## **Remembering Arthur and Star**

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#### Aims and objectives

- Summarise the findings of the national review
- Apply the learning to local practice and key messages for Swindon.
- Consider if this could happen in Swindon?
- Identify how we apply changes to our own practice based on the learning from today, to improve outcomes for children in Swindon



#### **Child Safeguarding Practice Review Panel**

- Children and Social Work Act 2017
- Independent and Multi-agency
- Commissions reviews of serious child safeguarding cases
- Reviewed all rapid reviews and CSPRs (case reviews) from local authorities nationally
- Focus on improving learning, professional practice and outcomes for children



## Methodology

- Chronology and significant events Key Practice Episodes (KPE)
- Reflective conversations with professionals; family members; perpetrators (Frankie Smith and Savanah Brockhill)
- 1,500 other rapid reviews, 30 of which featured poor management of risk and decision making
- Behavioural insights considered how decisions in other high risk environments Behavioural Insights Team to consider how behavioural science might inform decision making in CP practice





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.



#### **Arthur and Star's Lived Experience**

Consider:

Where are the **key critical points** and/or the **missed opportunities** 



### Chronology - table top exercise

Having heard Star and Arthur's stories, in your groups, discuss :

- The missed opportunities
- The key critical points
- Where could professionals have intervened?



#### **Arthur and Stars Lived Experience**





# Break for 15 mins



#### **Key Practice Episodes - Arthur**



KPE 1 {	<ul> <li>Support for Arthur to deal with the trauma of his mother going to prison</li> </ul>
KPE 2 {	<ul> <li>Response to domestic abuse incident between Thomas Hughes and Emma Tustin</li> </ul>
$\mathbf{KPE3}\bigg\{$	<ul> <li>a) Response to referral from Arthur's paternal grandmother</li> <li>b) Home visit and after</li> </ul>
KPE 4 {	<ul> <li>Response to photographs of bruising on Arthur</li> </ul>
KPE 5 {	<ul> <li>Understanding the role and impact of Emma Tustin after Thomas Hughes and Arthur move to live with her from March 2020</li> </ul>
KPE 6 {	<ul> <li>Contact with Arthur and the wider family by school and other agencies March - June 2020</li> </ul>

#### **Key Practice Episodes - Star**



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

## **Key findings:**

- Weakness in information sharing and seeking within and between agencies no clear picture of what was happening Maria Colwell; Tyra Henry; Peter Connelly, Victoria Climbe.
- Family concerns not listened to and too much taken at face value
- Lack of robust critical thinking and challenge professionals views became fixed Father was protective; family being malicious
- Failure to trigger statutory multi-agency CP processes SD not held; CP Medical
- Sharper specialist child protection skills and expertise
- Leaders' responsibilities to create conditions for this complex work.



#### **Recommendations:**

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



#### Recommendations:

- Core recommendation:
  - Develop a new approach to undertaking child protection work
- Eight further recommendations:
  - A new expert led, multi agency model for child protection investigation, planning, intervention and review
  - Establishing National Multi- agency Practice Standards
  - Strengthening the local Safeguarding Partners to ensure proper co ordination and involvement of all agencies



## **Eight further recommendations cont.:**

- Changes to multi agency inspections to better understand local performance and drive improvement
- A new role for the Child Safeguarding Practice Review Panel in driving practice improvement in Safeguarding Partners
- A sharper performance focus and better co ordination of child protection policy in central Government
- Using the potential of data to help professionals protect children
- Specific practice improvements in relation to domestic abuse



# Local Reviews and Rapid reviews - What we know in Swindon

- 1. LCSPR Babies with injuries- information sharing
- 2. LCSPR Bella and Ben January 2023
- 3. LCSPR Alan March 2023

Rapid Reviews – understanding of DA in the wider context of violence families; information sharing; reassessing new families; speed at which child's life can change



#### Systems Framework



#### Framework table exercise

On your tables you will see one of the System Frameworks:

- Systems and Processes
- Practice and Practice Knowledge
- Leadership and Culture
- Wider Service Context



#### SYSTEMS and PROCESSES

(including key decision points on continuum of care pathway, sharing information and use of specialist assessment)

Appropriate information sharing and seeking – the full picture of what is happening in a child's life – timely and appropriate information sharing ; information seeking

Critical thinking and challenge within and between agencies

**Behavioural Biases-**

**Diffusion of responsibility** 

Source Bias

**Confirmation Bias** 

**Risk aversion** 

Critical Thinking and Challenge within and between agencies

#### PRACTICE and PRACTICE KNOWLEDGE

(incorporating the Panels "Key Practice Them to make a Difference")

Understanding a child's daily life and where this might not be straight forward

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

Specialist Skills and Expertise for working wit families whose engagement is reluctant or sporadic

Woking with diverse communities

Appropriate responses to DA

Specialist skills and Expertise for undertaking child protection investigations

#### LEADERSHIP and CULTURE

Leaders create the operating context in which child protection decisions are taken – at a strategic level – clarity of vision; responsibilities and resources; robust governance; a culture of learning, improvement and challenge.

Laming 2003 – it is the vital necessity of CS Leaders to have their 2finger on the pulse" about the quality and effectiveness of child protection practice.

Leaders create a learning culture within which reflective supervision can take place and thrive

#### WIDER SERVICE CONTEXT

Effective risk assessment and decision making in Child protection is affected by:

Workforce development – recruitment and retention

Social Work and Health Visitor case loads

Access to mental health services

Funding levels and the strategic use of fundir to invest in family support services

Impact of wider socio-economic and matchin priorities to resources.

# Review the framework and answer these questions

- Does this describe Swindon?
- What do we do well?
- What do we need to change and how we might achieve this?



# Exercise Feedback some key themes?



#### **Message** to practitioners from National Panel

- Those working in frontline practice undertake one of the most onerous and complex of public services
- The media do not understand it is important that we recognise those children who are protected from harm by you and to thank you for what you do everyday, 24 hours a day over holidays, during Covid and that you go beyond what is expected of you.
- Thank you



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#### DfE implementation documents for consultation

#### Links to consultation events and an online consultation survey:

<u>Children's social care strategy: Stable Homes, Built on Love - Department for</u> <u>Education - Citizen Space</u>

<u>Children's Social Care National Framework and Dashboard - Department for</u> <u>Education - Citizen Space</u>

<u>Child and Family Social Worker Workforce - Department for Education - Citizen</u> <u>Space</u>



## Thank you

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