we refer to Key Practice Episodes where the assessments, decisions taken, and actions at these critical points subsequently affected what happened to Arthur. The next section analyses these Key Practice Episodes in detail, enabling us to understand more about what happened to Arthur and why. The final section of the chapter sets out key findings about the factors that enabled or limited the ability of key agencies to protect Arthur from the profound and ultimately fatal abuse and neglect that he suffered.

- 1.1 Arthur was six years old when he died on 17th June 2020. He was living with his father Thomas Hughes, father's partner Emma Tustin, and her two children. Arthur is described by family members and his teachers as a happy, healthy young boy who always had a smile on his face.
- 1.2 Professionals had not recorded any significant concerns about Arthur's welfare prior to June 2018. Arthur's mother and father separated in November 2015. Arthur continued to live with his mother. After the separation Thomas Hughes maintained a fully involved role in Arthur's life as a co-parent alongside Olivia, Arthur's mother. Arthur had extensive contact with both sets of grandparents and extended family members, who played a positive role in his life.
- 1.3 In February 2019, Arthur's mother was arrested for the domestic-related murder of her then partner, Gary Cunningham. Subsequently she was convicted of manslaughter and received a significant term of imprisonment. The relationship had been characterised by arguments and domestic abuse after excessive alcohol consumption. Olivia was the victim of a domestic abuse incident in June 2018, when Arthur was not present. This prompted a Children in Need² assessment by Birmingham Children's Trust (BCT). It concluded with no further action required for the Trust, but with recommendations for help and support from other agencies.
- 1.4 Following his mother's arrest, Arthur was cared for by his father. A further Children in Need assessment by BCT also concluded with no further action for the Trust.

² A 'child in need' assessment under section 17 of the Children Act 1989 will identify the needs of the child and ensure that the family are given the appropriate support in enabling them to safeguard and promote the child's welfare.

Arthur's father was assessed to be a 'protective factor' for him. They lived with Arthur's paternal grandparents and Arthur moved to a new school and settled well. He made good progress in his learning, made friends quickly, and engaged in sporting and other opportunities in school. School was a positive place for him with staff who knew Arthur and his family well.

- 1.5 Initially Arthur had telephone contact with his mother three times a week. In October 2019, his father stopped the contact between Arthur and his mother, his maternal grandmother and the maternal extended family. In December 2019, his mother initiated the process to establish contact arrangements with Arthur again through a Child Arrangement Order³. The Child and Family Court Advisory and Support Service (CAFCASS)⁴ therefore became involved with Arthur as part of this process.
- 1.6 Escalating concerns about Arthur's behaviour and emotional well-being in the autumn of 2019 were noted by his father at home and by staff in school. These concerns led to a referral to SOLAR⁵ (Child and Adolescent Mental Health Service) from his GP in January 2020. Arthur was assessed by SOLAR for specialist support on 4th March 2020 but was not offered a service. On the same day, Arthur was seen by a CAFCASS officer in the course of the completion of a Section 7 report for the Family Court. The report in April 2020 recommended that Arthur should have only indirect contact with his mother in the form of letters.
- 1.7 In autumn 2019 Thomas Hughes had begun a relationship with Emma Tustin. She was previously known to children's social care and other agencies in Solihull, including the police, Community Mental Health Team (CMHT), and Solihull Community Housing. There was a history of domestic abuse with Emma Tustin as both victim and perpetrator. Emma Tustin had four children, two of whom continued to live with her. It is not clear about the extent to which Thomas Hughes knew about Emma's previous history, and Arthur's wider family were not aware of these issues.
- 1.8 Thomas and Arthur moved into Emma Tustin's home on 23rd March 2020, when the UK entered the first period of national lockdown during the COVID-19 pandemic. Family members report that the arrangement was put in place due to the announcement of lockdown. Like most children, Arthur was not attending school, having not been classified within the group of vulnerable children identified to continue

³ A Child Arrangements Order (CAO) is an order that settles arrangements for a child or children that relate to the following: with whom the child is to live, spend time or otherwise have contact.

⁴ CAFCASS represents children in family court cases in England. Its duty is to safeguard children and young people through the family justice system, understanding their experiences and speaking up for them when the family court makes critical decisions about their futures.

⁵ SOLAR is a partnership between Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT), Barnardos, and Autism West Midlands. It provides emotional well-being and mental health services to children and young people up to their 19th birthday.

with daily school attendance. The school was not aware of the details of father's new partner or that Arthur was no longer living at his grandparents' address.

- 1.9 On 14th April, Arthur and his father stayed overnight at the paternal grandparents' house following a disagreement between Thomas and Emma, which led to Thomas leaving the house with Arthur. Emma later sent Thomas a text message threatening suicide; Thomas sent Emma a hostile text message in reply.
- 1.10 On 15th April, when Thomas was unable to contact Emma, whose phone was turned off, he filed a missing person report with the police. During subsequent enquiries by the police, Arthur was seen and deemed to be safe and well with his father at his paternal grandparents' house. Emma was located later the same day by the Birmingham and Solihull Street Triage team and declined the offer of referral back to the Community Mental Health Team.
- 1.11 On 16th April, Thomas and Emma reconciled their differences. Thomas and Arthur returned to Emma's address, despite strongly expressed misgivings from the paternal grandparents, who were concerned about the return to what they saw as an abusive situation for Arthur. This was the last occasion that Arthur was seen by his wider family until the day of his death.
- 1.12 Late in the evening on 16th April, Arthur's paternal grandmother contacted the Solihull Emergency Duty Team (EDT)⁶ regarding bruising to Arthur's back and scratches on his face that she had noticed when Arthur had been staying. She questioned the explanation given by Arthur's father that the bruising was a result of a playfight between Arthur and Emma's son. In response to this referral, the EDT contacted the police and requested a welfare check that evening. The police did not consider that such a visit was necessary as Arthur had been seen safe and well the previous day. The EDT advised Arthur's paternal grandmother of the police response and assured her that her referral would be considered by the Solihull MASH⁷ the following day.
- 1.13 On 17th April, having reviewed the paternal grandmother's referral and the observations from the police who had seen Arthur safe and well the previous day,

⁶ EDT provides an emergency out of hours social work response to concerns relating to both Children and Adults as well as providing an out of hours Approved Mental Health Practitioner response where mental health concerns have been identified. They then pass their work over to the day teams for them to carry on the work as required.

⁷ The MASH function provides a contact point for members of the public or professionals if they have a concern about a child or young person. It enables partner agencies such as the Police, Education, Health and Housing to share information, knowledge and skills to enable the right decisions to be made for a child, so that support is identified and put in place at the right time for a child to be safeguarded and protected.

Solihull MASH decided that the concerns about bruising warranted a home visit. According to the social worker's case recording from the visit, a scratch on Arthur's face and a faded bruise on his back were observed. No safeguarding concerns were identified from the visit.

- 1.14 Family members continued to express their concerns. There were further contacts to children's social care, the police, and Arthur's school. Photographs of the bruising on Arthur's back, taken by Arthur's paternal grandmother when Arthur and his father had stayed for two nights at her home, were emailed initially to the police by another family member, two days after the photographs were taken. The photographs were not passed on by the police to the Solihull MASH, which subsequently received them from Arthur's maternal grandmother seven days after the home visit by children's social care.
- 1.15 The photographs were considered by children's social care once they arrived in the MASH from Arthur's maternal grandmother on April 24th. They indicated more extensive and severe bruising than the practitioners reported seeing during their visit on 17th April. This was a very significant moment to re-assess the risk to Arthur in the light of important new evidence of potential physical abuse. The concern and uncertainty on the causation and timing of these injuries should have prompted a strategy discussion and advice sought from health professionals. Instead, it was concluded that the bruising seen in the photographs could be consistent with the adults' explanation that there had been a playfight between the two boys. Accordingly, it was decided that no further investigation was needed in relation to the family's concerns about bruising. It was hoped that the family would consent to an offer of 'life story' work with Arthur, which would be an opportunity to monitor and escalate any safeguarding concerns.
- 1.16 At the end of April, Arthur's father declined the offer of 'life story' work with Arthur. Thomas stated that he had a good relationship with the key worker in school, who was in contact weekly, and he could speak with them if he needed help with Arthur's behaviour. The case was closed to children's social care. The home visit in mid-April was the last time that Arthur was seen by any professional until the day of his death.
- 1.17 Having been advised by children's social care about Arthur's new address, school contacted father and spoke to Arthur at the end of April. Father was offered support strategies from the school's lead for Social, Emotional and Mental Health (SEMH) when he talked about struggling with Arthur's behaviour. Thomas confirmed that he would be taking up the offer of a school place for Arthur when school re-opened in June.

- 1.18 Arthur did not attend school as planned on June 8th. Thomas advised the school that Arthur was unwell and would look to return later in the week. On June 11th, Thomas spoke to the school office and shared increasing concerns about his son's well-being – he had lost interest in eating and was lethargic. The school's Designated Safeguarding Lead (DSL) later spoke to Thomas and advised that he contact his GP. On the following Monday, the DSL made a referral to the School Nursing Service. Thomas notified school that Arthur would not be returning until June 18th as there would be two days of celebrations for his partner's birthday. The GP made two attempts at telephone consultation with Thomas but the calls failed, and there was no option to leave voicemails.
- 1.19 On 16th June, emergency services were called to Emma Tustin's address in response to a report of Arthur being in cardiac arrest. Arthur had sustained a substantial head injury. The ambulance crew raised concerns regarding Arthur's presentation. He was described as looking unkempt, with bruising on his body. Arthur was conveyed to hospital and a CT scan found that he had sustained a devastating and fatal head injury. It was not possible to stabilise him and he died of his injuries. Arthur died in the early hours of the following morning.
- 1.20 The explanations for Arthur's injuries given by Thomas Hughes and Emma Tustin were not considered plausible. They were arrested and subsequently charged with the offence of causing or allowing the death of a child. In court proceedings concluded on 1st December 2021, Emma Tustin was convicted of murder and Thomas Hughes of manslaughter.

Evidence from video footage and text messages seen at the criminal proceedings revealed a shocking scale of physical abuse and neglect suffered by 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, for which Emma Tustin was convicted. In the days leading up to his murder, 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.

Professionals regrettably had very limited understanding of what was happening to Arthur and what his life was like when he and his father were living with Emma Tustin. The decision by children's social care not to investigate formally and fully the allegations of bruising any further, together with Thomas Hughes' choice not to take up 'life story' work, were pivotal moments when crucial decisions were made.

After March 2020, Arthur lost the contact and support of loving family members who adored him. Family members suspected Arthur may be at risk and did everything they could to try and speak up for Arthur. They contacted every agency they could think of – children’s social care, school, police – and some several times. But their voice was not heard.

The following timeline sets out the key events in Arthur’s life until March 2020.

Jan 2014	Arthur Labinjo-Hughes born
Nov 2015	Arthur's parents separate
June 2018	Domestic abuse between Arthur's mother and new partner
	<ul style="list-style-type: none"> • A domestic abuse incident (when Arthur was not present) prompted a Children in Need assessment by Birmingham Children’s Trust (BCT) that concluded with no further action.
Feb 2019	Arthur's mother arrested
	<ul style="list-style-type: none"> • Olivia Labinjo-Halcrow arrested for Domestic Murder of Gary Cunningham. Arthur moves in full time with Thomas Hughes. A further Children in Need assessment by Birmingham Children’s Trust (BCT) concluded with no further action. Arthur’s father was assessed to be a ‘protective factor’ for him.
Oct 2019	Contact with maternal family stopped
	<ul style="list-style-type: none"> • Arthur’s father stopped the contact between Arthur and his mother, his maternal grandmother and the maternal extended family. Around this time, autumn 2019, Thomas Hughes had begun a relationship with Emma Tustin.
Dec 2019	Mother attempts to re-establish contact
	<ul style="list-style-type: none"> • Arthur’s mother initiated the process to establish contact arrangements with Arthur again through a Child Arrangement Order. CAFCASS therefore became involved with Arthur as part of this process.
Jan 2020	Arthur referred to mental health services
	<ul style="list-style-type: none"> • Escalating concerns about Arthur’s behaviour and emotional well-being in the autumn of 2019 were noted by his father at home and by staff in school. These concerns led to a referral to SOLAR (Child and Adolescent Mental Health Service) from his GP.
March 2020	Arthur assessed by SOLAR and CAFCASS
	<ul style="list-style-type: none"> • Arthur was assessed by SOLAR for specialist support but was not offered a service. On the same day, Arthur was seen by a CAFCASS officer in the course of the completion of a Section 7 report for the Family Court. Lockdown is established in the UK and Arthur moves with Thomas Hughes from his paternal grandparent’s home into the home of Emma Tustin.

The following timeline sets out the key practice episodes after Arthur and Thomas move to live with Emma Tustin in March 2020.

14th April**Arthur moved to grandparents' house**

Thomas and Emma get into a dispute. Thomas removes Arthur and himself back to his parents' house. Emma's suicidal text met with hostile reply.

15th April**Arthur seen safe and well**

Thomas filed a missing persons report in regard to Emma. Police visit Thomas' house and found Arthur to be safe and well. Emma was found that day and assisted by the Street Triage team.

16th April**Grandparents raise concerns about bruising**

Emma and Thomas reconcile their differences. Thomas returns to Emma's home with Arthur. Paternal grandparents voice growing concerns about bruising with Solihull Emergency Duty Team (EDT). EDT call police that evening relaying grandparents concerns. Police deny request for a 'Safe and Well' visit based on their observation of Arthur the previous day.

17th April**Social work team check on Arthur**

Following paternal grandparent's concern, the MASH send social workers to check on Arthur. Social workers report that Arthur and Emma's son are willing to show bruises – no safeguarding concerns were identified. An offer of 'Life Story' work is made.

18th April**Police receive photos of bruising**

Photographs of bruising are sent to the police by Arthur's uncle. They are received by the police but never sent onto the MASH.

24th April**MASH receive photos of bruising**

Family members continue to express their concerns to Children's Social Care, the police, and Arthur's school. The photos of bruising are passed onto the MASH by maternal grandmother on April 24th.

End of April**No further investigation**

It was decided that no further investigation was needed in relation to the family's concerns about bruising. It was hoped that the family would consent to an offer of 'life story' work with Arthur, which would be an opportunity to monitor and escalate any safeguarding concerns. At the end of April, Arthur's father declined the offer of 'life story' work.

16th June**Emergency services called**

Emergency Services called as Arthur is suffering Cardiac Arrest after sustaining a severe head injury. He dies the next day.

Analysis and findings

The analysis that follows:

- seeks to understand what happened to Arthur and why; and,
- evaluates how agencies acted to safeguard Arthur, and what factors enabled or limited their ability to protect him from the profound and ultimately fatal abuse and neglect that he suffered.

The analysis is structured around six **Key Practice Episodes (KPE)** where professionals were directly involved in working with Arthur and his wider family to respond to possible safeguarding concerns, assess risk of neglect, abuse or significant harm, and consider his wider support needs. The assessments, decisions, and actions taken at these critical points subsequently affected the outcomes for Arthur. We evaluate the effectiveness of multi-agency safeguarding practice in each of the six Key Practice Episodes. From that analysis we then set out findings in relation to **cross-cutting themes**⁸ that inform the national or local recommendations in this report.

At different points across the practice episodes in Solihull there was one social worker from the Emergency Duty Team, one duty social worker and a referral and advice officer in the MASH, one social worker and family support worker in the Family Support Team, and four assistant team managers.

KPE 1	<ul style="list-style-type: none"> • Support for Arthur to deal with the trauma of his mother going to prison
KPE 2	<ul style="list-style-type: none"> • Response to domestic abuse incident between Thomas Hughes and Emma Tustin
KPE 3	<ul style="list-style-type: none"> • a) Response to referral from Arthur's paternal grandmother • b) Home visit and after
KPE 4	<ul style="list-style-type: none"> • Response to photographs of bruising on Arthur
KPE 5	<ul style="list-style-type: none"> • Understanding the role and impact of Emma Tustin after Thomas Hughes and Arthur move to live with her from March 2020
KPE 6	<ul style="list-style-type: none"> • Contact with Arthur and the wider family by school and other agencies March - June 2020

⁸ The analysis for the cross-cutting themes draws on Key Lines of Enquiry (KLOE) drawn up by the review team. The KLOEs are linked to the Panel's analytical framework for Risk Assessment and Decision Making in child safeguarding.

Early years – Arthur living with his mother

- 2.1 Arthur was known and considered by children's social care twice when he lived with his mother. Firstly, in June 2018, Gary Cunningham assaulted Arthur's mother when Arthur was not present and BCT undertook a Children in Need assessment which concluded with no further action. There was no overt consideration in this assessment on the possible impact on Arthur of being in a household where domestic abuse and alcohol abuse were present.
- 2.2 Secondly, following the domestic manslaughter of Gary Cunningham by Olivia on 23rd February 2019, a multi-agency strategy discussion took place. It was agreed that BCT would carry out another Children in Need assessment to consider whether Arthur could be well looked after by his father now his mother was in prison, and work out what support Arthur might need in the circumstances.
- 2.3 The case was allocated to a social worker who contacted Thomas by telephone on the same day. Thomas outlined the immediate steps he had taken to support Arthur, including arranging for Arthur to move schools and attend Dickens Heath Primary School in Solihull. At a home visit with Thomas and Arthur the social worker noted no concerns regarding the care given to Arthur by his father. There was considered to be a positive network of family support from paternal grandparents. Arthur told the social worker that time spent with paternal grandparents was positive for him.
- 2.4 A judgement was made at this point which seemingly became fixed throughout all the children's social care interactions with Thomas Hughes that followed. This was that Thomas Hughes was a protective father. This was a reasonable judgement to make in 2019. Thomas Hughes, with the support of his family, did provide good care to Arthur over the coming months, until he began his relationship with Emma Tustin.
- 2.5 However, the assumption that Thomas was a protective factor for Arthur would nonetheless have benefitted from further critical thinking and challenge as early as 2019. Thomas Hughes was aware of the continuing relationship between Olivia and Gary Cunningham. He reported being present and protecting Arthur during a domestic abuse incident between the couple in November 2018. He had described increasing concerns in the weeks leading up to the domestic homicide, with Olivia increasing her consumption of alcohol. The assessment might have explored whether, given these circumstances, Thomas had the capacity to act to protect Arthur from physical or emotional harm. Thomas did not demonstrate steps he might have taken to protect Arthur in the short period before Olivia killed Gary, but he had remained active in co-parenting his son and immediately took on Arthur's full-time care when Olivia was arrested, supported by his family.

- 2.6 Assumptions about Thomas Hughes being a ‘protective father’ would be an important factor when professionals in Solihull responded to safeguarding concerns about Arthur in subsequent months, and these assumptions might have been reconsidered in the light of changing circumstances and the new relationship formed between Thomas and Emma.
- 2.7 The assessment also did not give any consideration to the needs of Arthur as a child whose mother had been sentenced to a long prison term. The issue was, however, discussed with Thomas, and recommendations made about services that could support Arthur. The agreement was that Arthur’s new school would make the appropriate referral. The BCT assessment concluded with no further action needed from the Trust. The case was kept open until the school’s referral to SOLAR had been completed.

Key Practice Episode 1

Support for Arthur to deal with the trauma of his mother going to prison

The need to consider mental health support for Arthur was included in the assessment completed by BCT in March 2019. It indicated that referral to SOLAR would be taken forward through Arthur’s new school. The first referral to SOLAR was made promptly by the school on 11th March. The referral was not accepted as it was felt there were no obvious mental health issues. The response from SOLAR was not challenged by the school.

Concerns about Arthur’s behaviour at home and his emotional well-being increased in the period after September 2019. Olivia had been sentenced and Arthur was aware that his mother was in prison. School made a second referral to SOLAR on 21st November. The referral was made by post. The SOLAR team had no record of receiving this referral and no support was offered to Arthur. School liaised with Arthur’s GP and supported Thomas to seek a further referral to SOLAR in January 2020. At the GP consultation on 6th January, Thomas reiterated his concerns about Arthur’s behaviour and emotional well-being. The GP sought advice from the Practice Safeguarding Lead. They agreed that Arthur’s behaviour was triggered by traumatic experiences and initiated an urgent further referral to SOLAR.

After a period of delay, in part because for six days the service was unable to make contact with Arthur’s father to arrange and agree the appointment date, Thomas and Arthur were seen for a Choice Assessment (an initial meeting to talk to the child) by SOLAR on 4th March. Thomas reported that Arthur’s anxiety and aggression were reducing. Thomas shared information that Arthur had begun to disclose distressing

experiences whilst in the care of his mother. Arthur was present for almost all of the assessment meeting. Father was seen alone for a short time due to the nature of the discussion being potentially distressing for Arthur. The assessment concluded: 'no mental health need due to anxious and aggressive behaviour decreasing – to be discharged, with advice for family to monitor Arthur's disclosures and discussions around his mum and offer time and space to explore this. To re-refer if mental health needs escalate.' On the same day as the SOLAR assessment Arthur was seen by a Family Court Adviser from CAFCASS as part of the preparation of a Section 7 assessment, following Olivia's decision to seek a Child Arrangement Order under Private Law proceedings.

- 2.8 SOLAR's decision to discharge Arthur in March 2020 was surprising, given the diagnostic formulation in the assessment, which suggested that Arthur met the eligibility criteria for the service. The clinical impression from the assessment was that: *'Arthur is presenting with loss and confusion following mum's arrest, additionally having experienced and witnessed abuse in the family home. He has internalised these experiences and it is unknown how it has impacted upon him or if he has experiences to share. This can manifest itself in low level anxiety or aggression.'*
- 2.9 The decision may have been influenced by Thomas's statement that the behaviour that had prompted the referral from the GP was now reducing. The SOLAR practitioner did not see Arthur alone. In the notes from the assessment, he was described as 'very smiley, happy and played independently, proudly showing off his colouring at the end.'
- 2.10 The decision by SOLAR to not offer a service was a missed opportunity to receive some of the support Arthur needed and would have allowed professionals to have a better sense of what life was like for him. In interviews for this review, managers with oversight of the SOLAR service in Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) have reflected on the limited quality of the assessment of Arthur's needs and accept that he would have met the eligibility requirements for a service for SOLAR well-being support and anxiety management. They have noted that at the time there was a waiting list for assessment appointments and limited capacity to meet the demand for services.
- 2.11 The court order for CAFCASS to undertake a Section 7 assessment following Olivia's decision to seek a Child Arrangement Order to spend time with Arthur was also an opportunity when there might have been a more in depth understanding of, and response to Arthur's emotional and social needs, in the context of the significant changes and disruptions that he had experienced in a relatively short period of time. Arthur was seen once by the Family Court Adviser (FCA) in March 2020 on the same day as the SOLAR assessment. The Section 7 report was filed with the court on 14th

April 2020. Whilst accepting that the FCA completed their enquiries in accordance with the court ordered work for the report, our review considers that wider liaison with CAMHS and extended family members might have enabled a better understanding of Arthur's emotional health needs. Senior managers at CAFCASS have recognised this, noting in particular that more consideration could have been given to the potential for the maternal extended family to facilitate positive contact between Arthur and his mother in support of her application.

Response to allegations of bruising to Arthur

- 2.12 This is the critical period in Arthur's story. The response by professionals to concerns about bruising to Arthur involved a number of significant Key Practice Episodes. It is important to consider the response from children's social care, the police and Arthur's school over the whole period from 14th April 2020, when a disagreement between Thomas Hughes and Emma Tustin took place, through to the decision by children's social care to close the case on 27th April 2020. Assumptions and decisions taken at different points over this fourteen-day period informed and limited the basis on which professionals acted subsequently in response to the continuing concerns of family members and in their engagement with Thomas Hughes.
- 2.13 Professionals interviewed for our review have highlighted the context of the COVID-19 pandemic and its impact on their working arrangements. In response to the impending pandemic, the local authority had put critical incident arrangements in place from early March 2020. These were at an early stage of implementation in April 2020 when concerns about Arthur were notified to the MASH. Children's social care made a number of important adaptations for COVID-safe practice. In the MASH, social workers continued on duty and were office-based. The shared police link officers to the MASH for Solihull and Coventry worked remotely. Referrals were 'RAG (red-amber-green) rated' for priority response to safeguarding concerns and then allocated as 'tasks' to social workers and Family Support Workers (who were working from home and deployed on a more fluid basis than formal team structures) based on their home geographical location and ease of travel for visiting the child and family. There was more limited information gathering and provision of previous case information and chronology.
- 2.14 Children's social care put in place guidance for home visiting during the pandemic. Specific criteria were established for children and young people in need of support and protection, with a requirement for them to be seen alone and to assess child safety and parenting capacity. Whilst responsiveness to referrals was maintained, the impact of the modifications was some fragmentation in the management oversight of

the response to individual referrals and lack of clarity about case-holding accountability. These aspects have been carefully considered in our analysis.

Key Practice Episode 2

Response to Domestic Abuse incident between Thomas Hughes and Emma Tustin, 14th – 16th April 2020

On 14th April there was a disagreement between Thomas Hughes and Emma Tustin following an apparent fight in which Arthur allegedly hit Emma's son. This led to an argument between Thomas and Emma. Thomas and Arthur left the property and returned to the paternal grandparents' house where they stayed for the next two nights.

The following day, 15th April 2020, Thomas Hughes contacted the police to report that Emma Tustin was threatening suicide and he could not locate her. In responding to the missing person notification, a police officer attended Arthur's paternal grandparents' house where he spoke to paternal grandmother and saw Arthur in the course of his enquiries.

Late afternoon, the police made contact with Emma by phone. She stated that she was fine and her mobile was then turned off. Police completed comprehensive record checks, including some health records. These checks revealed that Emma was known to mental health services with previous thoughts of suicide. The police attended Emma's property and broke the door down to gain entry for a safe and well check. Emma was not at the property. The locks were changed to secure the property; as a result, when she returned later, she was unable to get into the house and contacted a neighbour.

The Birmingham and Solihull Street Triage team later located Emma and screened her mental health. Emma told them that she was experiencing low mood and was offered a referral back into the Community Mental Health Team. Emma declined this offer of support and provided some information to the Street Triage team about 'difficulties at home with her stepson, Arthur, bullying her son.' Emma reported that Arthur punched her son, which led to an argument between Thomas and Emma, during which Thomas had pushed her son with his elbow, causing him to fall over. On the basis of this information, the police generated a crime report for Wilful Assault.

On 16th April Thomas decided that he and Arthur would return to live with Emma and her children at her address. Arthur's paternal grandparents and other family members expressed strong misgivings and there was a falling out between Thomas and his family before he and Arthur left.

On the morning of 16th April, Arthur's paternal grandmother noted bruising on Arthur's back and shoulders. She was doubtful that these had been the result of a playfight with Emma's son and took photographs of them on her mobile phone.

- 2.15 The actions by West Midlands Police over the period 15th – 20th April were the subject of a complaint by Arthur’s paternal grandmother. The Independent Office for Police Conduct (IOPC) has conducted an investigation and is reviewing its findings.
- 2.16 The police appropriately recorded the alleged assault on Emma’s son by Thomas as a crime.⁹ This should have been reported to the Public Protection Unit and referred to the Solihull MASH.
- 2.17 There were good processes in place for the police to respond to reports of suicide ideation, with sustained enquiries to locate Emma Tustin. The Street Triage service, comprising a mental health nurse, police officer, and paramedic in one vehicle, enabled a swift and coordinated response. The team was able to access police and some health records to assist in the assessment of risk, but it did not have access to information from children’s social care. Although Emma was offered access to CMHT support, there was no wider consideration of the risks to her own children or to Arthur, given the mental health difficulties she had described and her historic issues which were known to the Street Triage team. The incident warranted a referral to the Solihull MASH because of the potential impacts on both Arthur’s and her children’s welfare.
- 2.18 Arthur and Thomas were seen at paternal grandmother’s house by the response police officer who was in charge of locating Emma Tustin. The officer (who had received general awareness training on child safeguarding but was not a specialist in child protection) considered that Arthur looked fit and healthy, with no obvious injuries. Thomas Hughes was observed to be mentally stable and a concerned and caring father. The same police officer also undertook the forced entry of Emma Tustin’s property as part of the search for her. The property was seen to be clean and tidy. There was a child’s bedroom, children’s beds and age-appropriate toys. These observations, made in the context of responding to the report of a high-risk missing person, were important in framing subsequent responses to and decision making about reports of bruising to Arthur.

Key Practice Episode 3 (a)

Response to referral from Arthur’s paternal grandmother 16th – 17th April

Late on 16th April, Arthur’s paternal grandmother contacted Solihull Emergency Duty Team with a concern that she had seen bruises and scratches to Arthur’s body. Arthur and his father had told her that these injuries had been done by Emma’s four-year-old son. She was concerned that this explanation was not true and that the injuries could have been caused by Emma. Arthur’s paternal grandmother maintains that the EDT was informed

⁹ This allegation was later shown in court to be unsubstantiated.

that she had taken photographs of the bruising. The record of the call in the case notes from EDT does not include any mention that photographs had been taken.

In response to paternal grandmother's referral, the EDT contacted the police and requested a welfare check that evening. EDT gave the police the contact details for Arthur's grandmother and father. The police were informed that Arthur's grandmother would care for Arthur if it was felt that he needed to be removed. It was agreed that the police would contact grandmother to update her following the visit.

The police officer who had dealt with the domestic abuse incident the previous day contacted EDT. He advised that they had no safeguarding concerns and described Thomas as a caring father who was able to manage Emma's mental health concerns and prioritise Arthur's care. Thomas had mentioned the argument between Arthur and Emma's son and the police had not seen any visible injuries so the police view was that a further welfare visit would not be proportionate. It was agreed that the police would contact grandmother with their decision, EDT agreed to pass on the information and concerns to the MASH for consideration the following day.

Arthur's grandmother challenged the police officer about his decision not to undertake a welfare check. She called back to EDT and stated that she was not certain that Thomas would protect Arthur (if he was at risk) as he had taken him back to the household with Emma, even though she had expressed her concerns to him. The EDT officer assured her that the MASH would look at the situation as a priority the following day, and that, as the referrer, she would be contacted about next steps. This follow-up contact did not happen.

On 17th April social work duty screening took place in the MASH. The decision was that as Arthur had not made a disclosure children's social care should follow up the referral by contacting Thomas Hughes and arranging a threshold visit¹⁰ to see Arthur that day. This was a single agency process – statutory multi-agency child protection processes were not initiated. Thomas Hughes was contacted by the MASH and told that children's social care needed to visit to see Thomas and Arthur 'within the next hour.' He was initially reluctant to agree a home visit but ultimately gave consent.

2.19 The decision by the police officer not to visit on the evening of 16th April was not appropriate. Although the officer had formed the view that Thomas was a caring father, and Arthur had been seen apparently safe and well the previous day, the information that Arthur's grandmother had found bruising on Arthur had not been known and the area of alleged bruising (on Arthur's back) would not have been seen. The rationale for not visiting on the evening of 16th April seemed to take more account of the reaction of the adults in the household rather than placing Arthur's needs at the centre of the decision making. A visit that evening (preferably jointly by the police and

¹⁰ Threshold Visits were single agency visits undertaken by duty social workers in the MASH in circumstances where children were not deemed to be at immediate risk and managers needed more information to determine whether the threshold had been met for a social work assessment to be initiated.

EDT) should have revealed the bruising and led to the initiation of child protection procedures.

2.20 Decision making in the MASH was not robust. The relevant joint guidance in the region at the time stated that a joint investigation should take place where there was: *'any allegation of physical abuse to a child or a suspicious injury to a child, or inconsistent explanations or an admission about a non-accidental injury.'*¹¹ Although a discussion did take place between the duty manager in the MASH and the linked police officer, this did not constitute a strategy meeting. The information available from EDT warranted the convening of a multi-agency strategy meeting.¹² This is likely to have enabled the wider consideration of the events over the previous two days, the sharing of the full range of information held by partner agencies about all family members (including Emma Tustin) and next steps to be agreed, including whether to undertake section 47 enquiries.¹³ A robust strategy discussion would have identified the need to go back to Arthur's paternal grandmother for further clarification about the referral; and this in turn is likely to have resulted in her repeating the fact she had photographs of the bruising. A strategy discussion would also have highlighted the need to: seek advice about whether a Child Protection Medical might be required; agree the purpose and format for the home visit; and decide whether or not to inform Thomas Hughes ahead of it. The lack of a strategy discussion set the tone for subsequent practice weaknesses in responding to the allegations about bruising to Arthur.

2.21 The decision taken by children's social care to initiate a threshold visit, without having convened a strategy discussion, was not appropriate, given the nature of the concerns in the referral from Arthur's paternal grandmother. Threshold visits were a local arrangement in Solihull in situations where a child was not deemed at immediate risk and managers needed more information to make a decision. The intention was to ensure a timely and proportionate response to needs and concerns, with children and families only subject to a social work assessment if they needed to be. Managers in the MASH may have taken the view that these circumstances applied in respect of the concerns about Arthur, relying on the observations of the police officer who had seen Arthur on 15th April. The MASH should have contacted Arthur's paternal grandmother prior to the visit to ascertain further details about the bruising she had seen and provide reassurance to her about the response from children's social care.

¹¹ West Midlands Joint Protocol – Joint Investigation – Child Protection enquiries and related criminal investigations 2011.

¹² See West Midlands Child Protection Procedures, section 1.8. 'A strategy meeting is an opportunity to share as much of the available information as possible between participants to inform the next steps.'

¹³ Section 47 of the Children Act 1989 requires local authorities to undertake enquiries if they believe a child has suffered or is likely to suffer significant harm.

2.22 In initiating a swift response to arrange a face-to-face home visit the duty social worker appropriately challenged Thomas Hughes to ensure that the visit took place in the home rather than an external location. Within the framework of a threshold visit, and the adaptations for COVID-safe working arranged by the local authority, it was appropriate to allocate the visit to a social worker and family support worker. The practitioners who carried out the home visit had the necessary experience for what was required.

Key Practice Episode 3 (b)

Home visit and after: 17th – 18th April

The home visit was allocated to a Social Worker and Family Support Worker. The practitioners have reported that they were told by Thomas about the plan for he and Arthur to move to Emma's address on a full-time basis. The couple explained that the domestic abuse incident was a 'one off' when they were getting used to living together. The argument was triggered by Arthur telling Thomas that Emma had hit him. Arthur later told Thomas that this was not true. Arthur and Emma's son had been physically fighting and had to be pulled apart. Freezer packs had later been applied to take down the bruises.

Arthur and Emma's son were observed at play and spoken to. The visit record describes them as eager to show their bruises, and reports that Arthur was found to have a scratch on his face and faded bruise on his back. Emma's son also showed a bruise. The children gave 10/10 when asked to rate how safe and happy they felt.

Thomas described the relationship with his parents as raw and felt the referral to Children's Services had escalated the situation. Thomas and Emma raised concerns about Arthur's behaviour. He had experienced change and trauma over the previous twelve months and they said that he had disclosed physical abuse by his mother (these claims have never been substantiated). Thomas agreed to consider an offer of 'life story' work with Arthur from the Family Support Worker. The visit report recorded that there were no safeguarding concerns identified from the visit and recommended Level 3 support (Solihull LCSP has four levels of need. The threshold at Level 3 was for children requiring early help, which would include mental health support).

Home visit – 17th April

2.23 The home visit on 17th April lasted for around ninety minutes. The practitioners undertaking the visit considered that Thomas and Emma had engaged well. It is important to remember that, at this point, and in an ongoing way, Thomas and Emma were seeking to mislead and manipulate professionals. We know from evidence at the criminal trial that Thomas and Emma exchanged text messages and a video of Thomas examining Arthur on the day of the visit; it is possible that this was in order to

prepare a plausible account for Arthur's injuries.¹⁴ The practitioners spoke to the boys about the fighting between them. They were asked about and showed their bruising. The case note stated that '*both children were keen to show their injuries – observed a scratch on the face and a faded bruise on Arthur's back.*'¹⁵ We now know from the court evidence (a) the photographs of bruising taken by the paternal grandmother were taken just 25 hours before the home visit; and (b) the consultant physician confirmed that the bruising shown in the photos would not have faded in the time from when the photos were taken to the time of the home visit.

- 2.24 We must therefore conclude that (a) the bruising to Arthur was there on 17th April when the visit took place; and (b) the limited examination of the boys meant that the full extent of the bruising was not seen during the visit, or if it was seen, its significance was not recognised. Either way, the thoroughness of the physical examination during the visit, and thus the conclusions drawn from it, were insufficient given the reason for the visit was to explore allegations of non-accidental injury. Any physical examination of the boys should have been undertaken only following a strategy discussion between safeguarding partners.
- 2.25 The practitioners had to make a judgement call about whether Arthur had experienced or was at risk of significant harm on the basis of a single visit. They have told the review team that they left the visit with absolute confidence that Arthur was not living in circumstances that suggested a need for Section 47 enquiries. Thomas and Emma had responded positively to an offer to support Arthur through 'life story' work in the light of the trauma that he had experienced in the previous twelve months.
- 2.26 The limited nature of a threshold visit meant there was strong reliance on self-reports from Thomas and Emma, which required further critical examination and triangulation with other information (for example about Thomas's presentation of the views of the family and their motivation for expressing concerns). This applied particularly to the account of the domestic abuse incident on 14th April and the circumstances in which Arthur had told his father that Emma had hit him and then later told him that this was not true. Although Arthur and Emma's son were seen together without adults present, Arthur was not seen on his own during the visit, which may well have limited the opportunity to hear the truth from him.
- 2.27 Interviews with practitioners and managers have indicated some lack of clarity about the nature and purpose of the visit. In part, this could have been as a result of the adaptations for COVID-safe working. The practitioners, who were working from home with remote access to case records, responded to an email requesting availability to carry out the visit. They were briefed by the team manager and provided with limited

¹⁴ West Midlands Police, MG5 document for criminal trial, page 7.

¹⁵ Solihull case records

screening information about Arthur and the immediate background to the referral. They then travelled separately to Emma's address. Case records show the task allocated and logged as a threshold visit and witness statements from the practitioners at the criminal trial described it as such. The practitioners and a senior manager have also told us that the visit was more extensive in its scope and length than would normally be done on a threshold visit. We consider that a threshold visit, with whatever refinement of the brief, limited the scope for responding effectively to the concerns about Arthur.

- 2.28 It is notable that since May 2021 children's social care has ceased to use threshold visits. A key reason for this was a concern that such visits were completed on a single agency basis by children's social care, excluding practitioners from partner agencies and their expertise from the process, with critical evidence missed as a result.
- 2.29 Practitioners report that they saw two small boys, showing all outward signs of being happy, with consistent stories about their injuries, in what looked like a safe and comfortable home. Uncovering what was really happening to Arthur would have required greater challenge to the self-reported explanations of Thomas Hughes and Emma Tustin; and greater triangulation of evidence from across agencies particularly with reference to Emma Tustin's history. Reference to information already held about Emma Tustin in children's social care could have been drawn upon more extensively to frame the focus of the visit. There also needed to be greater interrogation of the information shared that Arthur had said Emma had hit him and then later changed his mind. Finally, there needed to be much greater analysis of the concerns being raised by Arthur's wider family, to understand more fully why they were so concerned that a previously loving father may now be failing to protect his son.
- 2.30 There would have been a better chance of uncovering what was happening to Arthur if statutory multi-agency child protection processes had been initiated. A multi-agency strategy meeting would have been the place to bring together everything that was known about Emma Tustin and Thomas Hughes, to consider in greater depth the allegations about bruising and for professionals to challenge any potential bias such as the assumption that family allegations were unfounded. It would also have provided an opportunity to consider whether or not Thomas Hughes should be made aware of the nature of the allegations ahead of the visit. As it was, they both had an opportunity to prepare an account of any injuries. Using the single agency 'threshold visit' meant that these issues were never addressed with enough persistence.
- 2.31 Following the visit, it would have been expected practice for the MASH to inform Arthur's paternal grandmother about the outcome of her referral. This did not happen. Similarly, the police were not informed about the outcome from the referral and were proceeding, without any further information, on the basis that children's social care

was responding on a single agency basis. This lack of communication with the police affected the way in which the police responded to concerns about Arthur from family members over the next few days.

Key Practice Episode 4

Response to photographs of bruises on Arthur: 17th – 27th April

On 18th April, Arthur's uncle called the police to say he was worried about Arthur as he had bruises. He stated that he had been shown photographs of Arthur with bruises all over his back. He was also worried that he had found out that Thomas was self-harming and saying he was suicidal, as was his partner Emma. When he had tried to talk to his brother, Thomas had threatened to tell the police that he was being harassed. The police officer responding confirmed that Arthur had been seen safe and well and children's social care were handling allegations about bruising. The police officer did accept and agree that Arthur's uncle could email the photographs of Arthur's bruises and these were sent through to the police officer afterwards. On receiving the photographs (which did not have a date stamp) the police officer sought management advice and updated the call log with an action point for response officers picking up the log to contact children's social care. This did not happen. There was no contact with children's social care and the photographs were not sent from the police to the MASH.

On 20th April, Arthur's maternal grandmother telephoned the police to say that she had seen a photograph of Arthur covered in bruises. She was advised that the police had attended previously and children's social care was now involved. On the same day she also called the MASH and advised that she had seen photographs of Arthur and was concerned about bruising. She provided specific details about the nature and location of the bruises and did not believe the explanation given by Thomas Hughes that they were the result of a playfight. The MASH did not request copies of the photographs.

The same social worker contacted Thomas Hughes to make further enquiries about the photographs. Thomas Hughes stated that Arthur had told him that the grandparents had not taken any photographs of him. He informed the social worker that family members were harassing him. The social worker advised that Thomas should not open the door to family members to avoid a verbal or physical altercation. This was to ensure that children were not exposed to adult conversations that could make them feel worried or unsafe.

On 24th April, Arthur's maternal grandmother contacted the MASH and emailed photographs of Arthur with bruising. There was initial confusion about the date on which the photographs were taken. The maternal grandmother's email had indicated 7th April 2020 but records show that on 24th April the social worker telephoned Arthur's paternal grandmother who confirmed that the date on which the photographs were taken was 16th April.

Records show that the social worker made contact with Thomas Hughes to discuss the photographs that had now been received. Thomas explained that the fight between the boys had occurred on 14th April. The parents had intervened and applied freezer packs to their bodies. The boys' skin was initially red from the marks. This later developed into bruising. Later the boys were laughing and joking and did not complain about soreness – hence no medical intervention was sought. Thomas confirmed that the photographs could only have been taken on 15th or 16th April.

The photographs were considered and management oversight by an Assistant Team Manager recorded:

'I am concerned that when the SWs saw the boys on 17th April and they looked at their backs the injuries were not seen to be this severe and it is unlikely that a day later they would have healed. The children have however been seen to be safe and well and not shared any concerns about being intentionally harmed and the injuries could be consistent with the explanation given about a playfight. Had we seen these pictures on the day they were taken, consideration may have been given to a CP medical this is now not applicable a week later. I do not feel any further investigation is needed in relation to this and agree with the recommendation for Level 3, it is hoped the family will consent to work with FSW and [they] can monitor and escalate concerns of this nature raised in future.'

On 27th April, the Family Support Worker telephoned Thomas Hughes to discuss the offer of 'life story work.' Thomas advised that he felt able to support Arthur with explanations of his life story. He was in contact with school weekly and would speak to the school if he needed support with Arthur's behaviour. The case record noted that the threshold for Level 3 intervention required consent from the parent. As there was no consent the threshold for intervention was not met and the case was closed.

Complaints from Thomas Hughes about harassment from family members

2.32 On 18th April Thomas Hughes made two calls to the police alleging that his family were harassing him by driving past and parking outside Emma Tustin's address and knocking on the door. Thomas was not at the address but had viewed this remotely on CCTV. After the second call, two police officers responded, going firstly to Emma Tustin's address and then visiting the address of Emma Tustin's mother, where they saw Thomas Hughes with Arthur. A DASH assessment was completed and domestic abuse non-crime was recorded in relation to the dispute between Thomas Hughes and his mother. During their time at the property the police officers observed Arthur laughing and playing with toys on the floor in the kitchen. The police took no further action, advising Thomas Hughes to speak to his brothers and inform the police if there were any further incidents. The fact that Arthur was seen apparently 'safe and

well' by another police officer subsequent to the visit by children's social care would have some importance in the way that the police responded to the further contact from a family member and the receipt of photographs of bruising to Arthur later on the same day.

2.33 The call to the police from Arthur's uncle included important new information about the mental health of Thomas Hughes. This was also the first time that the photographs taken by Arthur's paternal grandmother on 16th April had been seen by any agency. After taking line management advice, this information was not responded to on the basis that Arthur had been seen (albeit briefly) on 18th April with no safeguarding concerns and there was on-going involvement by children's social care. The officer left a note in the call log: *'I advise whoever picks up this log calls social services as they have had recent interaction with the family and if any action plan is in place with the family'*. This did not happen. The contact from Arthur's uncle should have been recorded as a non-crime, with the new information and the photographs forwarded to the Public Protection Unit. This was a missed opportunity to share information and initiate a review of the risk to Arthur.

2.34 When photographs were received by the MASH on 24th April, there was a period of confusion about the date when the photographs were taken, and whether it was Arthur in the photographs. The practitioners who had visited on 17th April could not reconcile the injuries shown in the photographs of Arthur with what they had seen during their visit. However, there was verification that the photographs were indeed of Arthur and had been taken on 16th April, the day before the home visit.¹⁶ The case record stated that the photographs showed significant bruising. The concern and uncertainty on the causation and timing of these injuries should have prompted a strategy discussion and advice sought from a health professional. Our interviews with managers and practitioners have given no clear rationale for the decision that was taken to close the investigation. This was a very significant moment when there was an opportunity to re-assess the risk to Arthur in the light of important new evidence of potential physical abuse. Management oversight was fragmented, with four different team managers involved in decision making at different points. No single manager appeared to have a full picture of all the circumstances. As a result, management oversight and decision making was insufficiently inquisitive and robust.

2.35 The record of the decision to close the case noted that 'life story' work with Arthur, if taken up, provided the opportunity to monitor the situation and escalate any future concerns. When Thomas Hughes declined this offer of support, which practitioners have told us was a surprise given the concerns he had expressed about Arthur's behaviour and emotional well-being, there could have been further consideration of

¹⁶ Police evidence for the criminal trial has verified that the photographs were taken on 16th April 2020.

the risk to Arthur. Thomas's narrative about harassment from family members, the withdrawal of consent to share information with wider family, and the decline of the offer of support suggested a pattern of disguised compliance where the attention of professionals is deflected to respond to issues in relation to adults and away from the focus on risks to the child.

Key Practice Episode 5

Understanding the role and impact of Emma Tustin after Thomas and Arthur move to live with her and her children in March 2020

Children's social care had sporadic involvement with Emma Tustin from 2007. Extensive information about Emma's family history, relationships, domestic abuse incidents, mental health, and care for her children was held by children's social care but this was not included in the MASH screening information for the home visit on 17th April 2020. As a 'threshold visit,' this triggered only limited information gathering and was less detailed than would have been the case if there had been a strategy discussion and Section 47 enquiries had been initiated.

Between 2007 and 2018 there were a number of referrals to children's social care and eight social work assessments over an 11-year period. The concerns primarily related to incidents of domestic abuse between Emma and her previous partners. Emma was described as both a victim and a perpetrator, and was accused of coercive and controlling behaviour.

Emma Tustin had ongoing involvement with Adult Mental Health services. There are recorded at least two incidents of suspected attempted suicide by Emma; the latter occasion in 2013 resulted in her sustaining serious injuries requiring hospitalisation for a number of months. There was no direct liaison between children's services and adult mental health services in understanding the safeguarding needs of the children.

2.36 Given the previous children's social care involvement with Emma Tustin, and the wider history of domestic abuse and mental health concerns, we have considered whether this ought to have prompted wider consideration of the risks in circumstances where Emma and Thomas with their children were forming a new household. As previously discussed in our report, a strategy meeting in April 2020 would have given multi-agency professionals the opportunity to review all available evidence together, including the information about Emma Tustin's previous involvement with services. Without an up-to-date history of the involvement of key agencies in supporting Emma and her family it is possible that views about Emma's parenting capacity and future risk relied too heavily on the conclusions from previous assessments. In that regard, the review team's analysis of previous work by children's social care and partner

agencies with Emma Tustin and her children found it to be narrow in focus and over-reliant on self-reporting. Emma's mental health issues and experience of domestic abuse had not been analysed or understood in relation to her parenting capacity.

2.37 Practitioners and managers involved with the work with Arthur and his family in April 2020 have told us that the particular pattern of domestic abuse and mental health concerns was typical of vulnerable families in Solihull and would not have stood out. Practitioners described Emma as someone who presented well, was articulate and appeared to have insight into her behaviour.

Key Practice Episode 6

Contact with Arthur and his wider family by school and other agencies, March to June 2020

From 23rd March 2020, schools were closed during lockdown. The respective schools for Arthur and Emma's two children did not identify them as vulnerable (in accordance with Solihull criteria). The children were not invited to continue to attend school during lockdown.

On 27th April Thomas declined the offer of 'life story' work with Arthur and the case was closed to children's social care.

On 28th April the Family Support Worker telephoned Dickens Heath Primary School and provided the Designated Safeguarding Lead (DSL) with details of Arthur's new address.

On 29th April and 12th May there was telephone contact from school with Arthur and his father. Father stated that he was struggling with Arthur's behaviour. School suggested support strategies.

Father accepted a place for Arthur when school re-opened on 8th June but did not attend as had been planned. School made follow up calls.

On 11th June father rang school and expressed increasing concerns about Arthur's wellbeing. Arthur was chewing his food and spitting it in the bin. Father was worried that Arthur would faint or refuse to eat. School advised Thomas to contact his GP.

On 15th June the school DSL made a referral to the School Nursing Service following a further call with Thomas. Thomas had told them he was awaiting a call back from the GP. The GP made two attempts to call Thomas. The calls failed, with no option to leave a voicemail.

2.38 Schools received clear guidance to identify and assess risk for vulnerable pupils.

There were good systems in place at Arthur's primary school, where Arthur was appropriately identified as not vulnerable according to information available at the time. Arthur's class teacher set work for Arthur every week and tracked engagement in his learning. The school has described Arthur's participation in learning during the lockdown period at 'at the lower end' of engagement.

2.39 Operation Encompass (the system in which the police notify schools after a recorded domestic abuse incident where a child on the school's roll was present) was not in operation in Solihull in the weeks immediately following lockdown so the domestic abuse incident on 15th April 2020 was not notified to Arthur's school. The school has reflected that if it had been notified about the incident it would have offered a place to Arthur because of his increased vulnerability.

2.40 The local authority provided clear guidance to support schools for phased re-opening in June 2020, with a requirement for daily tracking and monitoring of attendance. Staff at Arthur's primary school were proactive in contacting Thomas Hughes when Arthur did not attend school on 8th June. School responded to his father's concerns about Arthur's behaviour with advice to contact his GP and made a referral to School Nursing service.

2.41 Family members have questioned whether Arthur's school should have revisited its decision not to designate Arthur as a vulnerable pupil. Following contact from family members in April 2020 the school's designated safeguarding lead did contact the MASH and was advised, in line with the conclusion from the home visit on 17th April, that there were no safeguarding concerns and that Emma Tustin had 'worked hard on her parenting'. Thomas Hughes attributed Arthur's absence from school in June to issues relating to his behaviour and well-being – issues that school was familiar with and for which it had supported Arthur's father in seeking help for Arthur previously. The school's advice to Thomas to contact his GP, and the notification to the School Nursing Service were appropriate in that regard.

2.42 Family members have also queried whether the school might have challenged Thomas Hughes when he advised that Arthur would be absent from school for two days of celebrations for his partner's birthday. It is important to note that school attendance for Year 1 children at that time was not compulsory. Dickens Heath, like other primary schools, made places available and strongly encouraged children to attend. Ultimately, parents made the final decision about whether their child came to school. With the benefit of hindsight, a home visit to check on Arthur's welfare might have been considered, but the information available to the school had been about Arthur's behaviour and emotional well-being about which school had alerted an appropriate service on the previous working day.

Solihull local context

Solihull Metropolitan Borough Council is one of the smaller local authorities in the country. It has a population of 217,500.¹⁷ It is overall a relatively affluent area. It currently ranks as the 32nd least deprived local authority in England, out of 151 (MHCLG, 2019). Around 13% of Solihull's children aged under 16 are in low-income families, 5% below the national average.¹⁸

Inspection findings

- 3.1 Solihull's Children's Services was rated by OFSTED as 'Requires Improvement' in its previous two inspections (OFSTED, 2016; OFSTED, 2019a). Whilst the 2019 report noted some strengths in child protection, areas of improvement included quality assurance and audit arrangements and reviewing the practice of 'threshold' visits. It was also noted that in some instances cases were closed without sufficient information being gathered. These issues featured in Arthur's case.
- 3.2 Solihull was issued with an Improvement Notice in February 2022 following concerns around serious weaknesses in parts of the council's children's social care functions. An Improvement Adviser has been appointed to Solihull by the Secretary of State for Education (Department for Education, 2022a).
- 3.3 Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) graded the performance of West Midlands Police (an area that covers Solihull) across eleven areas (HMICFRS, 2021). It was found to be 'adequate' at 'responding to the public' and 'requires improvement' at 'protecting vulnerable people' and 'investigating crime'.¹⁹ Areas for improvement included responses to domestic abuse and better recognition of vulnerability, although there had been some positive progress on domestic abuse responses.
- 3.4 The Care Quality Commission's (CQC's) 2014 inspection of Solihull's health services for children looked-after and safeguarding found that health professionals felt clear about thresholds for safeguarding referrals although some work was needed on the quality of referrals (CQC, 2014). CQC inspected SOLAR - the specialist community mental health service for children and young people in Birmingham and Solihull - in 2018 and rated the service 'good' (CQC, 2018).

¹⁷ Population estimates - local authority based by five year age band, ONS Crown Copyright Reserved [from Nomis on 21 March 2022

¹⁸ <https://www.gov.uk/government/publications/local-authority-interactive-tool-lait>

¹⁹ The report found the force was 'outstanding' in four areas, 'good' in four areas and 'adequate' in two areas.

3.5 A joint targeted area inspection (JTAI) of the multi-agency response to the identification of initial need and risk in Solihull was published in February 2022 (OFSTED, 2022).

Its headline findings were:

‘Children in need of help and protection in Solihull wait too long for their initial need and risk to be assessed...Weaknesses in the joint strategic governance of the multi-agency safeguarding hub (MASH) have led to the lack of a cohesive approach to structuring and resourcing the MASH. The Local Safeguarding Children Partnership does not have a clear understanding of the impact of practice from the MASH or the experiences of children and their families that need help and protection in their local area.’

Its areas for priority action identified were:

- Leaders of the local safeguarding children partnership taking urgent action to understand and identify the initial needs and risks of children presenting to Solihull’s ‘front door’ services’.
- West Midlands Police taking urgent action to improve the quality of information held on the Connect system so that risk to children can be clearly seen, recognised and shared when appropriate.

Solihull children’s social care – key figures

3.6 Solihull’s referral rate has been slightly higher than its statistical neighbours in recent years, however, it has been declining since 2019 (Department for Education, 2022d).

3.7 In recent years, a very large percentage of referrals to Solihull children’s social care were closed with no further action, as was the case with Arthur (Ibid). This may reflect issues in the MASH, which featured in Arthur’s story and was highlighted in the JTAI of Solihull.

3.8 The following charts show:

- the percentage of referrals that went to No Further Action (NFA) between 2013 and 2021. It shows that markedly more referrals went to NFA in Solihull compared to its statistical neighbours, the West Midlands region and England until 2020.
- the higher section 47 enquiry (S.47), Child in Need (CiN) and looked-after children (LAC) rate of Solihull compared to its statistical neighbours, the West Midlands region and England. It also shows that its rate of children on a child protection plan (CPP) is comparable to its statistical neighbours.

Chart 1: Referrals to children's social care closed with no further action

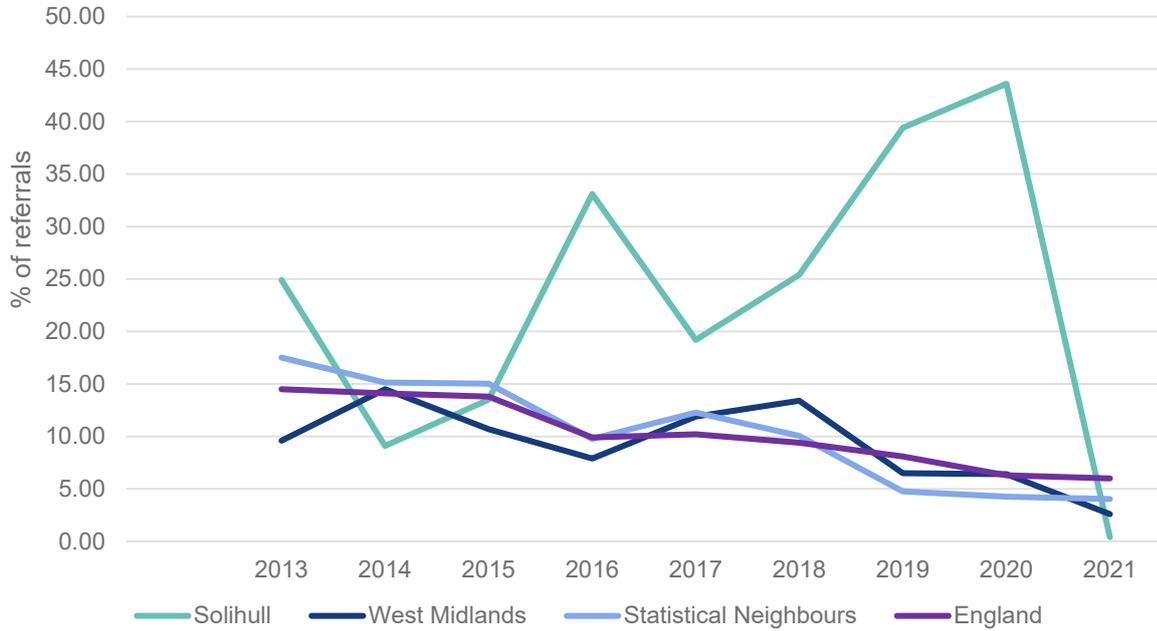
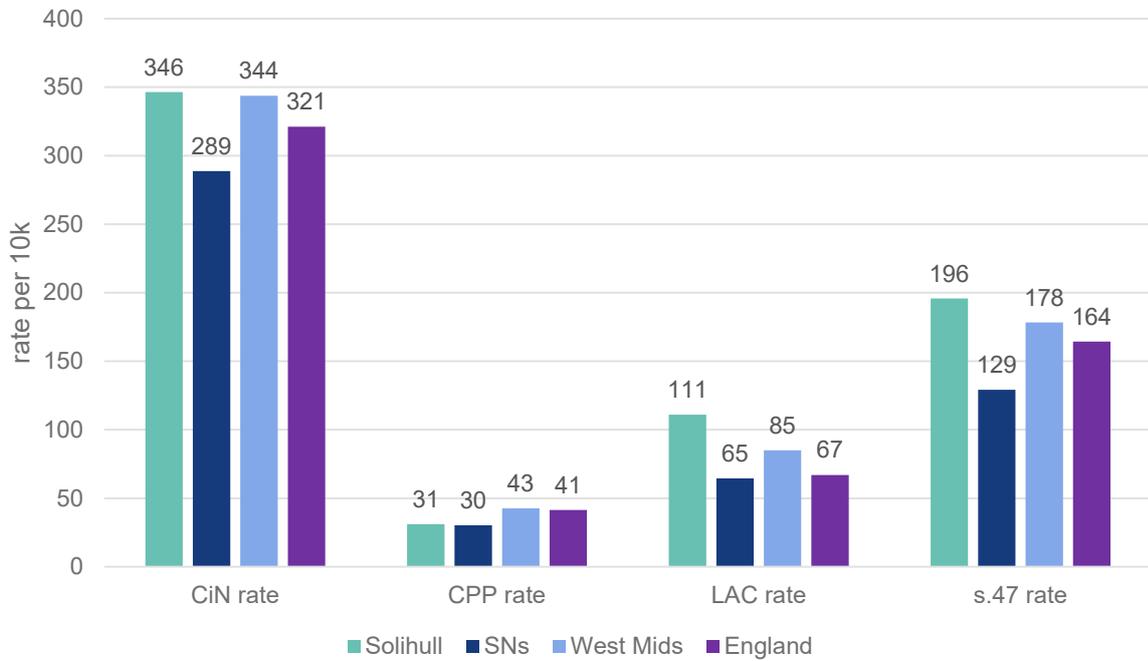


Chart 2: Children in need and child protection (31 March 2021)



COVID-19 adaptations

- 3.9 In response to the COVID-19 pandemic, the local authority put critical incident arrangements in place from March 2020. These were at an early stage of implementation in April 2020 when concerns about Arthur were notified to the MASH.
- 3.10 Children's social care made a number of important adaptations for COVID-safe practice. Whilst responsiveness to referrals was maintained, the impact of these modifications led to fragmented management oversight of the response to individual referrals and a lack of clarity about case-holding accountability. These aspects had some impact on the effectiveness of the response to concerns about bruising to Arthur and subsequent decision making.

Workforce

- 3.11 In Solihull, children and family social worker vacancy and absence rates have been declining in recent years. However, its social worker turnover rate has been increasing since 2019 and its use of agency staff is high when compared to its statistical neighbours (Department for Education, 2022d). These factors did not have a direct bearing on Arthur's case.
- 3.12 Other service pressures identified included:
- Under-resourcing of the Solihull MASH by all partner agencies. The recent JTAI in January 2022, found that this had been an unresolved issue by leaders of the partnership;
 - Limited capacity in children's mental health services. This may have had an impact on the delayed response to Arthur's emotional and mental health needs when he was referred to SOLAR in January 2020.

Impact of the Safeguarding Partners

- 3.13 Working between partner agencies in the interventions with Arthur reflects OFSTED's finding in 2019 that '*partnership working was not universally strong*'. Multi-agency capacity and resourcing of the MASH was a longstanding and unresolved issue for the Local Safeguarding Children Partnership (LSCP). This has been addressed and strengthened following the JTAI in January 2022 with additional police, health, mental health and education personnel.
- 3.14 The leadership of the partnership did not have a strong line of sight to frontline practice. Performance information and multi-agency learning from audits were not brought together at partnership level. This was evident notably in the quality assurance of MASH arrangements.

Conclusions

- 4.1. Professionals had only a limited understanding of what daily life was like for Arthur. The short time for developing a relationship and engaging with Arthur in assessments and visits limited the scope to establish trust.
- 4.2. Professionals did not always hear Arthur's voice. Arthur's voice was often mediated by his father in contact with professionals. Too many assessments relied on his father's perspective and did not include the views of the wider extended family or other professionals who had significant involvement with Arthur.
- 4.3. Thomas Hughes was seen from the very first assessment in 2019 as a protective father. Whilst this was a reasonable judgement at that time, this framing was never subsequently challenged by any professional when circumstances changed and when evidence to the contrary – such as reports from Thomas' own family that they were not sure he would protect Arthur – was available.
- 4.4. There was never proper consideration given to the risks to Arthur arising from the move to live with Emma Tustin, despite her long involvement with children's social care and the very significant information about her that was available.
- 4.5. Arthur's wider family members were not listened to, despite their many attempts to get agencies to look into what might be happening to Arthur. Their views were not sought and their concerns were not taken seriously. Family members and other connected adults can speak on behalf of the child and enable their voice to be heard.
- 4.6. The response to concerns about bruising to Arthur was undermined by the lack of a multi-agency strategy discussion, which should always be triggered when there are allegations about the suspected abuse of children.
- 4.7. The West Midlands Child Protection Procedures did not include practice guidance in relation to allegations of the physical abuse of a child. In the absence of a strategy discussion, the single agency nature of the response to the referral from Arthur's paternal grandmother left social workers to make judgements about evidence of bruising without the relevant professional knowledge, guidance on how reports of injuries are viewed and triangulated, or tools for accurately recording injuries observed.
- 4.8. Our conclusion is that a pivotal dynamic underpinning many of these practice issues was a systemic flaw in the quality of multi-agency working. There was an over-reliance on single agency processes with superficial joint working and joint decision making. This had very significant consequences. The nature of the assessments and decisions that child protection professionals are being asked to make are

extremely complex. They cannot do it alone. Robust multi-agency working is critical to the challenging work of uncovering what is really happening to children who are being abused.

Local recommendations

Safeguarding Partners in Solihull should:

- 5.1 Review their strategic and operational responsibilities as recommended nationally by this review. This review should include making sure that they have an understanding of learning from the review, oversight of performance, that priorities are agreed and funding is fair and equitable.
- 5.2 Review the partnership MASH arrangements to ensure:
- multi-agency capacity is able to meet demand
 - performance information and scrutiny activity is used to support core child protection procedures
 - frontline practitioners understand the importance of safeguarding and domestic abuse referrals
 - a more “Think Family” approach based on best practice specifically between Adult Mental Health, MARAC and Children’s Services
- 5.3 Review and commission strategies to 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
 - the risks to children of prisoners, that they are supported and safeguarded and considered as vulnerable in their own right.
- 5.4 Ensure 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.
- 5.5 Ensure that the right agencies are represented in the range of the LSCP activities and that there are sufficient resources to support the LSCP to carry out its statutory functions, particularly multi-agency quality assurance of practice.
- 5.6 Ensure that where consent is not given to Child and Family assessments or Level 3 support, all agencies must consider whether the subsequent lack of assessment and support is likely to cause significant harm. That they roll out communications and training resources in respect of consent to share information under GDPR as set out in the LSCP Thresholds Guidance.

- 5.7 Ensure that all practitioners understand their role when considering allegations of bruising including consideration of images which appear to show bruising. This should include:
- convening a strategy discussion with relevant agencies, both in and outside working hours
 - an assumption that a medical will be required and recording the rationale for any decision not to arrange a Child Protection Medical where there are allegations of bruising or other concerning external injury. The absence of visible marks should NOT be a reason, without consultation with a Paediatrician
 - discussion with the on-call Paediatrician with respect to arranging a Child Protection Medical Assessment
 - ensuring that all relevant information on the child and family is available at the time of this assessment
 - the medical assessment should be done in accordance with RCPCH's standards for such assessments, and such assessments subjected to peer review.
- 5.8 Seek assurance from West Midlands Police and Birmingham and Solihull Mental Health Foundation Trust that the Street Triage team are aware of their responsibility to make safeguarding and domestic abuse referrals.
- 5.9 Undertake scrutiny of the current thresholds for access to CAMHS services provided by Birmingham and Solihull Mental Health Foundation Trust to seek assurance that children are offered services appropriately and in a timely manner.

The Department for Education will hold the 'Improving Outcomes for Children in Solihull' board to account for the implementation of these recommendations.

- 5.10 The review recognises that Safeguarding Partners in Solihull are working to address a number of the issues identified through local learning processes and have acted swiftly following OFSTED's Joint Targeted Area Inspection. We are grateful to the Safeguarding Partners and professionals locally for their open and honest engagement with this review.

Star's Story

This chapter provides a short overview of Star's life and the involvement of key agencies with her and her family. In the overview we refer to Key Practice Episodes where the assessments, decisions taken and actions by key agencies at these critical points subsequently affected what happened to Star. The next section analyses these Key Practice Episodes in detail, enabling us to understand more about what happened to Star and why. The final section of the chapter sets out key findings about the factors that enabled or limited the ability of key agencies to protect Star from the profound and ultimately fatal abuse and neglect that she suffered.

- 6.1 Star was born on 21st May 2019 and was 16 months old when she was murdered on 22nd September 2020. She is described by family and friends as an easy baby who developed into an inquisitive toddler who loved to listen to music and would dance in her baby walker, laughing and giggling. She brought joy and pleasure to her extended family who supported Star's mother when she was struggling to look after a young baby.
- 6.2 Star's mother Frankie Smith was 17 years old when she became pregnant. Frankie was the oldest of 5 children and is described by her family as very young for her age. Frankie had not found school easy; she struggled academically and experienced bullying. Star's father had been in care and was living in supported accommodation but remained in contact with his parents. He was in regular contact with both a transitions social worker in Adult Social Care and a Personal Adviser from the Leaving Care team.
- 6.3 After her birth, Star had a somewhat unsettled life, moving households frequently and with times when people other than her mother were looking after her full time. Health visitors and nursery nurses were not aware of the extent of disruption in Star's life and found her to be developing as expected.
- 6.4 Frankie's relationship with Star's father was "on and off" both during the pregnancy and immediately after her birth. This relationship caused some tensions within Frankie's family, on one occasion necessitating police involvement. The relationship between Star's parents finally ended when Star was four months old. Arrangements were then made for Star to have regular contact with her father at his parents' home.
- 6.5 Frankie Smith met Savannah Brockhill around October 2019. Savannah was 26 years old and worked as a security guard. We now know that Savannah had a history

of domestic abuse with a previous partner and was made subject to a Restraining Order in 2015. There are consistent reports from family and friends about the change in Star after Frankie began her relationship with Savannah. There were also reports that Frankie was seen with bruises, possibly caused by Savannah, and that Savannah seemed to be controlling her. This control included restricting Star's contact with other family members.

- 6.6 In January 2020 a domestic abuse organisation was working with a friend of the family who often looked after Star. The friend was worried about abuse in Frankie's relationship with Savannah and Savannah's physical chastisement of Star. Following a written referral, the police made a welfare check and a social worker completed a child and family assessment, having seen Star at a home visit. The final assessment did not report any child protection concerns. The main need identified for Star was accommodation for her and Frankie. A letter was sent to the Housing Department and the case was closed to children's social care.
- 6.7 Meanwhile, family members describe Star in February 2020 as looking sad and depressed. Around this time Frankie asked Star's great grandmother to look after her as she could not cope after Savannah had ended the relationship with her. When Star arrived at her great grandmother's home, she had very bad nappy rash but soon began to thrive and become happy and content. She was able to crawl and walk around the furniture, was inquisitive, good fun and loved bath times. Star stayed with her great grandparents until April 2020 when, without any prior warning or discussion, Frankie removed Star from their care at the point when the relationship with Savannah resumed. Frankie and Star went back to live at Star's grandmother's house and Frankie stopped all contact with Star's great grandparents. Paternal grandparents saw Star for the last time in March 2020, after which point they were also denied contact.
- 6.8 During May 2020, family members became increasingly concerned about the way that Savannah was treating Star. Star's great grandmother made a referral to children's social care on 4th May 2020 which resulted in an unannounced visit the next day. Frankie told the social worker that she felt the referral was malicious as Star's great grandmother did not approve of same sex relationships. No visible injuries were seen, Star's grandmother said she had no concerns and agreed to supervise contact between Star, Savannah and Frankie for the duration of the assessment.
- 6.9 On Sunday 21st June 2020 Star's father contacted the Emergency Duty Team to say that he wanted to send some pictures of bruising on Star's face that had been sent to him by a relative of Star. He was given the contact details of the allocated social worker and advised to call 101 which he did. A police officer spoke to Star's

grandmother and another relative of Star at their home and then visited Star and Frankie, who had moved to live at Savannah's home. The police officer observed three bruises to Star's face which Frankie said had been caused by Star banging her head into a coffee table. Alerted by the police officer (who was concerned that accounts of how the bruising occurred were not consistent), the Emergency Duty Team and police safeguarding team agreed that a Child Protection Medical was needed. The medical examination was conducted the same day and concluded that the injuries were consistent with the explanation that Star's mother had given of an accidental injury. Star was discharged from hospital into the care of her mother.

- 6.10 After the medical the single agency child and family assessment was completed and the case closed on 8th July 2020 with a note that the concerns were unsubstantiated and the original referral from great grandmother was recorded as malicious.
- 6.11 Meanwhile on 29th June 2020, Frankie informed the homeless partnership that she had been living with her partner for a month and had to leave and was therefore homeless. She was offered accommodation by a social housing project and moved with Star into her flat on 3rd July. Savannah remained a regular visitor to the home.
- 6.12 On 27th August 2020 Star was being looked after by a family friend. Another friend of the family was there and noticed bruises to her face which looked like finger marks. The friend took a video and sent it the next day to Star's uncle. He shared the video with Star's maternal great grandfather. Star's father also saw a copy of the video and contacted the police on 31st August. The police tried to visit the home but were told that Star was with Frankie and Savannah in Scotland. The next day (1st September) Frankie called the GP to say that Star had sustained a cut lip when falling off cobbled steps and it was "swollen, oozing red and green stuff and split open." The GP surgery was about to close for the day and the GP asked Frankie to call NHS 111. A safeguarding note was entered on the file. A health visitor was asked to make contact with Frankie routinely to deliver accident prevention advice.
- 6.13 On Tuesday 2nd September 2020 Star's great grandfather contacted children's social care as he had now seen the video of the bruises. The Integrated Front Door²⁰ provided maternal grandfather with an email address to send in a copy of the video. A social worker in the IFD contacted Frankie, who said she had already contacted her previous social worker to say that Star had bruised herself falling downstairs. This call to the social worker was because her grandmother said she was going to inform children's social care of the bruises seen on the video. Frankie said that she had also contacted her GP, who, as the surgery was about to close for the evening, had advised a call to 111 if she had concerns.

²⁰ The Integrated Front Door (IFD) in Bradford is the service which receives contacts and referrals to children's social care. In some areas, this is referred to as a Multi-Agency Safeguarding Hub (MASH).

- 6.14 The social worker in the IFD reviewed the previous case records, noting that this was the second time that Star had fallen, and there seemed to be a pattern. The social worker also checked the health records, which indicated that Frankie had not followed up the advice to call 111. As the bruising to Star had not been seen by a medical professional it was decided that a social worker should undertake a home visit to assess whether there was appropriate supervision by Star's mother, and to address the numerous concerns raised by family members, some of which had previously been deemed to be malicious. The IFD contacted Frankie to arrange a home visit. Frankie told them that they were leaving at 4pm that day for a family holiday in Scotland and would be returning on Friday 4th September. The home visit was deferred until that date. Frankie told the IFD social worker that she was happy for the visit to take place at any time on the Friday. No specific time was set for the visit.
- 6.15 On 3rd September 2020 the GP, having seen that Frankie had not called 111, called her and offered a face-to-face appointment. Frankie said this was not possible as they were in Scotland. A booked call was arranged for the following morning and a face-to-face appointment for the afternoon.
- 6.16 On 4th September at 9.20am Frankie was called by the GP. She reported that Star's lip injury was now healing and declined the face-to-face appointment booked for that afternoon.
- 6.17 At 11am, the social worker visited Star, Frankie and Savannah at Frankie's home address. The social worker did not have a copy of the video showing the bruising to Star that had prompted maternal great grandfather's concerns or the photo of bruising that had been sent to the police. The social worker noted that the home was clean, warm and tidy and there was a "good attachment" between Frankie and Star. Frankie "happily stripped Star" and bruises were seen but perceived to be consistent with normal bruising. The referral was once again deemed to be malicious and concerns were not substantiated.
- 6.18 At 17.25 on 4th September Frankie rang the GP because she had noticed blisters on Star's tongue, something she had forgotten to mention in the call to the GP that morning.
- 6.19 The GP offered to see Star immediately. Frankie advised that this was not possible as they were in the car on the way to Doncaster. The GP told her they must access an emergency appointment at Doncaster and advised Frankie to ring NHS 111 to arrange this.

6.20 From early September 2020 it is clear that Frankie Smith and Savannah Brockhill acted to prevent professionals and family members from coming into contact with Star. A GP called Frankie on 7th September and she said that Star was now back to normal. After this, no professional saw Star or had contact with Frankie Smith before Star's murder on 22nd September 2020.

Photographs taken during this period and recovered 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. CCTV footage on September 13th, 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.

The final cause of death was an abdominal haemorrhage caused by blunt force trauma. A post-mortem found evidence of a recent skull fracture approximately ten days before Star's death; re-fracturing of her right tibia approximately three – seven days before; and multiple injuries to the scalp, forehead, cheek and back - stark evidence that Star had been physically assaulted on numerous occasions in the weeks and months leading up to her death. The following timeline outlines key moments in Star's life.

May 2019	Star Hobson born
Sept 2019	Star's parents separate
Oct 2019	Frankie Smith meets Savannah Brockhill
Jan 2020	Concerns of domestic abuse and bruising
	Following concerns by a family friend, a social worker visited Star. The assessment was completed which included 3 visits. There were no obvious concerns noted or observed during the visits and the decision was made that the main issue was housing for Frankie and Star.
Feb 2020	Star lives with maternal family
	Savannah and Frankie's relationship breaks down and Star moves in with her maternal great-grandmother. Star begins to thrive.
April 2020	Star removed from maternal family
	Frankie removes Star from the care of her maternal great-grandmother without warning.
May 2020	Referral to Children's Social Care
	Star's maternal great-grandmother made a referral to Children's Social Care in Bradford. The next day a social work team made an unannounced visit to Savannah's household and were content that Star was safe and well. It was concluded that the referral was malicious.
June 2020	Father submits photos of bruising
	Star's father submits more photos of Star to the MASH with concerns over Star's treatment by Savannah. Child Protection Medical is arranged after Police talk with family. CP medical finds no points of concern and concludes that the bruising to Star was most likely to be accidental and consistent with
July 2020	Assessment closed down
	After the medical report is received, the single-agency child and family assessment is closed down.

27th Aug**Video of Star with bruises emerges**

A video of Star with bruises on her face is exchanged between family members and some close adults on social media. The video is sent to the police. Police attempt a visit but Frankie and Savannah report that they are in Scotland with Star.

2nd Sept**Maternal family contact the Integrated Front Door**

Star's maternal great grandfather contacted the Integrated Front Door (IFD) stating he had a video of bruising to Star. He was asked to send it by email but was unable to do so. A social worker contacted Frankie. Frankie said that she had already contacted her previous social worker to say that Star had bruised herself falling downstairs. There is no record of such a contact. As a result, a home visit was deferred until 4th September.

3rd Sept**GP contacts Savannah and Frankie**

GPs contact family and advise Star be taken to be seen. This is never followed through by Frankie and Savannah.

4th Sept**Children's Social Care visit Star**

No further action is taken.

15th Sept**Star's case is closed**

The case was closed to Children's Social Care on the basis that concerns had been unsubstantiated and the referral was malicious in intent.

22nd Sept**Star dies**

There was no further contact with professionals between 5th and 22nd September, when Star passed away after sustaining multiple injuries inflicted by Savannah.

Analysis and findings

The analysis that follows:

- seeks to understand what happened to Star and why;
- evaluates how agencies acted to protect Star, and what factors enabled or limited their ability to protect her from the profound and ultimately fatal abuse and neglect that she suffered.

We have identified six **Key Practice Episodes** where professionals were directly involved in working with Star and her wider family to respond to possible child protection concerns, assess risk of neglect, abuse or significant harm, and consider her wider support needs. These were critical points that subsequently affected the outcomes for Star.

At different points across the practice episodes there were four social workers involved in the Integrated Front Door (IFD)²¹, two from the Locality Team, two Emergency Duty Team members, three Practice Supervisors (social work qualified), two Locality Team Managers and two Team Managers in the Emergency Duty Team. The same social worker and Team Manager from the Locality Team were involved in Key Practice Episodes 2 to 5.

KPE 1	• Identifying risk in the pre- and post-birth period
KPE 2	• Referral from domestic abuse service (Dare2) - assessment and decision making
KPE 3	• Concerns about Savannah's care of Star and domestic abuse to Frankie
KPE 4	Bruises to Star and the Child Protection Medical
KPE 5	• Continuing concerns about Star from family members
KPE 6	• Video of Star with bruises

²¹ The Integrated Front Door (IFD) in Bradford is the service which receives contacts and referrals to children's social care. In some areas, this is referred to as a Multi-Agency Safeguarding Hub (MASH).

Identifying risk and harm before and directly after Star's birth

- 7.1. There was a significant period directly before and after Star's birth where professionals missed the opportunity to understand the vulnerabilities of both parents, consider potential risks, and consider the support that would be needed for Star to be looked after adequately.

Key Practice Episode 1

Identifying risk and harm in the pre- and post-birth period (October 2018 to January 2020)

Frankie Smith presented as pregnant to her GP in October 2018 at the age of 17. There was a referral for routine antenatal care and Frankie saw a midwife for booking on 15th November 2018. At this stage Frankie said that the baby's father would not be involved in the care of the child, and she would not give his name. With limited exploration of social factors, including possible risk of domestic abuse, the pregnancy was classified as low risk. Frankie was not offered the support of the Teenage Pregnancy Midwife as she was over the age of 16.

Children's social care did become aware of the pregnancy in February 2019 via the leaving care service who were working with Star's father. This was not progressed to a referral as it was felt that "universal services" support would be sufficient. A second referral from the transitions team in May 2019 highlighted potential risks but again it was felt that there was sufficient family support available.

Star was born on 21st May 2019. Three days later she was moved to a paediatric ward due to excessive weight loss. Star was then transferred to hospital in Leeds where gastro-oesophageal reflux was identified. Star was eventually released home to live at her maternal grandmother's house, where she was seen for a new birth visit on 5th June 2019.

In the months immediately after Star's birth there were increasing family tensions about the relationship between Frankie and Star's father. There were three domestic incidents recorded by the police in June and July 2019.

Frankie relationship with Star's father ended in early September 2019. In October, children's social care received a referral about Star's father, who had attended the emergency department in a distressed condition. The referrer was concerned about a potential risk to Star. Children's social care spoke to Frankie who said that Star saw her paternal grandparents weekly and the contact with Star's father was supervised by paternal grandparents. The case was closed.

- 7.2. There were a number of important concerns raised about actual or potential risk to Star from before her birth until she was eight months old. The way that these concerns were framed and responded to evidences a number of important missed opportunities when Frankie's needs and vulnerabilities as a teenage first-time parent should have been identified. Had they been, then some of the risks in respects of her care of Star might have been better mediated and understood.
- 7.3. An opportunity for early help was missed as no ante-natal health visit took place. This is a requirement under the national specification for health visiting and should take place at 28 weeks or later in the pregnancy. Such visits enable health visitors to identify the appropriate level of health visitor support that a family needs. An ante-natal visit to Frankie would have been a moment to engage with Frankie and Star's father, and to understand better the wider family context and how this might impact on Frankie's care of her then unborn baby. It is of concern that this did not take place. The reason given by Bradford District Care Foundation Trust (BDCFT) was human error in the context of a service under some strain with high caseloads and reduced funding under a new contract from the local authority.
- 7.4. The information to children's social care from the two referrals in February and May 2019 should have prompted consideration of a pre-birth assessment²² for Star. Five of the 13 criteria in the Bradford Partnership pre-birth procedures for considering a pre-birth assessment were met. The case records do not indicate whether a pre-birth assessment was ever considered; if consideration had been given, the reasons for not initiating a pre-birth assessment were not recorded.
- 7.5. A pre-birth assessment would have brought together information about Frankie and Star's father's past, their current challenges, and provided a more accurate picture of the support that needed to be offered. It would have established a baseline and context for consideration of the accumulating risk factors that were present after Star's birth including lack of settled accommodation, domestic abuse, substance misuse, mental health issues and family tensions within Frankie's family.
- 7.6. Within Bradford there was no health pathway to support teenage mothers over the age of 16. Had such a pathway been available Frankie might have been supported by specialist health professionals who would have been expected to take time to understand her and make sure that necessary assessments were carried out.
- 7.7. The response within children's social care to the concerns expressed by the Transitions Worker was influenced by the assumption that support was available

²² Pre-birth assessment is a proactive process for analysing the potential risk to a new-born baby when there are concerns that would fall within the definition of children in need about a pregnant woman and/or the birth father and, where appropriate, her partner and immediate family.

from Frankie's family. These referrals occurred at a time when the focus within Bradford children's social care was on managing high volumes of referrals at the front door. Interviews with managers and practitioners for our review have highlighted that in these circumstances there was little consideration given to the background information. As a result, the complex relationships within Frankie's family were not fully understood.

- 7.8. Relevant information that would have helped decision making was not always shared by the police. The domestic abuse incident, between Star's grandmother and grandfather, did have a crime raised by the police officers but this was then deemed to require no further action after the grandfather, as the perpetrator, was removed by the police from the premises. There was no Domestic Abuse, Stalking and 'Honour'-based violence (DASH) assessment, no acknowledgement of Star and other children in the household, and no referral to children's social care as would have been expected practice. A referral to the IFD at that point might have provided a context to identify any emerging risks in relation to Star and the other children in the household.

Assessment and decision making in response to referrals

- 7.9. This significant event was the first time a referral had been received by children's social care citing specific concerns about Savannah Brockhill's treatment of Star and domestic abuse between her and Frankie.

Key Practice Episode 2

Referral from domestic abuse service (Dare2)

(First referral - 23rd January 2020)

Dare2, a specialist domestic abuse service for children and young people, was providing support for a young person who had a number concerns about Star, including:

- Domestic abuse between Frankie's partner (who was a frequent visitor but not living at the address) and Frankie, with children present;
- Frankie's partner had been seen to smack Star;
- Frankie increasingly left the care of Star to the referrer who had sometimes taken Star to her own home as she was frightened of mother's partner.

The domestic abuse practitioner and manager immediately recognised the child protection risks, completed their own internal safeguarding documentation and contacted children's social care who then referred them to the Integrated Front Door (IFD). As requested, they

submitted a written referral the same day. The domestic abuse organisation was concerned about the referrer's safety and asked to be contacted when action was taken so that they could safeguard the referrer. The referral was treated as anonymous at the request of Dare2. Savannah Brockhill was not named in the referral and no details were provided.

The immediate action by the IFD was to speak to Frankie on the phone, who at once denied any domestic abuse from her partner. Savannah Brockhill was present during the call from the IFD. The Duty Social Worker was sufficiently concerned by the details in the referral and the response to the call that they requested a police welfare check over the weekend. This check reported that there were no concerns; Frankie was in a relationship but denied any domestic abuse. A management decision was made the following day to undertake a child and family assessment.

This assessment was allocated to a newly qualified social worker who was supervised by a practice supervisor and a team manager. It was carried out between January – March 2020 and consisted of three visits during which all the children in the household, except for one, were seen. Enquiries were made of the health visitor and relevant schools although no checks were carried out in respect of Savannah Brockhill. There were no obvious concerns noted or observed during the visits and the decision was made that the main issue was housing for Frankie and her baby. It was decided that a letter would be sent to the local authority Housing Department and that there was no further role for children's social care.

We now know that in February 2020, during the period when the assessment was active, Savannah ended the relationship with Frankie, who then asked her great grandmother to look after Star as she could not cope. This was not known to the social worker carrying out the assessment. Other than the first name of Frankie's partner the assessment did not include any details about her.

7.10. Practitioners in the specialist domestic abuse service showed a good understanding of the impact of domestic abuse and the potential risks to children. They acted swiftly when the family friend expressed their concerns and filled in a thorough referral document. It demonstrates the importance of involving specialist practitioners in multi-agency working where there are concerns about risks to children. Continuing contact with Dare2 as the assessment progressed would have enabled children's social care to maintain an up-to-date view of changing risk and need without compromising the safety and well-being of the referrer. In February 2020, when the assessment was still open to children's social care, the referrer had disclosed to Dare2 that Star had gone to live with her maternal great grandmother as she was finding it difficult to cope with the care of the child. If this information had

been available to children's social care it might have prompted further enquiries before the assessment was closed in March 2020.

- 7.11. Given the designation of the referral by the IFD as 'Level 4 – Statutory Specialist and Child Protection', there should have been a strategy discussion to consider the range of concerns and how they would be addressed, share information, and plan the approach to the home visit. This should have included deciding whether or not to advise Star's mother ahead of the visit of some of the detail of the concerns. Raising these issues by phone ahead of the visit was problematic as it would have alerted Frankie and Savannah about what would need to be discussed.
- 7.12. The referrer had specifically cited a range of important concerns about Star and the environment in which she was living. Critically the referrer mentioned that Frankie's partner had been observed to be smacking Star, who was then an eight-month-old baby. Formal consideration should have been given to carrying out Section 47 enquiries. Given that the referrer had witnessed domestic abuse by Savannah to Frankie, a DASH assessment could have been completed and a crime raised, with further specialist involvement from the police. In interviews for our review, practitioners involved have reflected that the immediate focus became the children being left in the care of a young person and it was decided that this did not warrant Section 47 enquiries.
- 7.13. The assessment did not address the concerns raised about Savannah Brockhill. The initial direction to the social worker from a Practice Supervisor included the requirement to establish the partner's identity and any risks that she presented. The completed assessment recorded her first name as Savannah but provided no other details. The assessment case notes show that checks were undertaken with health and education regarding other children in the household, some direct work was undertaken, and a discussion was held with Frankie alone about domestic abuse from her partner, which she again denied. Star's maternal grandmother was seen to be a protective factor. However, the case notes show a superficial and mechanistic approach to the assessment. Limitations in the quality of this assessment and the decisions that were taken on the basis of it, significantly affected the way that subsequent child protection concerns about the care of Star by Frankie and Savannah were viewed and addressed.
- 7.14. Supervision of the social worker was equally split between the team manager and practice supervisor with a lack of clarity as to who was driving practice decisions and had oversight of the quality of assessment practice. The practice supervisor's focus was ostensibly reflective practice and supporting a newly qualified member of staff. They were placed in a difficult position as records show they discussed Star's family with the social worker but did not at any time see the assessment document in order to consider the quality of analysis, any missing information, and whether the original concerns in the referral had been addressed.

Key Practice Episode 3

Concerns about Savannah Brockhill's care of Star and domestic abuse to Frankie (Second referral - 4th May 2020)

On 4th May 2020, Star's maternal great grandmother contacted children's social care. Frankie had abruptly removed Star from her care when she had resumed her relationship with Savannah in April. Maternal great grandmother had been told by Frankie's siblings that Savannah had destroyed Star's dummy in front of her, forced her to eat garlic and that Savannah was 'slam-choking' Star (grabbing her by the throat and banging her against the wall) to 'toughen her up'.

This referral was passed to the social worker who had carried out the previous assessment and a new assessment started. An unannounced visit took place on 5th May and the social worker spoke to Frankie and Savannah. They also met one of Frankie's siblings. Frankie's mother was shielding at the time in another part of the house due to COVID-19 and was spoken to via a phone. The social worker did not observe anything that gave her cause for concern. They heard from Frankie that in her view the referral was because maternal great grandmother did not like being prevented from seeing Star, did not agree with Frankie and Savannah's parenting method – i.e. getting Star into a routine - and did not approve of same sex relationships. At the end of the visit another family member asked to speak to the social worker separately on the phone. Various attempts were made by the social worker to make contact but these were not successful.

After the visit the social worker spoke to Star's father on the phone. His view was that Frankie could not look after Star properly and that she slapped Star on the face when naughty. He also said that he saw a bruise on Frankie's face when she had visited him, which she said had been caused by Savannah. On 13th May, when the social worker spoke further to Frankie about the bruises she denied experiencing any domestic abuse from Savannah.

The agreed safety plan at this stage was that until the assessment was concluded maternal grandmother should supervise all contact with Star and that background checks should be made in respect of Savannah. Savannah gave permission for these to be carried out.

By 9th June the social work decision was that there was no role for children's social care and the case would be closed after receiving background checks. Police checks were received on 11th June; the detail of which is not recorded in the social work records. These were discussed with Savannah who questioned their accuracy. Frankie said that she was aware of these previous incidents and confirmed that all was fine between herself and Savannah. The plan remained that there should be no further action and that the case should be closed. At this stage Frankie had moved into the home of Savannah and Savannah's ex-partner.

- 7.15. The response to this referral was not commensurate with the seriousness of the allegations. A referral alleging serious harm to a child needs a response in line with child protection procedures and undoubtedly there should have been consideration as to whether a strategy discussion should be held with police and health professionals. A strategy discussion would have provided the opportunity to share information held by different agencies about Star, her mother, and the wider family. The decision to move directly to a single agency home visit appears to have been influenced by the fact that the case had recently been closed and could be reallocated to the same social worker.
- 7.16. It was appropriate to undertake an unannounced home visit, but the failure to make contact with the referrer to discuss her concerns more fully, together with the minimal questioning of the perspective given by Frankie, Savannah and maternal grandmother, circumscribed what was learned and achieved from the visit. Star's father did give an alternative point of view but this was not given sufficient weight. The hint from another of Star's relatives that there were issues to discuss further should also have raised questions that needed to be pursued before any decision was made that the case was to close. The explanation that the referral might have been malicious and rooted in a dislike of Frankie and Savannah's same sex relationship was also too easily accepted. Finally, the proposed safety plan for Star's maternal grandmother to supervise the contact between Star, Frankie and Savannah was problematic in that there was no detail about how this would work in practice or how the arrangement would be monitored. The notion of a safety plan suggests that there were concerns about possible risks but in practice these were not considered and robustly evaluated.
- 7.17. It is apparent that Savannah and Frankie were able to divert the attention of professionals from concerns about Star, including about being physically harmed, and about domestic abuse. As the social worker perceived a positive relationship between Savannah and Star, and checks with the health visitor had not identified any concerns, a number of very critical child protection issues were either left unexplored or addressed in an insufficiently in-depth way. It is important to remember that at both this point and in an ongoing way, the actions of Savannah and Frankie misled and manipulated professionals. As is often the case with child protection investigations, getting underneath the surface of what parents and carers may say to understand what is truly happening for children can be extremely challenging. Uncovering what was really happening to Star required greater challenge to the self-reported explanations of Savannah and Frankie. There needed to be more forensic follow-up of the divergent opinions suggested by, for example, Star's father; greater analysis of the concerns raised by Star's maternal great grandmother, including a more in-depth discussion with her about why she was so worried; and more specialist advice to the social worker in working with potential victims of domestic abuse.

7.18. Our analysis is that it is unrealistic to expect a single agency process undertaken by an inexperienced social worker to uncover and address these complicated issues. There would have been a better chance of uncovering what was happening to Star had statutory multi-agency child protection processes been initiated. A multi-agency strategy discussion would have been the place to bring together and critically analyse all that was known about Frankie Smith and Savannah Brockhill, including from the previous referral in January 2020. It would have meant that professionals could have challenged any assumptions such that family allegations were malicious; importantly it would have evaluated different and serious allegations, including that Star was being ‘slam choked’ and forced to eat garlic. Using a single agency assessment to investigate these concerns meant that these key questions were never asked with necessary rigour and follow through.

Responses to bruises on Star

7.19. This was a significant sequence of events after the police received photos of Star with a bruise on her cheek.

Key Practice Episode 4

Bruising to Star and a Child Protection Medical

(Third referral – 21st June 2020)

Star’s father contacted the police on 21st June 2020. He said that he had been sent a photo by a relative of Star that showed Star with a bruise on her left cheek. A response police officer visited and spoke to maternal grandmother who informed them that Frankie and Star had moved to Savannah’s address. She knew about the bruising and told the police that she had witnessed Savannah punching Frankie and that Savannah was too strict with Star.

A family member then arrived at the home and confirmed that they had sent the photos to Star’s father. They emailed the images to the police officer and also raised concerns about Star’s care, saying that Frankie would leave Star in her cot all day, in a dirty nappy and she heard Frankie swearing at Star.

The family member also told the police that one of Frankie’s siblings had sent them a Snapchat message stating that they had seen Frankie slap Star across the face. The police spoke to Frankie’s siblings at the address and they confirmed what they had seen to officers.

The police then visited Frankie at Savannah’s address and spoke to her alone. Frankie said that Star had ‘banged her head on the oval-shaped coffee table in the front room’ which was a different explanation than she had given to maternal grandmother. The Police Officers noted ‘two small circular bruises on Star that looked about the size of a fingerprint

each, plus one on her left temple. The police log notes, 'I initially thought that this would have been caused by somebody putting their hand across her face, with the thumb causing the mark on her left temple and the two on her right from fingers. There were 'two bruises on the back of her right thigh'.

The police contacted children's social care EDT and spoke to the social worker. The social worker spoke to the on-call Consultant Paediatrician who initially suggested seeing Star the next day as "*there is no accurate timeline for the bruising to have occurred and the bruising would still be present tomorrow*". The EDT Social Worker planned to set up a strategy discussion with the police but, after speaking to the police safeguarding team, a decision was made to request a Child Protection Medical Assessment that day. It was not possible for a medical to be undertaken at the local hospital (Airedale) and it was therefore agreed with the paediatrician that Star and her mother should be brought to the hospital in Bradford.

The Child Protection Medical Assessment was undertaken by a Senior Specialist Paediatric Trainee – who was compliant with child safeguarding training requirements to undertake such examinations. The examination took place at the Bradford Royal Infirmary and Star was accompanied by Frankie and a different Emergency Duty Team Social Worker. Some minimal background information was provided by the social worker about the referrals made on 23rd January and 5th May 2020. The Paediatric Registrar documented that the child and family assessment initiated following the second of these referrals had been concluded and that no further action was being taken. Mother told the doctor that the facial bruises were from Star 'toddling' into a drawer handle on the new coffee table three days earlier and that the small bruises to her legs were from playing with the new puppy.

The doctor identified two bruises to the left cheek overlying bony prominences plus four on the right leg. He discussed the case over the phone with the Consultant on-call and it was agreed that the injuries were consistent with the explanations mother gave and were most likely to be accidental in nature. Star was discharged from hospital to the care of Frankie. The police log noted that "*the findings from the medical do not give any concerns of assault on the child*".

7.20. With the information available to the paediatrician at the time, the conclusion from the Child Protection Medical was not unreasonable. The facial bruising to Star was over bony prominences – a pattern of bruising that is typically associated with accidental injury in infants and children and which could be considered consistent with Frankie Smith's explanation of what happened to Star.

7.21. The Bradford Children's Social Care guidance states that 'a request for a Child Protection Medical should be made as an outcome of a multiagency strategy discussion, in which the paediatrician partakes'. This did not occur. The lack of a

formal multi-agency strategy discussion, which could have pulled together and critically reviewed all relevant information about the family, meant that the Paediatrician was not making an assessment with a full understanding of the whole context.

- 7.22. A multi-agency strategy discussion may not have changed the physical assessment of the bruising, but it would have prompted a more probing and challenging approach to questions posed to Frankie about the circumstances surrounding the injuries. The outcome of Child Protection Medicals should contribute to, but never be the only consideration when making child protection decisions. It needs to be considered along with other information about the child and family, including any known risks and previous concerns (for example, the two previous and recent referrals involving the risk of physical abuse and harm to Star).

Key Practice Episode 5

Continuing concerns from family members about Star's care (Fourth referral)

The day after the Child Protection Medical (22nd June) the allocated social worker had a conversation with one of Star's relatives, who reported that Frankie spoke to Star in a horrible way and that one of her siblings had seen Frankie hitting Star. Previously the relative had been scared to speak to children's social care as Savannah intimidated them.

The social worker called maternal grandmother who said that Savannah had "got into" Frankie's head. Maternal grandmother had never witnessed anything herself; but, when asked about her specific concerns, maternal grandmother said that she was worried for Star's safety in Savannah and Frankie's care. She reported that Frankie had moved out of the family home and was now living with Savannah.

The social worker carried out a virtual home visit on 23rd June, which was conducted via a facetime mobile phone call. This noted no concerns and the Safety Plan was for Frankie to seek support from professionals when needed. The analysis recorded was: "*Frankie gave an explanation of the bruises found on Star. She explained that she had moved out of the family home and feels this has contributed to all the malicious concerns being raised. Star was observed following the visit from the hospital and she appeared content. Mum expressed that due to her family allegations she will not be letting them see Star for now as feels her family are causing so much disruption in her relationship*".

After the virtual visit the social worker contacted the relative who had reported concerns on 22nd June to inform them that the case would be closed. The relative was very upset and reiterated that Frankie was lying and that they "*had a strong feeling something bad was happening to Star*". On the same day, a family friend called children's social care to say that the family were scared to share their worries about Star and they were sure that Star

was being abused: children's social care "*would have another Baby P on their case as they are not listening to all the concerns.*"

The social work single agency assessment was completed and the case closed on 8th July without any further contact with family members. The concerns were noted to be unsubstantiated and the referral was regarded as malicious in intent.

- 7.23. Given the concerns leading up to the Child Protection Medical, and the further concerns that had been raised by family members soon afterwards, it is not clear why a virtual visit was undertaken rather than a face-to-face home visit. Although there was a discussion with Frankie, and Star was observed to be 'well dressed and alert [and] to respond to her name over the phone', a virtual visit limited the opportunity for the social worker to use their observational skills, becoming over-reliant on what they heard from Frankie and what they were shown. With a facetime call they could not be certain who else was in the room, listening to the conversation and not seen – a key issue in a situation where there were concerns that Frankie was subject to domestic abuse.
- 7.24. This second assessment did not achieve a balanced and critical approach to the assessment of risk. Too much weight was given to Frankie and Savannah's self-reported information, and too little time was spent with Star. The clearly expressed concerns of family and friends were assumed to be malicious and referrers were not consistently spoken to or informed of the outcome of the assessment. What happened highlighted how important it is to give due and equal weight to the views of and evidence from family members; in this instance, family members were a critical source of information and evidence as well as being important sources of support to Star.
- 7.25. When the assessment was closed to children's social care the 'Signs of Safety' scale recorded by the social worker on the assessment was eight.²³ This meant that Star was considered reasonably, but not completely, safe. The analysis within the assessment did not explore what the outstanding concerns might be and how they could be mitigated. There continued to be unanswered questions, particularly about the possibility of domestic abuse alongside family concerns from a range of sources. There was an overreliance on a binary approach whereby concerns were either 'substantiated' or 'unsubstantiated' with no consideration of whether a Child in Need Plan might be an appropriate way forward. It is possible that Frankie would not have consented to this approach but it should have been considered and explored.

²³ In Bradford, children's social care had implemented 'Signs of Safety' as a social work practice model. Key elements of the model were built into the case notes and assessment recording system, which included 'scaling' of risk on a scale from 0-10, where 0 was 'no safety' through to 10 'no concerns, fully safe'.

- 7.26. Despite the influence of the finding from the Child Protection Medical that the cause of bruising to Star was consistent with the explanation of the circumstances given by Frankie, there were many direct concerns expressed by family members, including from maternal grandmother who previously had been supportive of Frankie. The social work assessment did not hold in mind the possibility that there could be tensions and disagreements within the family alongside very real concerns about the abuse of Star. Frankie and Savannah's explanation that family members' concerns were motivated by their disapproval of same sex relationships was too readily accepted. The designation of these concerns as 'malicious referrals' in the case record gave validity to Frankie and Savannah's claims of malicious intent when family members contacted children's social care again at the end of August.
- 7.27. Again, professionals were negotiating two conflicting sets of information. The version of events put forward by Frankie Smith and Savannah Brockhill, which the paediatrician's report seemed to add weight to; and the growing body of concern from multiple wider family members. Again, a single agency assessment process – where decisions are being made by individual professionals in relative isolation – was not an appropriate way to fully interrogate and analyse all of the evidence available. A multi-agency strategy discussion involving relevant police, paediatrician and social workers, where professionals challenged one another and explored multiple hypotheses, with the full range of evidence in front of them, would have provided a better opportunity to get to the bottom of what was happening.

Key Practice Episode 6

Video of Star with bruises (Fifth referral)

A video of bruises was circulating among family members and Star's father saw a copy of the video and contacted the police on 31st August. The police tried to visit the home but were told that Star was with Frankie and Savannah in Scotland. On 2nd September Star's maternal great grandfather contacted the IFD, stating he had a video of bruising to Star. He reported concerns about Frankie's care of Star and domestic abuse towards her by Savannah. He was asked to send it by email but was unable to do so. A social worker contacted Frankie. Frankie said that she had already contacted her previous social worker to say that Star had bruised herself falling downstairs. There is no record of such a contact. A home visit was deferred until 4th September because Frankie, Star and Savannah said they were going to Scotland.

Frankie had already been in contact with her GP via phone on 1st September to say that Star had sustained a cut lip when falling off cobbled steps and, as the GP surgery was about to close for the day, the GP asked Frankie to call NHS 111. A safeguarding note was entered on the file and a health visitor was asked to make contact routinely to deliver

accident prevention advice. On 3rd September, the GP followed up with a call to Frankie when it was apparent that she had not contacted NHS 111 and the GP offered a face-to-face appointment which Frankie then cancelled as Star's lip injury was now healing. Frankie also did not follow up on GP advice to access an emergency appointment on 4th September when she told the GP she was travelling to Doncaster and that Star's tongue had blisters.

Prior to Star, Frankie and Savannah travelling to Doncaster, at 11am on 4th September a social worker saw Star, Frankie and Savannah. The social worker noted that the home was clean warm and tidy and there was a "good attachment" between Frankie and Star. The case notes recorded a faint bruise to Star's cheek, a previous bruise to the ear, and a bruise to the right shin 'consistent with normal marks and bruises'. The case was closed on 15th September 2020, just seven days prior to Star's murder, on the basis that concerns had been unsubstantiated and that the referral was malicious in intent.

- 7.28. The concerns noted in this fifth referral again warranted a strategy discussion. This would have ensured that children's social care, the police, the GPs and health visitors shared information and followed up any gaps in what was known, particularly securing a copy of the video showing the bruising to Star, which was never received in the IFD. There should have been more active follow up to secure this video.
- 7.29. The management direction from the IFD when the case was allocated lacked necessary critical analysis and challenge in the light of the continuing concerns of family members. The previous and recent closure of the work with Star with no further action, and the fact that previous referrals from family members had been deemed to be malicious, may well have influenced the decision to undertake a single agency assessment.
- 7.30. Important information held by the GPs and police was not brought together. Statements from Frankie that she was unavailable as she was in Scotland and Doncaster were taken at face value, with no consideration that there was an emerging pattern of possible avoidant behaviour, seeking to keep professionals and family members at arm's length.
- 7.31. An agency social worker carried out the home visit. They recorded details of the visit in case notes but left the local authority before the assessment was completed. Their intention to give notice was not apparent to local managers at the point when the case was allocated. A Team Manager completed the assessment from the case notes and closed the case. In an interview for this review, the manager described significant pressure to re-assign the cases that had been held by the agency worker. At the time there were very high caseloads for social workers in the locality team. It was because of these circumstances, and because of the number of

cases the manager had to re-allocate, that the assessment was concluded and the case closed without due critical reflection and challenge. The review has concluded that the assessment and related decision making following this fifth referral was inadequate and not commensurate with the concerns and risks that were being highlighted.

Bradford local context

Bradford is the fifth largest metropolitan local authority district in England. It currently ranks as the 12th most deprived local authority in England (MHCLG, 2019), over a third of children under 16-years-old come from low-income households (Department for Education, 2022d). The population is markedly more ethnically diverse than the national average. 26% of the working age population is from an ethnic minority, compared to 17% nationally. West Yorkshire Police force, of which Bradford is part, recorded the highest rates of domestic abuse-related crimes in England and Wales in 2020 and 2021.²⁴

Inspection findings

8.1 Bradford has struggled to deliver effective children's social care for a number of years, with its children's services rated 'Inadequate' by OFSTED since 2018 (OFSTED, 2018). In his report to the Secretary of State for Education in January 2022, the Children's Services Commissioner concluded that control of children's services needed to be removed from the Council (Department for Education, 2022c). Work is now underway to establish a Trust. This will run services for vulnerable children and families in Bradford and will operate at arms-length from the Council under an independent Chair and Board of Directors.

8.2 Practice concerns in the work with Star and her family were reflective of the social work practice found in Bradford over the period 2019 -20, as summarised in OFSTED monitoring reports over that period. Key points to note from these OFSTED reports were:

- 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:
- Premature case closures, with risks not fully understood or managed.
- Limited analysis of a child's 'lived experience'.
- Insufficient management oversight or critical challenge.
- Supervision was not supporting practice improvement or driving forward plans.
- Inconsistent support for care leavers.²⁵

²⁴ [Domestic Abuse Statistics Data tool](#)

²⁵ Source: OFSTED 2019b; OFSTED 2019c; OFSTED 2020a; OFSTED 2020b.

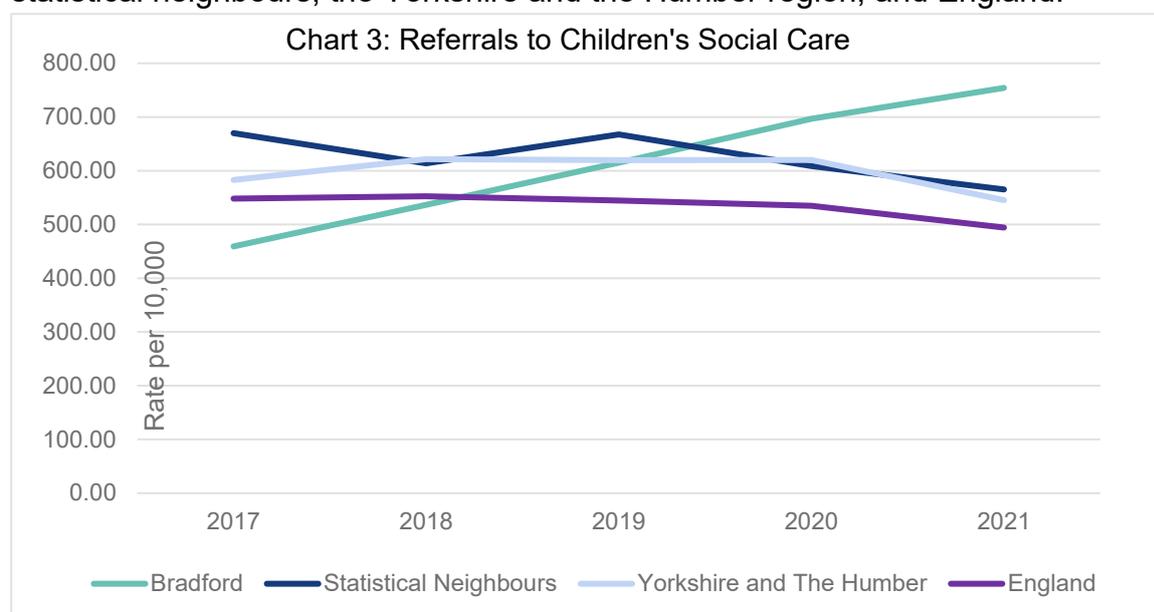
8.3 HMICFRS graded the performance of West Yorkshire Police (an area that covers Bradford) across ten areas (HMICFRS, 2021). It was found to be 'good' at 'Protecting vulnerable people' and 'Responding to the public' and 'adequate' at 'Investigating crime' and 'Providing a service to the victims of crime'.²⁶ Relevant strengths included domestic abuse reports being recorded well and reviewed by supervisors. An area for improvement was the lack of routine screening of referrals to children's social care, with referrals often made based on information about a single incident rather than the family history.

8.4 A CQC review of health services for looked after children and safeguarding in Bradford was carried out in 2019. As well as strengths, it also identified several areas for improvement including improving the quality and consistency of referrals made to the MASH (now Integrated Front Door) (CQC, 2019).

Bradford children's social care – key figures

8.5 Over the past few years, Bradford has seen an increase in children's social care activity and its referral rate is now markedly higher than the average for comparable local authorities (Department for Education, 2022d).

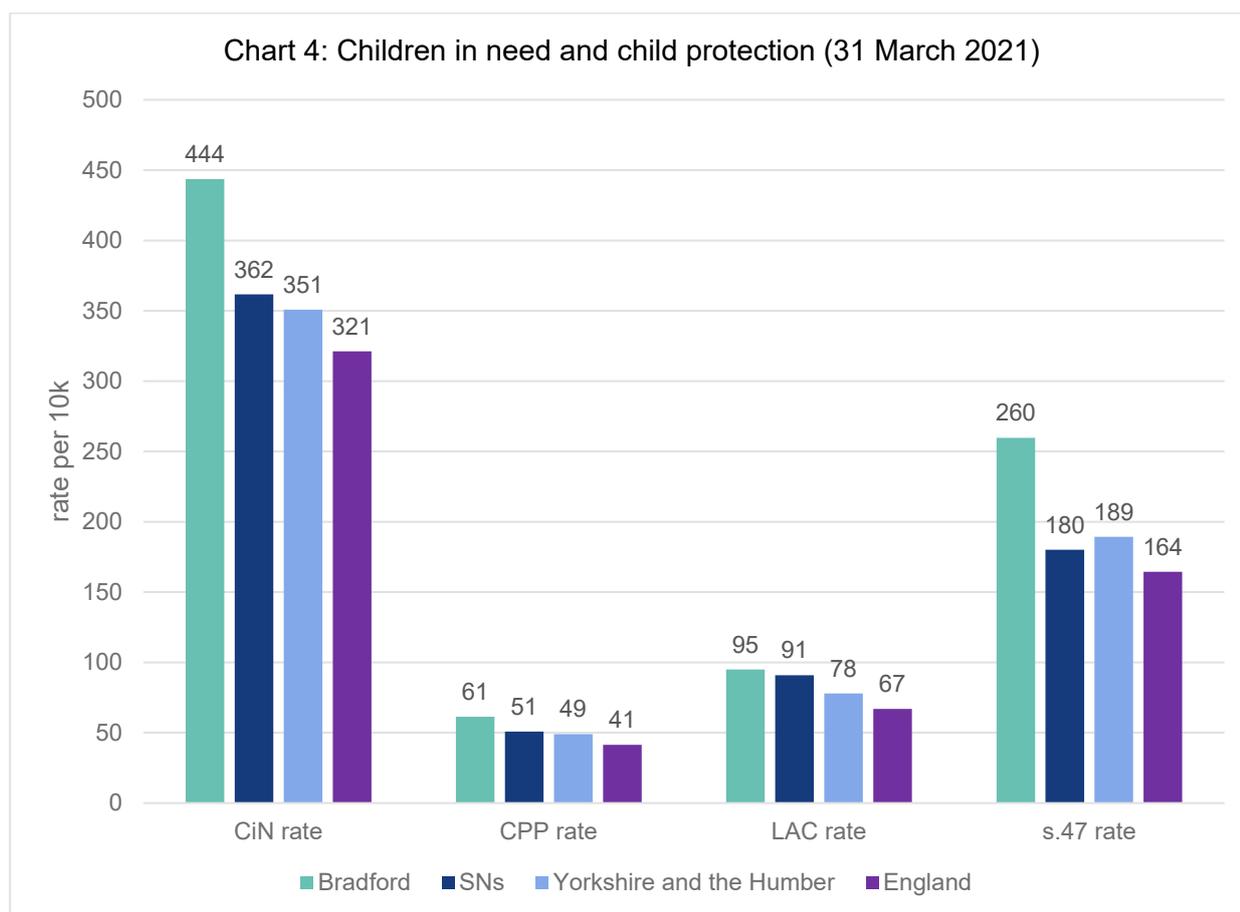
8.6 The following chart shows the rising rate of referrals in Bradford compared to its statistical neighbours, the Yorkshire and the Humber region, and England.²⁷



²⁶ The report found the force was 'outstanding' in four areas, 'good' in four areas and 'adequate' in two areas.

²⁷ Source: [Local authority interactive tool \(LAIT\) - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/tools/local-authority-interactive-tool-lait)

8.7 The following chart shows the higher rates of Section 47 (s.47) enquiries, Child in Need (CiN), Child Protection Plans (CPP) and Looked-After Children (LAC) in Bradford compared with its statistical neighbours, the Yorkshire and the Humber region, and England at 31st March 2021.²⁸



COVID-19 adaptations

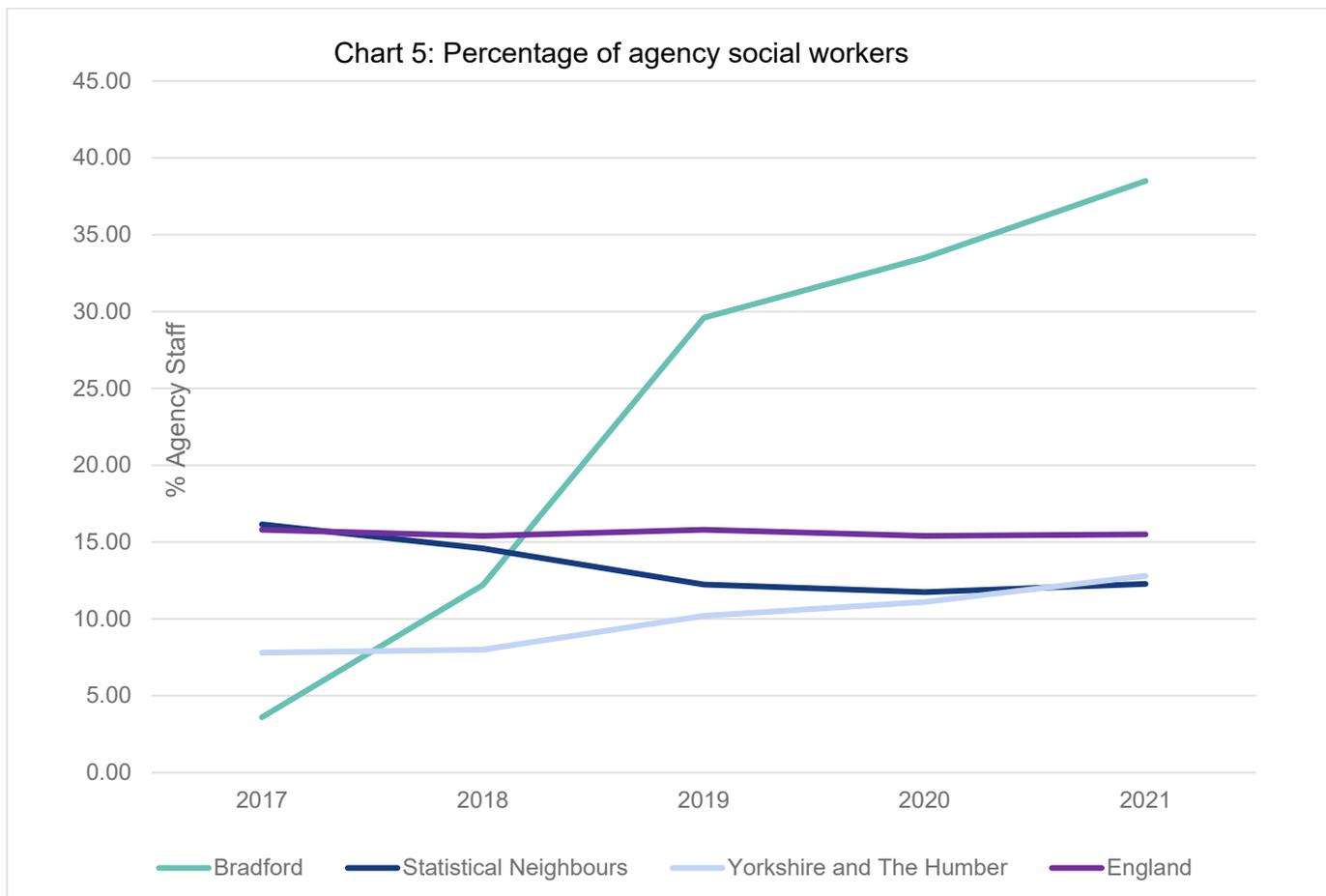
8.8. Interviews with practitioners have not indicated that adaptations for COVID-safe practice had a significant impact on the assessment and decision making in relation to Star. The involvement of Children's Services and partner agencies with Star and her family pre-dated the onset of the COVID-19 pandemic. The second assessment in May 2020 and the Child Protection Medical in June 2020 were in the period when lockdown measures were in force. Face to face home visits by social workers were very largely maintained in Star's case, with one virtual visit by a social worker in June 2020. As was common practice at the time for children offered health visiting at universal level, the Health Visitor carried out Star's 9–12-month assessment by telephone. This would have been more limited in nature than a face-to-face review

²⁸ Source: [Local authority interactive tool \(LAIT\) - GOV.UK \(www.gov.uk\)](https://www.gov.uk)

and offered less opportunity to explore wider aspects of Star’s care and development. GP contacts were initially through telephone consultation in early September 2020. Frankie was then offered a face-to-face appointment, which she declined.

8.9 The recruitment of social workers (already very problematic in Bradford) became more difficult during the pandemic. With staff working from home, it was difficult for managers to induct, support and get to know agency staff joining their teams. Home working limited the opportunities for training and development to support practice improvement.

Workforce



8.10. After the 2018 OFSTED inspection, Bradford lost experienced social workers and has struggled to replace them, relying predominantly on newly qualified and agency staff. Between 2017 and 2021 there was a tenfold increase in the use of agency staff (Department for Education, 2022d). In January 2020, the average caseload for social workers in Bradford was 20.1. This compares to an average social worker caseload in England of 16.3 (Department for Education, 2021g).²⁹

²⁹ Source: Local authority interactive tool (LAIT) - GOV.UK (www.gov.uk)

- 8.11. High turnover of social workers had a substantial impact on quality of practice. This was evidenced in the work with Star in September 2020. The social worker who made the home visit on 4th September 2020 had no previous knowledge of Star or her family. They left the service the following week (with one week's notice) with the assessment incomplete.
- 8.12. During the period in which key agencies were working with Star there were challenges of capacity across the system. In the local authority children's services there was inexperienced leadership and management at all levels. Social worker vacancies and turnover, with high levels of agency staff, affected the capacity to improve practice. The Children's Services Commissioner's report highlighted that progress was also affected by initial shortcomings in corporate support for Children's Services relating to IT and the recruitment and retention of staff.
- 8.13. Within the health economy, a CQC review of health services for looked after children and safeguarding in 2019 highlighted capacity issues in relation to health visiting and midwifery and the need to ensure timely and appropriate support for teenage pregnancy (CQC, 2019). In respect of the police, frequent changes of divisional leadership led to inconsistency of approach in some aspects of multi-agency working. Good collaborative working in response to domestic abuse was noted by the Children's Services Commissioner, but this was not necessarily evident in work with Star and her family (Department for Education, 2022c).
- 8.14. Faced with reducing local authority budgets, funding had been taken out of early help services but by 2018 the local authority had worked to restore preventative service funding, and with partners, had scaled up depleted early help services. An early help service was in place in 2020 offering both targeted early help and family support.

Impact of the Safeguarding Partners

- 8.15. The Children's Services Commissioner's report found weak local strategic partnerships and a lack of shared vision and plan. This was seen as a major gap and had impacted on the ability of partners to work together to deliver better outcomes for children in Bradford. Similarly, the review team found limited evidence of safeguarding partnership arrangements impacting positively on front line practice. From our conversations with senior leaders, it was clear that they recognised these concerns and were making a strong practical commitment to re-set relationships and establish a focus on ambitious outcomes for children and young people.

Conclusions

- 9.1. 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.
- 9.2. Decision making in the Integrated Front Door reflected management priorities to respond to a high volume of referrals and ensure throughput of cases. This resulted in minimal information gathering, including checking background information. Referrals about Star that would have benefited from a fuller assessment were not recognised.
- 9.3. Assessments did not explore the family context and interaction between family members, most specifically in relation to concerns raised about how Star was being treated. This meant professionals did not understand referrals from family members in context and dismissed them too readily.
- 9.4. Star’s wider family members were not listened to. The growing weight of concerned voices speaking on behalf of Star should have prompted professionals to reconsider the escalating risks to her. Framing family concerns as being ‘malicious’ was inappropriate and distracted professional attention from what might be happening to Star. The positive contribution that maternal great grandmother made to Star’s care was not fully recognised or understood.
- 9.5. Domestic abuse between Savannah and Frankie was cited by referrers to children’s social care in January and May 2020 but this was not assessed in the respective single agency assessments. Witness statements from family members and family associates to the police have attested to Savannah’s coercive, threatening, aggressive, ‘grooming’ and sometimes violent behaviour towards Frankie, but no professional understood this. Frankie was not given sufficient space to disclose what was happening to her.
- 9.6. Assessments within children’s social care were not fit for purpose and did not enable the identification of risks to Star and a plan for mitigating those risks. The practice framework underpinned by the Signs of Safety methodology was reduced in practice to the use of a formulaic list and rating scale and did not lead to a better understanding of risks and protective factors for Star. Assessments needed to move beyond superficial judgements and imprecise language, to the position where all

available information was used, triangulated and analysed in order to understand what was happening to Star.

- 9.7. The responses to the referrals with concerns about Star were significantly weakened by the lack of formal multi-agency child protection processes, especially strategy discussions and consideration of whether Section 47 enquiries should be initiated. This was particularly the case when there were allegations about bruising to Star. Robust strategy discussions would have allowed professionals to put all of the evidence together, interrogate it, challenge each other's perspectives, and agree a coordinated and strong response.
- 9.8. In 2020, Bradford children's social care service was a service in turmoil, where professionals were working in conditions that made high quality decision making very difficult to achieve. An overwhelming impression from our interviews with children's social care managers and practitioners was that this had been their experience.
- 9.9. The decision by the Secretary of State for Education on 25th January 2022 to place children's social care in Bradford into a not-for-profit trust, following a report from the Children's Services Commissioner, highlighted the scale and depth of systemic problems in Children's Services in Bradford which, in our view, had a substantive and material impact on the quality of practice and decision making about Star.
- 9.10. The volume of work and significant problems with workforce stability and experience, at every level, meant assessments and work with Star and her family were too superficial and did not rigorously address the repeated concerns expressed by different family members. These problems were compounded by weaknesses in multi-agency working. Taken together, these factors had a significant impact on the professional judgements made about Star's safety and well-being at several very critical moments; resulting in professionals not knowing about or addressing the harm she was suffering.
- 9.11. There were undoubtedly multiple fault lines in multi and individual agency practice arrangements in Bradford in 2020, some of which are unique to that area. These contributed to the practice issues identified by this review. However, as the next chapter will illustrate, many of these fault lines have been identified in other situations and in other places. The next chapter considers some of these wider issues and challenges.

Local recommendations

Safeguarding Partners in Bradford should:

- 10.1. Review their strategic and operational responsibilities as recommended nationally by this review, including making sure that they have a good understanding of learning from the review, good oversight of performance and that priorities are agreed, and funding is fair and equitable.
- 10.2. Review, develop, commission and resource 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. This offer should include:
 - A review of the Partnership's Pre-Birth Procedures to ensure that the assessment of parental and family risk factors are explored and decisions are appropriately documented. Any barriers to implementation should be identified.
 - Bradford District Care NHS Foundation Trust to ensure that ante natal health visiting is offered and priority is given to first time parents.
 - Teenage pregnancy support going beyond the age of 16
 - Develop the role of the Care Leaving services to ensure that it supports care leavers who become parents.
 - A whole family approach where the wider extended family and neighbourhood networks are involved in providing support to vulnerable young parents
- 10.3. Agree clear expectations regarding risk assessment and decision making and these are understood by all agencies. Partners should work with CSC to ensure that:
 - Decisions not to proceed following a referral are based on a review of previous history, background checks and a chronology of prior concerns
 - No referral is deemed malicious without a full and thorough multi-agency assessment, including talking with the referrer, and agreement with the appropriate manager
 - All staff are compliant with information sharing protocols
 - Risk assessments are always informed by multi agency information gathering which includes listening to family and friends and an assessment that goes beyond self-reporting
 - Supervision is always used to test assumptions and alternative hypotheses

- 10.4. Jointly review and commission 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. This should lead towards a coordinated community response by providing a bridge between services. Immediate action should be taken to provide multi-agency practitioners with guidance and/or training, supported within supervision, to enquire about domestic violence in mixed and same sex relationships, to develop safety plans for victims and their children and support perpetrator interventions. This should include that routine enquiry about domestic abuse is embedded in professional practice of midwifery and health visitor services.
- 10.5. Ensure that all practitioners understand their role when considering allegations of bruising including consideration of images which appear to show bruising. This should include:
- convening a strategy discussion with relevant agencies, both in and outside working hours
 - an assumption that a medical will be required and recording the rationale for any decision not to arrange a Child Protection Medical where there are allegations of bruising or other concerning external injury. The absence of visible marks should NOT be a reason, without consultation with a Paediatrician
 - discussion with the on-call Paediatrician with respect to arranging a Child Protection Medical Assessment
 - ensuring that all relevant information on the child and family is available at the time of this assessment
 - the medical assessment should be done in accordance with RCPCH's standards for such assessments, and such assessments subjected to peer review
 - providing social workers with relevant knowledge about bruising to children, so that they are alert to situations which require follow up, including discussion with medical practitioners.
- 10.6. Review information sharing protocols to ensure that practitioners have an accurate understanding what data is available what information must be shared. This review should pay attention to whether sufficient information is available to the emergency duty service.

The Department for Education's Children's Services Commissioner in Bradford should hold Bradford's improvement board to account for implementation of these recommendations.

- 10.7. The review recognises that Safeguarding Partners in Bradford have acted to address a number of the issues identified through local learning processes and are working to deliver the recommendations set out in the report of the Children's Services Commissioner. We are grateful to the Safeguarding Partners and professionals locally for their open and honest engagement with this review.

Key messages for all Safeguarding Partners

In the sections of this report which follow, we set out our wider analysis of the issues identified by the stories of Arthur and Star, and then propose a set of national recommendations which we think necessary to strengthen the child protection system. However, there are also a set of practice issues which we think all Safeguarding Partners across the country should immediately assure themselves are being dealt with effectively in their area.

11.1 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.

11.2 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.

Wider practice themes: the current picture of child protection in England

While undertaking this review it has been abundantly clear to the Panel that the experiences of Arthur and Star are, tragically, not unusual when considered against other serious safeguarding incidents.

This chapter looks at:

- The national child protection context.
- Patterns and trends in serious safeguarding incidents nationally to analyse whether Arthur and Star's experiences were similar to those of other children.
- The key practice issues highlighted by Arthur and Star's experiences, and whether these issues are widespread in child protection practice or not.

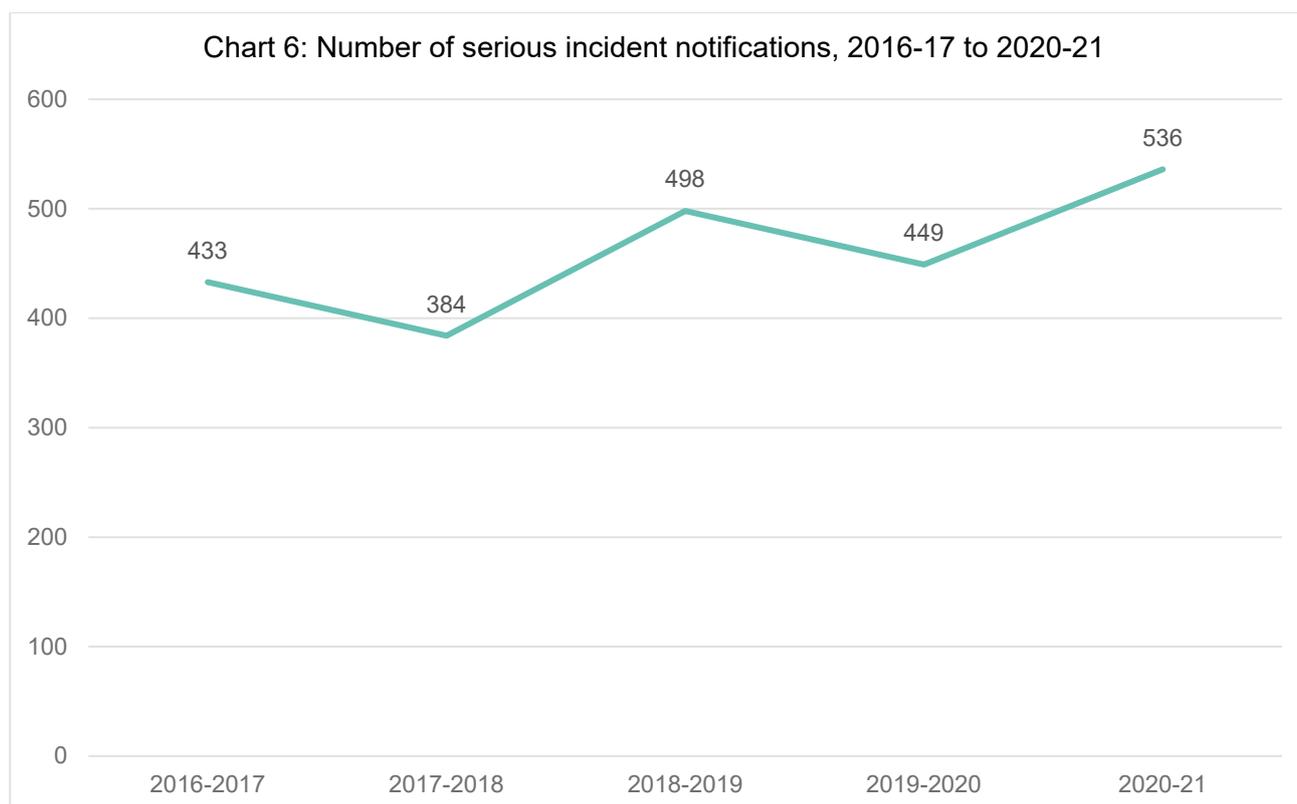
We need to acknowledge that the key practice issues in this review have been identified in the context of abuse within a family environment. They are not exclusive to this environment; the context for child protection is changing and there are a whole range of risks that children can face outside of the family home, some of which have been the focus of national reviews by the Panel (CSPRP, 2020a; CSPRP, 2022). Many of the reviews the Panel sees include criminal and sexual exploitation, serious youth violence, harmful sexual behaviour and online abuse which require equally strong multi-agency child protection practice. The same principles of prompt and effective multi-agency information sharing, discussion, planning and action apply whether it is children in the family home, outside the home, or in another setting where they are being cared for.

Child protection – overall context

- 12.1. The UK is not an outlier internationally when it comes to the prevalence of child mortality by homicide or assault. The number of child deaths in the UK, where another person was responsible or where responsibility was not determined, are some of the lowest in Europe (Fry, D. and Casey, T, 2017).
- 12.2. However, every year we see a significant number of serious safeguarding incidents, which are incidents where a child whom the local authority knows, or suspects, has been abused or neglected is seriously harmed or killed. The number of serious safeguarding incidents has fluctuated year-on-year. There has been a general increasing trend but comparisons over time are difficult to draw due to changes in 2018 to the reporting requirements placed on local authorities (Department for

Education, 2021e).³⁰ The 536 incidents reported in 2020-21 is an 8% increase on the 498 incidents reported in 2018-19 (Ibid). There has also been a sharp increase in child protection activity in recent years (Department for Education, 2021c).

12.3. The following chart shows that whilst the number of serious incident notifications have fluctuated year-on-year, there has been a general increasing trend; although, changes in reporting requirements make comparisons hard to draw.³¹



12.4. The following figures provide a snapshot of the latest child protection activity in England:

- At the more acute end of the children’s social care system, there were 50,010 children on a child protection plan at 31 March 2021 (Department for Education, 2021c). This is the equivalent to around 1 in every 250 children in England.³²

³⁰ The Children and Social Work Act 2017 placed a duty on local authorities to notify the Child Safeguarding Practice Review Panel of serious incidents. The duty came into effect when the Panel was established in June 2018. Prior to this, notifications (to OFSTED) had not been a legal requirement but guidance on them had been included in ‘Working together to safeguard children’ since March 2015. (Department for Education, 2021e)

³¹ Source: [Serious incident notifications, Financial Year 2020-21 – Explore education statistics – GOV.UK \(explore-education-statistics.service.gov.uk\)](https://explore-education-statistics.service.gov.uk)

³² [Population estimates - Office for National Statistics \(ons.gov.uk\)](https://www.ons.gov.uk). There are around 12 million children in England.

Children on a child protection plan have been assessed as suffering or being likely to suffer serious harm.

- There were also 198,790 Section 47 enquiries initiated in the same year, where significant harm or a likelihood of it was suspected (Department for Education, 2021c). Just over a third (37%) of those enquiries progressed to an Initial Child Protection Conference, convened when concerns are substantiated (Ibid).
- Children on a child protection plan form part of much larger cohort of children in need - 388,490 children were considered in need at 31 March 2021 (Ibid). This includes 80,850 looked-after children (Department for Education, 2021d).³³ Estimates suggest that around 1 in 10 children were considered in need in the past six years (Department for Education, 2019a).
- There were 536 serious incident notifications in the year ending 31 March 2021, relating to the death or serious harm to a child where abuse or neglect is known or suspected (Department for Education, 2021e). Arthur and Star would have been included in those figures.
- Around 1 in 10 (56) of those notifications related to children who were on a child protection plan at the time of the incident (Department for Education, 2021e). This equates to around 0.11% or 1 in 1000 children on a child protection plan that year. Whilst the vast majority were not on a plan a marked proportion - over 60% in 2020 - were previously known to children's services, as with Arthur and Star (CSPRP, 2021c).
- Of the 536 incidents, 223 (42%) were deaths (Department for Education, 2021e).
- Cases such as Arthur and Star's are uncommon in that the majority of deaths did not result from the deliberate intention of parents or parents' partners to kill or harm their child but reflect a more complex set of circumstances. In 2020, approximately 1 in 6 (17%) deaths were caused by maltreatment within the family, and of those, less than half (14 cases) had evidence of intentional murder/harm. Sudden Unexpected Death in Infancy (SUDI) was the most common category of fatal cases (30.6%) (CSPRP, 2021c).

Analysing the findings from Arthur and Star's stories

12.5. We have taken the following approach when analysing the issues highlighted by Arthur and Star's experiences:

- Triangulating the findings with the over 1500 rapid reviews which have come to the Panel's attention since it was established, as well as previous triennial analyses of serious case reviews.

³³ [Children looked after in England including adoptions, Reporting Year 2020 – Explore education statistics – GOV.UK \(explore-education-statistics.service.gov.uk\)](https://www.gov.uk/explore-education-statistics)

- Reviewing those findings against wider research on child protection.
- Drawing on new analyses commissioned by the Panel including an in-depth review of the quality of risk assessment and decision making in serious cases; and a review by the Behavioural Insights Team into the barriers to effective inter-agency information sharing and decision making.
- Convening a Challenge Group of leading thinkers from outside of child protection to provide a different perspective on tackling recurrent issues.

12.6. It is clear from our analysis that there are a set of chronic challenges getting in the way of good child protection practice in England. These issues are not new but they are complex and complicated to overcome. To do so effectively, requires that we consider death and serious harm from abuse and neglect within their system context rather than seeing them as isolated events. We need to recognise the patterns and similarities between such horrific events and identify what conditions would make it less likely for such events to reoccur (Reason, J., 2000).

12.7. We have set out below our analysis of the systemic factors influencing child protection practice on the ground; highlighting how these issues affected Arthur and Star; and how this connects with the wider evidence about child protection practice.

We have organised this analysis under four key domains:

- Practice and practice knowledge
- Systems and processes
- Leadership and culture
- Wider service context

12.8. These domains reflect the way that the Panel has analysed the key system factors that make for effective risk assessment and decision making. As well as featuring strongly in Arthur and Star's stories, weaknesses in risk assessment and decision making have been recognised as a predominant issue in serious cases by OFSTED, triennial analyses of Serious Case Reviews (Sidebotham *et al.*, 2016; Brandon *et al.*, 2020), the Panel's Annual Reports 2018-19 and 2020 and the independent review of children's social care.

Practice and practice-knowledge

Understanding what the child's daily life is like, where this might not be straightforward

- 12.9. At the heart of child protection is the need to really understand what life is like for a child, including in situations where adults are trying to obscure this. This is complex work and children who are experiencing abuse and neglect may be reticent or unable to speak out about their experiences. Practitioners need to have the right skills and expertise to develop a trusting and respectful relationship with the child, ask the right questions, and to critically reflect on what the child is saying or expressing through their words, actions or behaviours. Effective practice also necessitates understanding the impact that the histories of those involved in their life, e.g., their parents or parents' partners, may have on the child's experiences.
- 12.10. With both Arthur and Star, there was limited direct work; for example, Arthur's voice was often mediated by his father. There was also a lack of critical reflection on such engagement when it did take place; for example, Star was recorded as displaying "secure attachment" with her mother without explanation of what this meant or looked like. The histories of those involved in Arthur and Star's lives also required further exploration. Along with not probing further about Savannah Brockhill and Emma Tustin's histories, professionals in Bradford did not seek to understand Star's mother's own history in-depth and the potential impact on her parenting capacity.
- 12.11. Munro highlighted the persistent issue found by reviews into child deaths that the child was not spoken to enough (Munro, E. 2011).³⁴ Barriers to engaging the voice of the child, for example, lack of confidence or skills of some police officers (Allnock, D., Dawson, J. and Rawden, H. 2020), need to be remedied; and the child's views ascertained in a variety of ways (CSPRP, 2021c). Most importantly, practitioners need to be given the space and time to do quality work with the child and to critically reflect on the child's experiences (Ferguson, H. 2016), including putting together the jigsaw of information they hold about them and the network around them. Otherwise, there is a risk that the child will become invisible.

Listening to the views of the wider family and those who know the child well

- 12.12. A significant gap in understanding what daily life was like for Arthur and Star was the failure to talk to and listen to wider family members – especially grandparents

³⁴ This issue is also highlighted in other reviews e.g. CQC, 2016.

and great-grandparents – who had a very big part to play in the children’s lives. Effective child protection practice requires professionals to understand the significant relationships in that child’s life, including their extended family or peer network, and to build a picture of the child’s experiences that draws on their views and listens to their concerns.

- 12.13. Many different family members, in some cases on multiple occasions, raised concerns with police and social care professionals about the harm that they believed Arthur and Star were suffering. These family members knew Arthur and Star well but were not listened to in the same way that Arthur’s father and Star’s mother were. Instead, there was too easy an acceptance of the framing put forward by the children’s parents that the concerns being raised were ‘malicious’. Additionally, concerns raised by family (as well as family friends in Star’s case) about Thomas Hughes’ and Frankie Smith’s parenting capacity were not explored in depth. For example, Arthur’s paternal grandparents expressed concerns that Arthur’s father might not be able to protect him but these were not fully explored by professionals.
- 12.14. As well as featuring prominently in Arthur and Star’s stories, the impact of not considering grandparents’ and other adults’ views and overreliance on parental self-report is highlighted in other serious case analyses (OFSTED, 2011; Brandon *et al.*, 2020). The fact that concerns raised by family members are the least likely to proceed to further action also requires closer examination (Department for Education, 2017b). There needs to be greater consistency in speaking to and listening to the views of family/friends, recognising that they may be able to provide important insights into what the child is experiencing.

Specialist skills and expertise for working with families whose engagement is reluctant or sporadic

- 12.15. Child protection work requires sophisticated relational skills, with practitioners needing to build trust and cooperation with families who can be - or appear to be - reluctant to engage with them, whilst being authoritative and challenging where needed. Professionals need to be able to analyse the engagement of families critically, understanding the signs of parental disengagement and being able to interpret this as evidence when making decisions about a child’s safety. Practitioners also need good knowledge and understanding of the factors that might impact on such engagement, for example, different types of domestic abuse including coercive controlling behaviour.

- 12.16. In Arthur and Star's stories, professionals were increasingly kept at arm's length by those who were perpetrating abuse. From early September 2020, Frankie Smith and Savannah Brockhill actively prevented professionals and family members coming into contact with Star. Avoidant behaviour was also evident in Arthur's case - Arthur's father did not consent to share information about Arthur with family members; refused an offer of life-story work to support Arthur; and did not send Arthur back to school as required in mid-June.
- 12.17. Reviews into serious incidents often refer to a particular pattern of parental engagement when risk is escalating. The Panel's 2020 Annual Report outlined the importance of following up on 'missed appointments, blocking of communications, and cancelled visits', which are typical signs of parental avoidance (CSPRP, 2021c). Critical thinking in supervision and management can help professionals to identify a 'pattern of closure' whereby families try to minimise contact with the external world - an issue identified in over half of fatal abuse cases (Reder, P. and Duncan, S., 1999). Equally, it can bring a more forensic lens to situations where a parent seems to be co-operating in order to allay concerns; an issue that practitioners can lack confidence in identifying (Fauth *et al.*, 2010).
- 12.18. Ultimately, the Panel's analysis of risk assessment and decision making found that the skills of practitioners in establishing authentic 'support and challenge' relationships was key to having a timely response to changing risk. Developing those skills amongst the child protection workforce is therefore essential.

Working with diverse communities

- 12.19. Effective child protection work requires practitioners to unpack biases and assumptions that may impact on how they perceive and assess the risk to a child. This includes assumptions and biases that relate to culture, ethnicity, gender and sexuality. Practitioners need to be confident working with diverse communities and to be supported and challenged through supervision to reflect on these issues.
- 12.20. Assumptions about such issues impacted upon how practitioners understood Arthur and Star's daily experiences and made decisions about their safety. This includes:
- The perception of Arthur's father as a protective factor in his life.
 - The belief that referrals about Star were driven by dislike of her mother's same-sex relationship.
 - Potentially, the perception of women as unlikely perpetrators of harm to children.

- 12.21. Wider analyses of serious cases have found that practitioners need greater confidence and competence in exploring how ethnicity, racism and culture affect parenting and a child's lived experience (Bernard, C. and Harris, P. 2018; CSPRP, 2021c). Additionally, whilst case reviews often state a child's ethnicity, they do not tend to consider this in a meaningful way (Bernard, C. and Harris, P. 2018).
- 12.22. Similarly, the assumptions about Arthur's father's ability to look after him reflects a theme highlighted in the Panel's report 'The Myth of Invisible Men' that men are often framed in child protection contexts as either 'good' or 'bad', leading to a superficial understanding of their role (CSPRP, 2021b).
- 12.23. In both cases, the role of women in perpetrating abuse may have also impacted upon how professionals perceived the risk to Arthur and Star, given societal beliefs about women as caregivers etc. Whilst there is limited research about the role of women in serious incidents some international research highlights the prevalence of different mental health factors in maternal filicide (Krischer *et al.*, 2007; Kauppi *et al.*, 2010). It is also noteworthy that a previous triennial analysis of serious case reviews identified as a particular risk – for fatal physical abuse - domestic abuse where there is also a young or immature mother, with the situation exacerbated by social isolation, frequent house moves or a chaotic lifestyle (Sidebotham *et al.*, 2016). Irrespective of gender, Arthur and Star's stories underline the importance of the arrival of a new partner being considered as part of ongoing assessments of changing risk and need.

Appropriate responses to domestic abuse

- 12.24. Domestic abuse was a factor in over 40% of the serious incidents reviewed by the Panel in 2020 (CSPRP, 2021c). The risk posed by domestic abuse also features prominently in previous analyses of serious cases (CSPRP, 2020b; Sidebotham *et al.*, 2016; Brandon *et al.*, 2020).
- 12.25. In Arthur and Star's stories, there were a range of issues highlighted with regard to domestic abuse. In Arthur's case, Emma Tustin's experience of domestic abuse had not been sufficiently analysed in relation to her parenting capacity. Additionally, in Birmingham Children's Trust's assessment for Arthur, limited consideration was given to the impact on Arthur of witnessing domestic abuse. Similarly, domestic abuse as a feature in Star's family life was not explored in sufficient detail by any agency, with incidents considered individually rather than as part of an ongoing pattern. There were also limited efforts to engage Frankie Smith about reports of domestic abuse and to explore the concerns raised by family and friends further, for example, by talking to the referrers themselves.

- 12.26. Many of these issues resonate with the findings from the Panel's unpublished thematic review of multi-agency child safeguarding and domestic abuse which highlighted: a lack of understanding of domestic abuse, with it often being named but not explored; incident-driven responses; and the lack of a 'whole system' response to domestic abuse bringing relevant practitioners together. The importance of moving away from incident-based models of intervention to a deeper understanding of the ongoing nature of coercive control and its impact on victims, including the fear that can arise, has been highlighted by other reviews (Sidebotham *et al.*, 2016; CSPRP, 2020b). Ultimately, professionals need to build a picture of what is happening by linking together individual incidents and identifying patterns of behaviour in order to understand domestic abuse within a family (OFSTED, 2017).
- 12.27. Through Star's case, we also see the importance and value of specialist domestic abuse input when assessing risk. Practitioners in the specialist domestic abuse service (Dare2) recognised the risks to Star from domestic abuse but their expertise was not sufficiently drawn on by other agencies.

Specialist skills and expertise for undertaking child protection investigations

- 12.28. Child protection decision making is a highly skilled and intrinsically complicated activity. It involves extremely complex risk assessment in an ever-changing context, requiring analytical skill to collate and distil evidence forensically. Whilst there are many high skilled individuals working in child protection, we too often find the least experienced social workers undertaking statutory child protection work, often with inadequate supervision (Department for Education, 2021f). The importance of expertise and experience in police, health and other agencies' responses to child protection cases is also clear (HMIC, 2015; Cowley *et al.*, 2018).³⁵
- 12.29. In the case of Arthur and Star, there were gaps in such specialist skills particularly around interrogating and analysing evidence. The versions of events given by Thomas Hughes and Emma Tustin, and by Frankie Smith and Savannah Brockhill, were too readily accepted. Their framing of the concerns raised by wider family members as 'malicious' was accepted without enough investigation or triangulation with other sources. Additionally, issues of lack of experience and limited supervision and oversight were evident. For example, on the day photographs of bruising to

³⁵ 'Safeguarding children and young people: roles and competencies for healthcare staff' provides a framework which identifies the safeguarding competencies required for all healthcare staff. [Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff | Royal College of Nursing \(rcn.org.uk\)](https://www.rcn.org.uk/~/media/RCNorg/documents/2017/04/Safeguarding-Children-and-Young-People-Roles-and-Competencies-for-Healthcare-Staff.pdf)

Arthur were received by the police there was limited capacity in the police team and relatively inexperienced officers on duty.

- 12.30. A range of research highlights the importance of considerable expertise and practice experience in making effective decisions (summarised in Hood *et al.*, 2022). Whittaker has found that experienced practitioners were better at: recognising patterns; focussing on key information rather than treating all information as equal; spotting missing information; and triangulating wider information with their own observations and intuition. These skills were more developed in highly experienced practitioners - over five years' experience (Whittaker, A. 2018). Lord Laming described the importance of social workers retaining a stance of 'respectful uncertainty' when carrying out child protection investigations – a process involving critical evaluation of all information gathered and keeping an open mind (Laming, L., 2003). Ultimately, child protection work requires authoritative practice and 'the ability to negotiate the complexity and ambiguity of child protection work with confidence and competence' (Brandon *et al.*, 2020).

Systems and Processes

Appropriate information sharing and seeking

- 12.31. In order for professionals to make good decisions about children in need of protection, they have to have a full picture of what is happening in a child's life. Part of this is about having access to all the information known about the child. But just as important is seeking out missing information, considering disparate pieces of information in the round, and asking what bigger picture is being painted about a child's experience. As outlined, this is something that requires both experience and expertise.
- 12.32. In Arthur and Star's cases, we see three main information sharing issues: a lack of timely and appropriate information sharing; limited information seeking; and evidence not being pieced together and considered in the round. For Arthur, photographs of bruising received by the police were not passed on to the Multi-Agency Safeguarding Hub (MASH); and relevant information about Emma Tustin's background was not included in the MASH screening ahead of the April home visit. Additionally, information was not shared with referrers due to concerns about the lack of consent from Arthur's father meaning that opportunities to re-appraise risks and gather further information were missed. For Star, insufficient attempts were made to understand Savannah Brockhill's history, even when family members were raising significant concerns about her. In both cases there was limited evidence of

professionals trying to unpick the concerns being raised by family members and seek additional information. An episodic approach was taken to addressing concerns, with too much weight put on a single 'positive' observation, rather than looking at the evidence altogether.

- 12.33. Problems with information sharing have been raised by every national child protection review and inquiry – going back as far as the inquiry into the death of Maria Colwell in 1973. They have also been a central theme in all triennial analysis of serious cases (Sidebotham *et al.*, 2016; Brandon *et al.*, 2020) and in the Panel's two annual reports (CSPRP, 2020b; CSPRP, 2021c). Time and again we see that different agencies hold pieces of the same puzzle but no one holds all of the pieces or is seeking to put them together. As Eileen Munro summarised in her 2011 review of child protection, 'abuse and neglect rarely present with a clear, unequivocal picture. It is often the totality of information, the overall pattern of the child's story, that raises suspicions of possible abuse or neglect.' (Munro, E. 2011, p.79).
- 12.34. Arthur and Star's stories also highlight the behavioural biases that can impact upon information sharing within and between agencies, which need to be addressed. This includes:
- **Diffusion of responsibility** - the tendency for people in groups to fail to act on the assumption that someone else is responsible, an issue identified as a frequent contributor to children's deaths or serious injuries (Brandon *et al.*, 2009). In Solihull, the police did not share photographs with the MASH because they knew that children's social care had made a home visit and assumed that issues were 'in hand'.
 - **Source bias** - the tendency to interpret information depending on its source not substance, for example, the view in Star's case that family members' referrals were malicious.
 - **Confirmation bias** - the tendency to dismiss evidence which does not support your initial position. Practitioners' perceptions of Arthur's father as a protective factor in his life and their impression from the home visit impacted upon how photographs provided to the MASH later on were perceived.
 - **Risk aversion** - preference for more certain outcomes even when more uncertain outcomes could be of greater benefit, for example, practitioners' reluctance to share information with Arthur's family without his father's consent, potentially due to concerns that GDPR laws would be violated.
- 12.35. With regard to consent, legislation is clear that sharing information without consent for the purposes of safeguarding is permitted; and guidance, such as Working Together to Safeguard Children, should reinforce this unambiguously. Locally, child protection practitioners need to feel empowered to share information without

consent but we recognise that this is not commonplace (Department for Education and Kantar Public, 2021). The culture around information sharing and seeking must be driven by leaders at every level including central Government, and to this end we welcome positive steps such as the Department of Culture Media and Sport's proposed amendment to GDPR.³⁶

Critical thinking and challenge within and between agencies

- 12.36. Key to overcoming behavioural biases is critical thinking and robust challenge within and between agencies. Good child protection practice requires professionals to consider a wide range of evidence from many sources, and to synthesise it into meaningful working hypotheses within a very short time frame. This relies on professionals engaging in critical thinking both individually and as a collective and having the right support and opportunities to do this well, for example, manageable case numbers, supervisor stability and good quality supervision.
- 12.37. For both Arthur and Star, we see missed opportunities for critical thinking and challenge. For example, as part of Star's first assessment, practitioners did not go back and test their findings about domestic abuse with the specialist domestic abuse service, who may have been able to provide important challenge. The opportunity for professionals to consider information altogether and see the bigger picture was also missed in both cases when Strategy Meetings were not held including prior to the home visit to see Arthur and Star's Child Protection Medical. Instead, single perspectives, for example, the conclusions of the police officer from the 'safe and well' visit to Emma Tustin's home were too heavily relied upon.
- 12.38. The issue of inter and intra-professional challenge features as a key theme in case reviews and has been found to particularly affect decisions in contact, referral and assessment (CSPRP, 2021c). A range of factors can impact upon professionals' willingness to challenge one another's hypotheses and assumptions. Issues that feature prominently include: a lack of confidence to challenge decisions; a lack of clarity about how to escalate concerns; and a lack of reflective space (Sidebotham *et al.*, 2016; Allnock, D., Dawson, J. and Rawden, H., 2020; Brandon *et al.*, 2020). To tackle this, requires a change in culture to one where challenge is promoted and encouraged and more regular opportunities to bridge siloes and consider different professionals' perspectives are created. Countries such as Finland have embraced this approach, with Finnish social workers more likely to cite the role of peers and interdisciplinary teams in decision making than other countries surveyed (Berrick *et al.*, 2016). Without such a shift, professionals risk continuing to see cases only

³⁶ The proposed amendment will ensure that sharing information without consent for safeguarding purposes always passes the legitimate interest test.

within the narrow frame of their own professional background and without a holistic picture of risk (Sidebotham *et al.*, 2016).

Leadership and culture

- 12.39. It is leaders who create the operating context in which child protection decisions are taken. At a strategic level, leaders need to ensure: clarity of vision, responsibilities and resources; robust governance; and a culture of learning, improvement and challenge. When there are conflicting agency priorities, capacity issues, and a lack of shared vision and values, effective multi-disciplinary and multiagency working becomes very much dependent on individual will and relationships. Children cannot rely on that alone.
- 12.40. Both Solihull and Bradford's Safeguarding Partners have distinct challenges to address around effective multi-agency working and driving forward improvement. However, common to both Bradford and Solihull was a weak 'line of sight' to frontline practice by Safeguarding Partners.
- 12.41. In Solihull, leaders of the Safeguarding Partners did not have a clear enough understanding of the impact of child protection practice. The impact of this was directly felt by practice in the MASH where weaknesses in the joint strategic governance of MASH led to key staffing gaps going unresolved. This came through in Solihull's JTAI report (2022) and in conversations with leaders, managers and practitioners (OFSTED, 2022).
- 12.42. In Bradford, the Children's Services Commissioner's report (2022) set out very clearly the absence of an agreed partnership vision and the impact that this had on delivering good outcomes for children in Bradford. Our analysis of interviews with senior leaders, managers and practitioners supports this conclusion and we found little evidence of Safeguarding Partners' arrangements impacting positively on front line practice.
- 12.43. The Behavioural Insights Team's literature review also highlighted the importance of leadership support in fostering good child protection practices and in particular effective cross-organisational information sharing. Embedding trust and a shared set of values between organisations is key to this (Abrams *et al.*, 2003; Skopik *et al.*, 2011). Without such trust, staff may lack the motivation to share information (Cress, U., Kimmerle, J. and Hesse, F.W. 2006); be unwilling to share information out of fear of criticism (Goodman, P.S. and Darr, E.D. 1998); and/or may withhold information to protect their own position (Constant, D., Kiesler, S. and Sproull, L., 1994).

- 12.44. Lord Laming's Inquiry (2003) pointed to the vital necessity of children's services leaders having their 'finger on the pulse' about the quality and effectiveness of child protection practice. This involves using a range of mechanisms to know what is happening, what is working well and what is not. It means meeting and listening to practitioners and children and families. It entails reading case files, contributing to file audits and other forms of quality assurance, and generally engaging with a diverse range of quality assurance mechanisms so that they speak with authority and authentically about where and how practice should improve. An important aspect of the role of Safeguarding Partners is making sure that there is strong and robust management oversight of the quality of multi-agency practice and that quality assurance mechanisms are in place.
- 12.45. Case reviews also highlight the importance of management oversight and quality assurance to promote and assure good practice standards (CSPRP, 2021c). Effective oversight can enable timely escalation of concerns and facilitate challenge of other agencies' decisions (Brandon *et al.*, 2020). Additionally, it helps ensure that core processes, which help protect children, are being adhered to.
- 12.46. Reflective supervision also plays a key part in intra-agency challenge and requires leaders to create a learning culture within which supervision can take place and thrive (Wonnacott, J., 2020; Rothwell *et al.*, 2021). In both Solihull and Bradford, the impression gained from interviews was that reflective supervision was superficial and not a constant feature of professional life. Yet the lack of meaningful and regular supervision in these cases reflects wider national issues (Wilkins, D. Forrester, D. and Grant, L. 2017). Over a third (34%) of social workers receive reflective supervision less than every 6 weeks, a figure which has increased in recent years, and social workers in 'Requires improvement' or 'Inadequate' local authorities are less likely to receive regular supervision (Department for Education, 2021f). A review of clinical supervision in the workplace also identified a number of barriers to effective supervision including lack of time and heavy workloads; lack of staffing, shift working; and a lack of supervisor training and support (Rothwell *et al.*, 2021).

Wider service context

- 12.47. Effective risk assessment and decision making in child protection is also affected by factors in the wider service context. This includes:
- workforce development

- funding levels and the strategic use of funding to invest in family support services
- the impact of wider socio-economic factors and matching priorities to resources.

- 12.48. In Bradford in particular a range of wider service issues impacted on risk assessment and decision making and the protection offered to Star.
- 12.49. With regard to workforce development, there were and are acute issues in Bradford with recruitment and retention of social work staff and the capacity to conduct sustained direct work with families. The social worker vacancy rate increased fourfold between 2017 and 2021 and the agency rate sevenfold (Department for Education, 2022b). The high turnover of staff had a direct impact on the quality of practice provided to Star. For example, the social worker who visited Star in September 2020 had no previous knowledge of Star or her family and left the service the following week with the assessment incomplete. Whilst particularly acute in Bradford, the social worker workforce challenges evidenced – instability and inexperience – and the impact on support for children and families reflect national issues.
- 12.50. There were also issues with funding levels, capacity and turnover within other Bradford services. For example, in relation to health visiting (CQC, 2019). During the interviews, we heard that health visiting caseloads had increased from an average 299 in 2018 to 479 in 2022. In Star’s case, a pre-birth family health needs assessment would have been an opportunity to understand her mother’s support needs and the wider family context but this did not happen due to human error in the context of a service under strain.
- 12.51. The issue of capacity in health visiting services is a national concern and merits further attention. Only 9% of health visitors in England work with the recommended ration of 250 children aged 0-5 or less, with nearly half (49%) accountable for over 500 children (Institute of Health Visiting, 2021). This is particularly concerning from a child protection perspective as health visitors are some of the few professionals likely to have ‘eyes on’ vulnerable infants and pre-school age children.
- 12.52. In Solihull, limited capacity in children’s mental health services may have had an impact on the response to Arthur’s emotional and mental health needs when he was referred to SOLAR in January 2020. Additionally, there was a lack of a domestic abuse commissioning strategy in place. Similar constraints feature in the Panel’s analysis of cases featuring weak risk assessment and decision making, with gaps in early intervention provision limiting support for vulnerable families as well as there being issues accessing specialist support.

National recommendations

- 13.1. In the previous chapter, we set out how the issues highlighted by Arthur and Star's stories resonate with the other serious incidents reviewed by the Panel every year. We identify the following fundamental issues with practice:
- Weaknesses in seeking, sharing and acting on information from multiple sources.
 - A lack of robust critical thinking and challenge within and between agencies.
 - 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 all of the above, a need for leadership and management which has a powerful enabling impact on child protection practice; and creates and protects the optimum organisational context for undertaking this complex activity.
- 13.2. Whilst there are also examples of good practice, it is clear that these issues affecting practice in Arthur and Star's cases are not local but national. These are problems which successive reviews and inquiries have pointed to and sought to address. And yet they keep recurring. We are advocating therefore that our approach to child protection practice should be strengthened at both a local and at a national level.
- 13.3. In this chapter, we set out what we think needs to be done on a national level to address these issues. The focus of our recommendations is the child protection system. We use the term 'child protection' rather than 'safeguarding' intentionally, to mean what happens when there are concerns that a child might be being (or at risk of being) significantly harmed. There is value in the concept of safeguarding being 'everyone's business' but it is our contention that its meaning has become so broad and elastic that there has been some distraction from the need for those investigating abuse and neglect to have highly specialist expertise and a forensic focus on child abuse and potential perpetrators. A stronger focus on the specialist skills required to work with this relatively small but extremely vulnerable group of children and their families should, in our view, lead to more clearly differentiated responses to concerns about abuse and neglect.
- 13.4. Therefore, at the heart of our recommendations is a proposal for a new approach to undertaking child protection work; this will entail a significant change to the way that

professionals from all agencies work with children and their families day to day, building on best practice developments. We are proposing that child protection practice needs to be a genuinely multi-professional, multi-agency endeavour, end to end. Operational delivery should be organised at a local level so that the key practitioners best placed to investigate and oversee child protection planning work together in established units under a single line of management and leadership. We want to see fresh thinking about the multi-disciplinary make-up of these units and encourage, for example, dedicated time from psychologists, psychiatrists and paediatricians. We want to move away from having to jump through multiple hurdles to access multi-disciplinary skills and multi-agency input, and instead have that expertise as central to child protection investigation and planning.

- 13.5. Child protection work is intrinsically complex and complicated and should be led by a diverse multi-professional and multi-agency team, with extensive expertise. Too often we see inexperienced professionals – social workers in particular – being asked to undertake this work without sufficient supervision and support. This is not fair to the social workers or to the children they serve. This is why we are recommending that Multi-Agency Child Protection Units – integrated and co-located multi-agency, multi-professional teams staffed by experienced child protection practitioners – are established in every local authority area.
- 13.6. Our other recommendations are all about enabling these new Multi-Agency Child Protection Units to deliver excellent practice. The most important enabler of excellent practice is of course leadership. This is even more pertinent in a multi-agency context where professionals are reliant on the right authorising environment – the right multi-agency budgets, protocols, values and systems – being in place. We have therefore put forward proposals for strengthened multi-agency leadership and accountability, and for better multi-agency co-ordination and system oversight from central government. We have also recommended the development of new National Multi-Agency Child Protection Practice Standards, to help deliver consistently good practice across the country.
- 13.7. It is important to clarify at the outset that we do not think child protection work should be separate from the rest of children’s social care, but integral to its effective delivery. Help and protection are of course a continuum, and the Panel’s analysis on risk and decision making in child protection highlighted the heightened risks for children associated with frequent hand off/ hand over points. Families frequently move in and out of different statutory processes as their needs shift and professional concerns about the safety of children change.
- 13.8. To address this issue, the independent review of children’s social care recommends the introduction of multi-disciplinary Family Help Teams working with families who would currently fall into targeted early help, child in need or child protection. Where

there are concerns of significant harm or a case is on a child protection plan the case would be held by a social worker in the Family Help Team and co-worked by an Expert Child Protection Practitioner (IRCSC, 2022). We welcome this emphasis on maintaining relationships and on the importance of specialist expertise.

- 13.9. Under our recommendations, the Multi-Agency Child Protection Units will need to work hand-in-hand with the new multi-disciplinary Family Help teams, enabling decisions about child protection to be made jointly cross agencies and by those with the right expertise. The dedicated Multi-Agency Child Protection Units, responsible for child protection investigation and planning, will ensure that protecting children remains in sharp and forensic focus without disrupting the established relationships with existing practitioners.
- 13.10. It is also important to recognise that more child protection activity does not necessarily mean a safer child protection system. Inappropriate child protection activity can overheat the system and obscure the children facing the greatest risks. We think that the changes we are proposing through Multi-Agency Child Protection Units should lead to stronger risk assessment and decision making, and more of the right children protected at the right time.
- 13.11. We have summarised our recommendations below and provide more detail in the following pages.
- Recommendation 1: A new expert-led, multi-agency model for child protection investigation, planning, intervention, and review.
 - 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.

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

13.12. In Star and Arthur's cases, we have seen:

- Photos of bruising not shared across agencies (Arthur).
- A Child Protection Medical taking place without full information about contextual factors (Star).
- Children with suspected injuries not being subject to Child Protection Medicals when they should have been (both children).
- Gaps in the information shared about Emma Tustin's background ahead of a social work visit (Arthur).
- Very concerning referrals from family members being dismissed without enough investigation (both children).
- Too easy an acceptance of the version of events put forward by parents, and a difficulty challenging the early framing of Thomas as a protective father and Star as at the centre of a protective wider family (both children).
- A failure to identify a pattern of parental disengagement and avoidant behaviour (both cases).

13.13. The previous chapter has set out the problems of information sharing across agencies; insufficient professional challenge within and between agencies; and a lack of specialist child protection skills and expertise. These are common features across serious incidents and across the wider child protection evidence base.

13.14. Complex child protection decisions need to be reached after inter-agency deliberation with inter-professional challenge encouraged, and all available information in view. This improves professional understanding of what is happening for a family, and therefore improves the quality of decision making. For example, the evaluation of Family Safeguarding Hertfordshire found that the introduction of multidisciplinary working and group supervision provided for better communication between agencies, with agencies reporting improved understanding of risk factors (Department for Education, 2017a).

13.15. Research has given us a good understanding of the features of effective inter agency collaboration and cross agency working. Miller, C. and McNicholl, A. (2003) point to unified management systems, multi-agency common governance, shared training, integrated information sharing systems, and co-location as factors for success. Research by Department for Education and Kantar Public (2021) highlights the importance of clarity on cross-agency roles, appropriate and well understood policies, formal communication structures at strategic and operational level, cross agency commitment and shared time and space at the front line.

Alfandari, R. and Taylor, B. (2022) also highlight co-location, inter-professional in-service training, developing an overarching commitment to collaboration at all levels, and mechanisms to support long term collaborative working as critical.

- 13.16. Agencies already work seamlessly together in some parts of the English child protection system. Over the past ten years, we have seen the MASH model spread widely. This involves multi-agency professionals working in a single co-located team at the front door of child protection, sharing information effectively, making joint decisions and delivering co-ordinated interventions.
- 13.17. For this review, we commissioned the Behavioural Insights Team (BIT) to undertake a rapid review of literature on cross agency working and information sharing not just in children's social care but across all sectors. By looking at examples of where this has gone particularly well and examples of where it has gone wrong, the team identified the following five conditions for effective information sharing across agencies:
- **Trust, shared values and identity:** Creating a culture of trust and support for colleagues where information sharing is the norm.
 - **A clear information sharing policy:** Ensuring overarching data sharing agreements are in place where feasible to permit easy and timely sharing.
 - **Leadership support:** Modelling collaborative behaviours and ensuring sufficient resources are available to set up and sustain information sharing across organisations.
 - **Regular feedback loops:** Establishing processes whereby feedback is solicited and provided on a regular basis both internally and across organisations.
 - **Systems that minimise the cost of sharing:** Removing friction costs associated with sharing information.
- 13.18. BIT's findings were based on a range of research but in particular Yang and Maxwell's review of success factors for information sharing in public organisations (Yang, T.M. and Maxwell, T.A. 2011). It is clear that the way child protection practice is organised at the moment – and the persistence of organisational barriers between agencies – means these conditions are not sufficiently reflected.

Multi-Agency Child Protection Units

- 13.19. Therefore, we are recommending a new operational framework be developed for undertaking child protection investigations, and the necessary planning, delivery and review of children who are at risk of significant harm. We are proposing the development of new multi-agency child protection units in every local authority – a

multi-agency, co-located team led by an expert social worker with a wealth of child protection experience.

13.20. Child protection is absolutely core work for all children’s social workers. It is also a priority for any agency that works with children, especially police, health and schools. This is as it should be – all professionals need to be equipped with the right level of knowledge and skills to protect children, in the context of their role and in the context of the different harms experienced. Any practitioner working with children and adults need sufficient understanding about child protection to be able to recognise when a child might be at risk, and have access to talk those concerns through with an experienced child protection professional.

13.21. However, the core child protection statutory processes – of investigating child protection concerns, child protection planning and implementation, and reviewing progress – are the points where integrated multi-agency involvement and specialist child protection skills are most critical. It is in these processes that the most difficult and finely balanced decisions about children are being made. Currently, the extent to which child protection investigations are properly multi-disciplinary and multi-agency is too variable. We have heard evidence of children’s social care sometimes finding it difficult to get other agencies to engage, and of other agencies feeling they are kept out of the loop. We have seen in Star and Arthur’s cases the limitations of taking a single agency approach to investigating concerns when statutory multi-agency procedures were needed. A single-agency approach to investigation creates the problems we see with information sharing, and means the opportunity is lost for appropriate deliberation and professional challenge. It also means that child protection work is often being led by inexperienced and insufficiently supported social workers, and overseen by managers with multiple demands and organisational pressures.

13.22. The unit’s functions would include:

- providing specialist child protection advice and consultancy across the local multi-agency system;
- convening and leading child protection Strategy discussions;
- undertaking section 47 enquiries;
- organising/ undertaking Child Protection Medicals;
- undertaking Achieving Best Evidence interviews;
- chairing child protection conferences;

- overseeing child protection planning and review;
- supporting the implementation of child protection plans;
- advising other multi-agency and local authority children's social care teams (including MASH/ front door, Children in Need, more specialist teams such as disabled children's teams, children in care services) on whether a child and family should be on a Child Protection pathway;
- recommending applications to court for removal and providing expert multi-disciplinary evidence to court where necessary.

13.23. As set out earlier, operational delivery should be organised at a local level so that key practitioners and managers best placed to investigate and oversee child protection planning work together in established units under a single line of management and leadership. We want to see fresh thinking about the multi-disciplinary make-up of these units. We would expect membership of the unit to include as a minimum representatives from the police, health services, education, and children and adult mental health.

13.24. Multi-agency professionals would be employed by their 'home' agency but seconded into the child protection unit, bringing their agency function with them. We expect units would be hosted by the local authority to ensure smooth join-up with the rest of children's social care. It is important for the unit to be staffed by professionals employed by their 'home' agency so that they retain strong links to that agency (much of their role will be coordinating the involvement of their colleagues so these links are crucial) and also so they retain proper professional development, oversight and supervision for their specific profession. In addition, the local area may wish to employ directly multi-disciplinary practitioners for the unit, through either joint or single agency funding.

Links between 'Family Help' teams and Multi-Agency Child Protection Units

13.25. The independent review of children's social care proposes comprehensive reform to the way families are supported by children's social care – a 'revolution in Family Help'. It states that:

'The proposed model of Family Help ... will improve the safety of children by making sure families get the help they need to get through painful, dangerous or isolating times - whether this is an abusive relationship, struggles with mental health or a child being exploited. The majority of serious incidents in 2020 (64.5%) involved children already known to children's social care (Child Safeguarding Practice Review Panel, 2021). By

bringing more help into families' lives delivered through a single multidisciplinary team, workers are more likely to build better relationships with families, develop a holistic understanding of the situations in which children are living, address the underlying reasons that families become involved in social care, and more accurately identify situations where there are more serious concerns. By making help less stigmatising and more meaningful, and by giving professionals more time with families, we will also increase the likelihood that families will want to engage with social care. By removing the arbitrary distinction between early help and social care, we will improve the ability of the system to respond to changing risk, without the inherent weakness in hand off points.' (IRCSC, 2022), p. 70

- 13.26. Providing much better help to families facing difficulties will both help to alleviate pressure on families, and also provide better insight into the situations children are living in.
- 13.27. At the same time, fundamental reforms to the core child protection system are needed. There will always be children in need of protection and the response to these children must be robust.
- 13.28. Key to this is having a cadre of skilled and experienced social workers leading child protection work. We envisage the Expert Child Protection Practitioners, proposed by the independent review of children's social care, as those leaders. Additionally, the five-year Early Career Framework for social workers proposed by independent review of children's social care is a sensible model for delivering the level of skill and expertise required.
- 13.29. The question of how the Multi-Agency Child Protection Unit and wider Family Help teams work together is an important one. We would want to ensure that introducing Child Protection Units does not create additional 'hand-off' points for children where their case was passed to someone new. We also want to maintain the relationship between a child and their family, and their lead worker, whether they are subject to statutory child protection processes or not. Therefore, we think a co-working model, where specialist Child Protection social workers co-work cases with the allocated family social workers, is the right approach. It is important that the Child Protection Unit – where the most expertise resides – has decision making authority and oversight of the process; but also that the allocated Family Social Worker continues their programme of work with the family.
- 13.30. We envisage that the unit's functions would include all section 47 enquiries relating to both intra-familial and extra-familial harm; managing investigations relating to public institutions; and the role of the Local Authority Designated Officer. We recognise the tensions that these arrangements bring and welcome discussion over

how best to operationalise these distinct functions and decision making responsibilities across the multi-agency response. There is no room for ambiguity.

Links to the Multi-Agency Safeguarding Hub

- 13.31. Most local authorities now use a 'Multi-Agency Safeguarding Hub' or 'MASH' model at the front door of children's social care. These are co-located multi-agency teams involving at least police, health and children's social care. They review referrals as they come into children's social care and make decisions about next steps. Their core aim is to improve safeguarding responses at the front door of children's social care through:
- Better information sharing
 - Joint multi-agency decision making
 - Co-ordinated interventions with families
- 13.32. The Multi-Agency Child Protection Unit model we are proposing shares similarities with some MASH models. We have heard about cases where successful authorities have extended the MASH model or aspects of it to deliver a multi-agency response across more of the child protection process. For example, in Hampshire children's services, strategy discussions take place in the MASH which has led to 'comprehensive information sharing' (OFSTED, 2019d).
- 13.33. It is important that we learn from the MASH model when designing Multi-Agency Child Protection Units. What is clear from the evidence base on MASH is that, as ever, success comes down to the quality of the implementation – especially whether all agencies are involved and resourcing the MASH appropriately, and the extent of genuine integration between agencies (Home Office, 2014). This is of course directly dependent on the quality of leadership overseeing the arrangements. We know from the Joint Targeted Area Inspection of Solihull that reported in February 2022 that gaps in resourcing in the MASH impacted on the quality of decision making there. There is a high level of variability in what different MASH models involve, and therefore variability in their quality.
- 13.34. We think that, alongside developing Multi-Agency Child Protection Units, there is also an opportunity to level up the quality and consistency of MASH models across the country. We believe our proposed National Multi-Agency Child Protection Standards should underpin this. To support the development of those standards, we also recommend government commission a more up-to-date evaluation of the

MASH model, to establish more clearly the key success factors and different operating models.

Implementing Multi-Agency Child Protection Units

13.35. Developing the Multi-Agency Child Protection Unit operating model should be done in close partnership with multi-agency child protection practitioners and leaders, locally and nationally. We think an ‘early adopter’ approach to roll out would be a good model, where some areas are supported to implement the new model quickly as part of a first wave, with following waves learning from their implementation experience. Central Government should sponsor a cross-Departmental programme to design, develop and implement the new model, working in partnership with local areas. It will be important to take into account the workforce pressures already facing the multi-agency child protection system, and recognise that implementing new ways of working requires additional resource. Government should provide start-up funding that helps areas to transition to the new model, whilst recognising that ongoing operation will need to be funded locally. There will be an important role for the new national Child Protection Board in overseeing the implementation of Multi-Agency Child Protection Units.

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

13.36. Intervening in private family life through a child protection process is one of the most serious responsibilities of the state. And yet, there is very little in the way of a national set of standards or expectations, based on evidence, for how this work should be carried out. The ‘Working Together to Safeguard Children’ government guidance sets out processes to be followed, and it is right to be cautious about excessive levels of practice prescription. The Munro Review (2011) points to the way that increased prescription can erode good professional practice. It states:

‘The level of increased prescription for social workers, while intended to improve the quality of practice, has created an imbalance. Complying with prescription and keeping records to demonstrate compliance has become too dominant. The centrality of forming relationships with children and families to understand and help them has become obscured.’ (Munro, E. 2011, p. 7-8)

13.37. We do, however, think it is necessary to develop a set of national standards – as exist in other fields – which capture the best available evidence of what works when working with children and families in a multi-agency child protection context. This is especially important in this area because we are asking a group of practitioners

from different professional backgrounds to come together and work as a single team. They need a common practice framework to operate from if they are to do this effectively and consistently across England. It is also right that the public have access to this kind of information so they know what to expect from a child protection process and how to challenge when standards are not met.

- 13.38. We believe there is great value in giving evidence-based guidance through Multi-Agency Child Protection Practice Standards because of the complexity of different agencies working seamlessly together. These standards must be truly multi-agency in their nature and speak to all local Safeguarding Partners. To this end, they should be co-designed with practitioners and leaders from the range of multi-agency backgrounds.

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

- 13.39. Protecting children from abuse and neglect is a multi-agency endeavour. When things go wrong, a lack of co-ordination across agencies is often a key issue. This isn't a problem that front line police, social workers or health professionals can solve on their own, despite their best efforts. It is a problem which stems from a lack of joined up leadership in the local area. In both Bradford and Solihull, the impact that the local Safeguarding Partners was having on front line practice was not clear, and leaders did not have a sufficient line of sight over what was happening on the ground.
- 13.40. Ensuring the proper involvement of and oversight by all agencies – including agreeing a shared set of values, establishing the right systems and processes for working together, and securing the right resources to undertake the work – requires leaders across the key agencies of health, police and the local authority jointly leading the system. This is why the Children and Social Work Act 2017 created a strengthened set of arrangements to ensure the full engagement (and accountability) of the most senior level through local Safeguarding Partners. However, as the Wood report (Wood, A. 2021) and the Panel's Annual Report (CSPRP, 2021c) also set out, there is inconsistent evidence of the added value of the new governance arrangements. The ambition of the 2017 reforms is yet to be achieved in all areas and the Panel believe that Safeguarding Partners are currently struggling with the following key issues:
- A lack of clarity about their functions – especially a confusion about whether this should be a strategic or operational body, with too much delegation making it impossible for them to make strategic decisions.
 - Limited oversight of performance and learning – with Safeguarding Partners not always receiving the right data, information and practice insight to oversee and

assure performance at the strategic level; and not always demonstrating sufficient ownership over the learning review process in response to serious incidents.

- A lack of accountability, especially around funding decisions, with Safeguarding Partners not managing to agree a level of funding that is fair and equitable in the way required in *Working Together to Safeguard Children*.

13.41. The independent review of children’s social care proposes changes to the way Safeguarding Partners operate including greater clarity on their functions and how they provide senior, strategic, leadership. Expectations for how multi-agency arrangements provide strategic oversight of the system, delegate operational delivery and how arrangements are properly resourced must be clearer. We think this offers the right platform for change.

13.42. Operational oversight of day-to-day working must also reinforce the cultural significance of a shared responsibility and we therefore recommend that each area establish a multi-agency operational sub-group of the Safeguarding Partners to direct operations, chaired by any of the three statutory partners. This group would direct the implementation of new Multi-Agency Child Protection Units in each area.

13.43. This group will give Safeguarding Partners a clear route to get intelligence about performance of the system locally, a way of holding operational leaders to account and a clear escalation route when issues affecting joint working cannot be resolved at the operational level.

Role of education in multi-agency arrangements

13.44. Schools, colleges and other educational settings have a pivotal role to play in protecting children. In seeing children every day, they are in a unique position to identify concerns early, to recognise when concerns are escalating, and to share key information with Safeguarding Partners. Where a child is on a Child Protection Plan, they have a lot to offer to help protect children from harm, for example, working with a child’s social worker to ensure that the child attends school.

13.45. For many vulnerable children, school is a place of safety and support. For Arthur, school was a positive place with staff who knew him well. They helped him develop his different interests and supported his wellbeing. Professionals also frequently have an insight into family life that would otherwise be unknown, through their contact with parents and carers. Arthur’s school was the last to have contact with his father in the days leading up to Arthur’s death. The critical role schools and other educational settings play is highlighted in previous reviews of serious incidents (Sidebotham *et al.*, 2016; CSPRP, 2021c).

- 13.46. At present, Working Together (2018) expects Safeguarding Partners to name schools, colleges and other educational settings as 'relevant agencies'. However, it is then for safeguarding partners to determine how they engage and involve educational settings overall, and individual institutions specifically, in their local arrangements. Whilst the Wood report (Wood, A. 2021) found that there was successful engagement of schools in most areas and examples of good practice, there were also issues with consistency and schools being 'kept out' of discussions. The Department for Education and Kantar Public report (2021) highlighted that schools can feel like an 'add-on' and are not always involved in feedback channels.
- 13.47. The Panel believes the involvement of schools, colleges and other education providers needs to be reconsidered and there must be full involvement of schools and education services at both the strategic and operational level. There is a compelling argument for their inclusion as a Safeguarding Partner. We recognise that this poses practical challenges (Wood, A. 2021). However, this is not insurmountable and it is vital that schools are given 'a seat at the table' (Children's Commissioner, 2022, p. 17). Doing so will strengthen educational settings' role in shaping child protection systems, including the critical sharing of data and the establishment of the proposed Child Protection Units. At the same time, it will ensure that they are consistently engaged as an equal partner at both an operational and strategic level and that they are held to account in the same way as other Partners.

Leadership development for Safeguarding Partners

- 13.48. One additional area where we think central Government action is needed is in relation to the support given to local leaders to develop in their role. Our final recommendation in this area is that a National Safeguarding Leadership Programme should be established for all Safeguarding Partners. Exercising leadership in a shared way is complicated. This is compounded by the fact that those leading the police, NHS and local authority in a local area have a wide portfolio of responsibilities and will not necessarily have had much experience of child safeguarding across their careers.
- 13.49. Therefore, we think it is critical that all Safeguarding Partners have access to a shared set of knowledge, as well as an opportunity to develop their leadership roles together. Leadership programmes such as the Directors of Children's Services programme (UPON), the Aspire Leadership development Programme offered by College of Policing and the NHS Leadership Academy programme all offer a range of resources, training and development to grow and strengthen leaders within their own professional parameters. We think there is a significant gap around support for

leaders to work across professions and organisations. There should be a bespoke leadership development programme for Safeguarding Partners to help to really unlock the potential of joint and equal responsibility, with each partner grounded in their own professional background but also understanding how to work together to set shared values and ambition for all those working with vulnerable children in need of help and protection.

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

- 13.50. The three key agencies involved in child protection are inspected by their own separate inspectorates – OFSTED for children’s social care, the Care Quality Commission for health and Her Majesty’s Inspectorate of Constabulary, Fire and Rescue Services (HMICFRS) for the police. However, inspecting services from a single agency viewpoint does not give a full picture of partner contributions to multi-agency arrangements. Alan Wood’s 2021 report on Safeguarding Partners found that single agency inspections provide only partial coverage of the effectiveness of the multi-agency arrangements, and therefore it is not clear how the three statutory partner organisations (as a group) are held accountable for their contribution to delivering effective and coherent multi-agency safeguarding arrangements (Wood, A. 2021).
- 13.51. To fill this gap, the Joint Targeted Area Inspection (JTAI) was developed. During a JTAI, OFSTED, HMICFRS, CQC and HM Inspectorate of Probation jointly inspect and report on the impact of local multi-agency safeguarding arrangements for children. The JTAI evaluates the quality and impact of the agencies’ leadership and local multi-agency safeguarding arrangements on practice with children in relation to the ‘front-door’ of child protection.
- 13.52. These joint child protection inspections do provide a more robust assessment of how police, probation, health, and children’s social care work together to help and protect children – but the number of inspections carried out and the span of child protection activity that is covered is limited. There are only around 10-12 JTAs per year, of which half focus on the ‘front door’ of child protection and the other half on particular themes. And JTAs do not look past the front door, at the way multi-agency partners are working together across the child protection response.
- 13.53. The Panel shares Sir Alan’s concerns that the current framework of single agency inspection with a very limited number of joint targeted area inspections is not sufficient to provide an up to date and comprehensive picture of how the system is operating. Against a backdrop of 135 partnerships an annual total of 5 or 6 JTAs looking at how well partners are working together to safeguard and protect children is not adequate. As a result, we lack a system wide picture of how well the multi-

agency area arrangements are operating, and there is a gap in how Safeguarding Partners are held to account.

- 13.54. Multi-agency inspection should play a stronger role in ensuring all areas are held to account for their multi-agency partnership working, both operationally and strategically. Multi-agency inspection needs to mirror and model sound multi-agency practice, and focus relentlessly on outcomes for children. This requires significant reform to the overall culture, commitment including resource commitment, models for working together, and frameworks for inspection in the medium term. We recommend that the inspectorates draw up proposals for a more genuinely integrated and comprehensive model of multi-agency inspection, adequately resourced by all partners, and integrated into the ongoing work of each inspectorate. This is likely to entail taking stock of the overall system of accountabilities for inspection so that individual and joint agency inspections are proportionate and scheduled carefully to avoid unnecessary impact on those delivering services.
- 13.55. However, in the shorter term there is a gap in our national understanding of the current baseline effectiveness of multi-agency arrangements. Therefore, we recommend the inspectorates undertake an initial thematic review of multi-agency arrangements in a number of areas, looking not just at the front door but at the multi-agency response across the child protection journey. We note the current suspension of HM Inspectorate of Probation in Joint Targeted Area Inspections during 2022/23. We recommend that this is reviewed for future years as the role and contribution of the probation service to multi agency safeguarding arrangements is extremely important.

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

- 13.56. One of the key findings of our review is about the impact multi-agency leaders are having on child protection practice. We understand that it is hard for Safeguarding Partners to benchmark their performance or learn from the best when there is very little information available about good practice.
- 13.57. The Panel's role in child safeguarding practice is through system oversight, learning and leadership in identifying national issues, encouraging local learning and influencing policy. Our focus has been to ensure that the learning from individual cases is reviewed systematically and disseminated locally and nationally to ensure recommendations bring about change and improvement. Our lens to do this has primarily been through the learning from serious incidents. We recognise the need to review this role, and consider again the scope and priorities of the National Panel. In particular, we recognise the need to facilitate greater sharing of learning

and insight about how agencies work well together to protect vulnerable children and especially the role of the safeguarding partners in facilitating this.

- 13.58. We know that peer support is highly valued by those that have used it and it can be powerful in providing support and challenge. For example, through the local authority sector-led improvement programme, a genuine partnership between local and central government has brought together the best practitioners and leaders in children's social care to improve the system leading to a greater understanding of the conditions needed for excellent practice to flourish. The investment has encouraged sector led improvement through peer support to authorities which need to improve.
- 13.59. The Local Government Association, in response to continuing demand from local authorities, have a number of peer reviews and diagnostics that have been designed to assist local authorities on their improvement journey. Local authorities have valued the co-produced methodology, challenge and advice. The College of Policing facilitates similar organisational support from peers to help understand issues, solve problems and try new initiatives. The support is inclusive, promotes diversity of thinking and is founded on the key principles of respect, shared responsibility and mutual agreement of what is helpful.
- 13.60. We think there is a role for the Panel to facilitate greater sharing of learning and insight across Safeguarding Partners in the way that already happens through a single agency lens. This can be done, in part, through the Panel's programme of national reports and reviews. But in addition, we believe the Panel should offer greater facilitation to enable Safeguarding Partners to learn from each other and provide more hands-on, practical support. There may also be scope to encourage and incentivise better self-assessments. This role goes beyond learning from when things go wrong to capturing the best practice that protects the most vulnerable children, for example, building on the Panel's six key practice themes found to make a difference in reducing serious harm and preventing child deaths from abuse or neglect (CSPRP, 2021c).
- 13.61. Therefore, we are recommending that a national peer support capability for Safeguarding Partners is developed. This should be overseen by the panel - working in partnership with all key stakeholders - so that it can aggregate and disseminate learning about effective practice, however, this work would necessarily and importantly be co led with all key stakeholders. This capability should be jointly funded by the Department for Education, Department for Health and Social Care and the Home Office. The peer support capacity would include the three national facilitators already working to support Safeguarding Partners, who would be joined

by a wider team of subject matter experts, analysts and researchers from health and mental health, policing, education, and social care.

13.62. The operation of this model needs to be worked through with partners but we see the role of the Panel as responsible for identifying good practice and common challenges faced by Safeguarding Partners across the country, and facilitating peer to peer support between Safeguarding Partners. They would also coordinate problem solving on common issues.

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

13.63. As well as improving local governance of child protection, we believe the way that child protection activity is overseen and coordinated at a national level also needs to be strengthened.

13.64. There needs to be clearer, stronger leadership and support from central government departments for local multi-agency safeguarding arrangements. At the moment there is no clear, joined up national oversight of the multi-agency child protection system, and as a result issues are often dealt with by one department in an ad hoc way. This leads to fragmented policy development and implementation. It also means there is no clear escalation route for issues impacting locally which need national action. The issues we have seen reflected strongly in our analysis, around workforce sufficiency, capability and capacity, are an example of this. There is no national cross government programme of action around these issues and as a result the performance of local areas is undermined.

13.65. Therefore, we believe that a new and more robust means of co-ordinating policy activity and of exercising oversight and accountability is needed at the national level.

13.66. We are recommending the establishment of a national Child Protection Board, bringing together all relevant central Government departments, local Government, the police, education and health representatives and others. The Board will have three roles:

- To oversee performance in the child protection system, spotting emerging issues, ensuring the delivery of reforms, and acting as the escalation route for issues which need resolving at the national level
- To develop a set of national operational standards for multi-agency child protection work; and

- To oversee and ensure delivery of multi-agency child protection units in all local authorities.

13.67. Whilst the core membership would be fixed, there should be scope to invite additional attendees for specific themes and issues. It will also be important to clarify how the National Panel should work with the new Board as a key source of system intelligence.

13.68. In order to carry out its role effectively, the new Child Protection Board will need to ensure it receives the right set of meaningful multi-agency data. It will use this alongside practice insight, inspection findings and insight from serious incident analysis to understand performance across the system. We think that there is potential for multi-agency data to play a bigger role in helping us to understand performance both locally and nationally, and for greater transparency around this data. However current data collections and the way that data is used does not serve this purpose. Therefore, we think an important function for the national Board will be to review this landscape and oversee the development of meaningful and incisive data collection. The Child Protection Board should be accountable to a new Ministerial child protection oversight group, bringing together Ministers from DfE, HO, DHSC and DLUHC. We recommend this group is chaired by the DfE Minister for Children and Families, as the department with the largest policy responsibility for child protection. The Ministerial Group should appoint an independent chair for the Child Protection Board, directly accountable to them.

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

13.69. There is one final specific area where greater national level coordination is needed. As part of the wider evidence work on the review, we convened a group of leading thinkers from the fields of data science, behavioural science and economics to give us insight into areas where learning from other sectors could be used to improve child protection responses across the country. The group concluded that:

- There is huge scope for better use of data and technological solutions in child protection and a need to ‘upgrade’ the digital landscape and innovate within it; but
- Any innovation needs to be done with the user (practitioner) and families in mind – thinking about how best to support practitioners to do their job rather than trying to replace professional judgement.

13.70. Over the course of this review, we have also heard from family members about the importance of digital improvements, with a national child database being suggested in order to make it easier to access information about children moving between agencies and areas. Similarly, professionals interviewed as part of the review have raised concerns about technical barriers to sharing information and the need for

change. These findings resonate with learning from other serious case reviews, for example, practitioners' lack of access to IT systems outside their professional role inhibiting information sharing and impacting upon accurate cross-service chronologies of a child and their family (CSPRP, 2021c). Conversely, through the wider evidence review we have heard about the potential of data to support practitioners when making decisions. For example, in the USA, the Allegheny Family Screening Tool was found to help identify children at heightened risk of physical harm (Vaithianathan *et al.*, 2020).

- 13.71. At the most fundamental level, to help protect children we need to ensure that when practitioners make decisions on crucial issues and under pressure that they are equipped with the best available information in a timely way and that this information is easy to understand. Various reports highlight the challenge of social workers and other practitioners making difficult decisions on the basis of incomplete and inconclusive information and the tension between making timely decisions and gathering and verifying information (Helm, D. 2017; Saltiel, D. 2016). Good data and technology is part of the solution and smarter data systems can help build up our system defences and reduce the potential for errors to occur (Reason, J. 2000). Effective data systems is something we already expect for professionals operating in other high risk contexts, for example, counter terrorism and aviation. We must now expect the same for professionals working to protect some of the most vulnerable in society.
- 13.72. Where central Government has put its weight behind technological improvements we have seen how it can yield results. For example, the Child Protection-Information Sharing system, which helps health and social care staff share information securely about vulnerable children, has already been rolled out to unscheduled healthcare settings and is now being expanded to scheduled healthcare settings – with a number of reported benefits.³⁷ Additionally, NHS Digital's investment in the Social Care Digital innovation Programme has funded a number of promising projects.³⁸ Cross-government work is also underway focussed on implementing a consistent identifier, following the commitment in the Health and Social Care Bill. The Panel welcomes this work, given its centrality to better information sharing, and urges that it moves at pace.
- 13.73. Whilst there has been positive progress, we believe a step change in the energy and investment targeted at this area and the innovation within it is needed. Building on the challenge group, we therefore recommend that the Secretary of State

³⁷ <https://digital.nhs.uk/services/child-protection-information-sharing-project/benefits-of-child-protection-information-sharing>

³⁸ [Social Care Digital Innovation Programme | Local Government Association; NHSX Technology and Digital Skills Review Main Report November 2021.pdf \(ipsos.com\)](#)

urgently convenes a task and finish group of high-profile data and technological experts from a range of sectors, and chaired by a child protection expert, to answer the question: 'How can we transform our use of data to better protect children?'. The group should report back to the Secretary of State by the end of the year on its findings including the scale, pace and nature of change required.

Recommendation 8: Specific practice improvements in relation to domestic abuse

- 13.74. In general, throughout this review, we have focused on recommendations for the overall child protection system framework and architecture. However, domestic abuse is one area which we consider to be in need of significant focused work given its prevalence not only in these cases, but across society. There are no simple and straightforward solutions for tackling domestic abuse, which is a complex and pervasive issue.
- 13.75. In order to develop this recommendation, we have taken our learning from the stories of Arthur and Star and combined this with the breadth of Panel evidence in this area. Of the rapid reviews seen by the Panel in 2020, domestic abuse was a factor in over 40% (CSPRP, 2021c). The Panel's Annual report for 2018-19 and previous triennial serious case review analyses further demonstrate the prominence of domestic abuse as a factor in child harm and death (CSPRP, 2020b; Sidebotham *et al.*, 2016; Brandon *et al.*, 2020). As such, the Panel commissioned a thematic review of multi-agency child safeguarding and domestic abuse. The learning from that report has fed into this report and the findings are aligned. The Panel will publish a practice briefing on safeguarding children in families where there is domestic abuse in Summer 2022, this will include more specific recommendations.
- 13.76. As our preceding recommendations outline, improvements must be made in developing the specialist skill and expertise of staff, and in information sharing between agencies. These two factors are relevant to all elements of child protection, but we believe the situation in relation to domestic abuse is so severe that these areas must be particularly strengthened for practitioners working with victims and perpetrators of domestic abuse. This work builds on the recently published Domestic Abuse Act and subsequent Victims Bill. We have also taken on board advice from the Domestic Abuse Commissioner on the work she is currently delivering.
- 13.77. Therefore, in line with recommendations 1, 2, and 3 we are calling for specific changes in relation to the way domestic abuse is approached in multi-agency safeguarding arrangements:

- Safeguarding Partners to improve how they work with specialist domestic abuse services by establishing stronger working relationships and clear information sharing protocols.
- Safeguarding Partners must be committed to, and fully invested in, the commissioning of DA services and ensure all staff have a robust understanding of what the DA support offer is in their area.
- Appropriate responses to domestic abuse should feature clearly in the new National Child Protection Practice Framework and training should be embedded across all Safeguarding Partners for all practitioners to ensure they provide a domestic abuse informed response.

Appendix A: Contributors to the review

We are very grateful to all of those that have dedicated time and provided perspectives that have shaped the Review.

For gathering information about Arthur Labinjo-Hughes' life and the involvement of key agencies with him and his family, we:

- Interviewed 5 family members
- Conducted 33 interviews with approximately 48 professionals

For gathering information about Star Hobson's life and the involvement of key agencies with her and her family, we:

- Interviewed 2 family members
- Interviewed 2 perpetrators
- Conducted 34 interviews with approximately 50 professionals

We also held a combination of in-person and virtual stakeholder sessions and roundtables with specific sectors to discuss the design and implementation of any recommendations.

Stakeholder organisations were as follows:

- | | | |
|---|--|---|
| - Action for Children | Young People's Mental Health Coalition | - Local Government Association |
| - ADCS | - College of Policing | - National Association of Head Teachers |
| - Association of School and College Leaders | - Coram | - National Children's Bureau |
| - Barnardo's | - Domestic Abuse Commissioner | - Network for Designated Healthcare Professionals |
| - Bedfordshire University TASP | - Essex Local Authority | - NHS England |
| - British Association of Social Workers | - Family Rights Group | - Nottingham Local Authority |
| - CAFCASS | - For Baby's Sake | - Norfolk Police |
| - Children's Society | - Institute of Health Visiting | |
| - Children and | | |

- NSPCC
- Office of the Children's Commissioner
- Pause
- Principal Social Worker Network
- Police Vulnerability, Knowledge and Practice Programme
- Relationships Alliance
- Royal Collage of GPs
- Royal Collage of Nursing
- Royal Collage of Paediatrics and Child Health
- School and Public Health Nurses Association
- Social Care Institute for Excellence
- Social Work England
- SOLACE
- The General Medical Council
- University of East Anglia
- UNISON
- West Mercia Police
- Wakefield Local Authority
- What Works Centre for Children's Social Care

Individuals with relevant expertise that were consulted:

- Professor, Andy Bilson (University of Central Lancashire) (Social Work, Birmingham University)
- Sir, Anthony Finkelstein (University of London) - Tim Leuning (London School of Economics/ HMT)
- David Halpern (Behavioural Insights Unit, Cabinet Office)
- David Maguire (The Kings Trust)
- Professor, Donald Foster (CASCADE Director, Cardiff University)
- Professor, Eileen Munro (London School of Economics)
- Dr, Jonathan Bright (Oxford Internet Institute)
- Lord Laming (CBE, PC)
- Professor, Paul Bywaters (Coventry University)
- Professor Harry Ferguson

Appendix B: Glossary of terms

Child Arrangement Order

A Child Arrangements Order (CAO) is an order that settles arrangements for a child or children that relate to the following: with whom the child is to live, spend time or otherwise have contact.

Child in need assessment

A 'child in need' assessment under section 17 of the Childrens Act 1989 will identify the needs of the child and ensure that the family are given the appropriate support in enabling them to safeguard and promote the child's welfare.

Child Protection

Part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

Domestic Abuse

Domestic abuse can encompass a wide range of behaviours and may be a single incident or a pattern of incidents. Domestic abuse is not limited to physical acts of violence or threatening behaviour, and can include emotional, psychological, controlling or coercive behaviour, sexual and/or economic abuse. Types of domestic abuse include intimate partner violence, abuse by family members, teenage relationship abuse and adolescent to parent violence. Anyone can be a victim of domestic abuse, regardless of gender, age, ethnicity, socio-economic status, sexuality or background and domestic abuse can take place inside or outside of the home. (Working Together, 2018)

Emergency Duty Team (EDT)

Provides an emergency out of hours social work response to concerns relating to both Children and Adults as well as providing an out of hours Approved Mental Health Practitioner response where mental health concerns have been identified. They then pass their work over to the day teams for them to carry on the work as required.

Level 3 Support (Solihull)

Solihull Local Safeguarding Children Partnership has published guidance to help professionals make judgements about levels of need for children (often referred to 'thresholds'). There are four levels of need, with Level 4 representing children who require statutory intervention as they are in need of protection. The threshold at Level 3 was for children requiring early help, which would include mental health support.

Looked After Child

A child is looked after by a local authority if they are provided with accommodation for a continuous period of more than 24 hours; are subject to a care order or are subject to a

placement order.

The MASH/ Integrated Front Door

Provides a contact point for members of the public or professionals if they have a concern about a child or young person. It enables partner agencies such as Social Care, Police, Education, Health and Housing to share information, knowledge and skills to enable the right decisions to be made for a child, so that support is identified and put in place at the right time for a child to be safeguarded and protected. In Bradford this was referred to as the Integrated Front Door, in Solihull this was referred to as the MASH.

Pre-birth assessment

Pre-birth assessment is a proactive process for analysing the potential risk to a new-born baby when there are concerns that would fall within the definition of children in need about a pregnant woman and/or the birth father and, where appropriate, her partner and immediate family.

Safeguarding Partner

A safeguarding partner in relation to a local authority area in England is defined under the Children Act 2004 as: (a) the local authority, (b) a clinical commissioning group for an area any part of which falls within the local authority area, and (c) the chief officer of police for an area any part of which falls within the local authority area. The three safeguarding partners should agree on ways to co-ordinate their safeguarding services; act as a strategic leadership group in supporting and engaging others; and implement local and national learning including from serious child safeguarding incidents. To fulfil this role, the three safeguarding partners must set out how they will work together and with any relevant agencies as well as arrangements for conducting local reviews.

Section 47 enquiry

If a local authority identifies there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm, it will carry out an assessment under section 47 of the Children Act 1989 to determine if it needs to take steps to safeguard and promote the welfare of the child. (IRCSC, 2021).

Strategy Discussion

Strategy discussions are part of the local arrangements for how cases are managed once a child is referred into local authority children's social care. Whenever there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm there should be a strategy discussion involving children's social care, Police, Health and other relevant agencies. The purpose of the discussion is to determine a child's welfare and plan rapid future action if there is reasonable cause to suspect the child is suffering or likely to suffer harm. For further details, see *Working Together to Safeguard Children 2018*, pp. 39 – 41.

Threshold Visit (Solihull specific)

Threshold Visits were single agency visits undertaken by duty social workers in the MASH in circumstances where children were not deemed to be at immediate risk and managers

needed more information to determine whether the threshold had been met for a social work assessment to be initiated.

Appendix C: Bibliography

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