City of BRADFORD METROPOLITAN DISTRICT COUNCIL

Report of the Chief Executive Office to the meeting of Council Executive to be held on 7th June 2022

Subject: National Review into the murders of Arthur Labinjo-Hughes and Star Hobson

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Summary statement:

Following the tragic deaths of Arthur Labinjo-Hughes in Solihull in June 2020, Star Hobson in Keighley, Bradford in September 2020, and the subsequent two murder trials and convictions in December 2021 of their parents and partners, a national review of learning from the two cases was initiated.

The review was undertaken by the national independent Child Safeguarding Practice Review Panel. This panel commissions reviews of serious child safeguarding cases, focusing on improving learning, professional practice and outcomes for children, based on the possibility of identifying improvements from cases that it views as complex or of national importance.

The review's primary focus was to try and understand how and why public services and systems designed to protect children were not able to do so. The review looked in detail at service responses to the two children's experiences, to make sense of what can be learned and must do differently in the future locally and nationally. The review, published on the 26th of May 2022 has six local and eight national recommendations. This Executive report focuses primarily on the national and local recommendations in respect of Star Hobson.

EQUALITY & DIVERSITY:
This case highlights the role of hidden partners and in particular women in perpetrating crimes against children**.**

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Portfolio:

Children and Families

Overview & Scrutiny Area:

Children`s Services

1. SUMMARY

1.1 Following the tragic deaths of Arthur Labinjo-Hughes in Solihull in June 2020, Star Hobson in Keighley, Bradford in September 2020, and the subsequent two murder trials and convictions in December 2021 of their parents and partners, a national review of learning from the two cases was initiated.

1.2 The review was undertaken by the national independent Child Safeguarding Practice Review Panel (the Panel). The Panel are an independent panel that commissions reviews of serious child safeguarding cases, focusing on improving learning, professional practice and outcomes for children. Their purpose is to oversee the identification of learning from cases that it views as complex or of national importance.

1.3 The Panel is appointed by the Secretary of State for Education but its independent from Government. The Panel has experienced members representing the Statutory partners of Social Care, Police Criminal Justice, and Health who are supported by other experts.

1.4 The review's primary focus was to try and understand how and why public services and systems designed to protect children were not able to do so in these two cases. The review looked in detail at service responses to the two children's experiences and to make sense of what can be learned and must do differently in the future locally and nationally.

1.5 The review has six local recommendations in respect of Star Hobson and eight national recommendations all of which are detailed in full in the report.

2. BACKGROUND

2.1 The issues that emerge in both these cases are distressing to read and in particular demonstrate that significant learning was needed, and that both children had not been kept safe.

2.2. It is important to remember that Star was killed by the people who should have been there to protect her. Savannah Brockhill was convicted of the murder of Star Hobson and jailed for a minimum of 25 years.

2.3 Frankie Smith, the mother of Star Hobson was found guilty of allowing or causing the death of Star. She was sentenced to eight years in prison, which was increased to 12 years after being referred to the Court of Appeal by the Attorney General for being “unduly lenient.

2.4 **Methodology:**
The methodology used by the Panel in determining this review was not to undertake two individual child safeguarding practice reviews in relation to Arthur and Star, but to apply learning from the deaths of these two children to the national system.

2.5 The Panel`s key working principles were to draw on its independent national role to analyse robustly and objectively the effectiveness and quality of safeguarding systems, processes, policy and professional behaviours.

2.6 Recommendations are evidence based and drawing upon Panel experience and research.

2.7 The Panel engaged key organisations and representative bodies at relevant points of review. This included appropriate engagement with the Independent Review of Children`s Social Care (MacAlister Review) which was published on Monday 23rd May 2022

2.8 **National Learning**:
In analysing what happened to Arthur and Star, and how agencies responded, the Panel identified a set of issues which hindered professionals understanding of what was happening to both children.

2.9 The review acknowledges that these issues are not uncommon and have been identified from the analysis of Serious Case Reviews and other thematic practices review including all previous inquiries into child deaths.

2.10 There are eight national recommendations. These recommendations are set out in full in the review but can broadly be grouped into key areas of action.

- Weakness in information sharing and seeking
- A lack of robust critical thinking and challenge within 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

2.11 **Learning from the death of Star**
The review identifies 6 key practice episodes where professionals were directly involved with Star and her family which affected outcomes for her.

These were
- Identifying risk in pre-birth and post birth period
- Referral from domestic abuse services
- Concerns about Savannah Hill`s care of Star and domestic abuse of Frankie Smith
- Bruises of Star and child protection medicals
- Repeated Concerns about Star from friends and family
- Submission of Video material of Star with bruises

2.12 Recommendations to Bradford
The review sets out six key recommendations for the partnership in Bradford.

. 1. To review strategic and operational responsibilities as recommended nationally by this review, including making sure that there is a good understanding of learning from the review, good oversight of performance and that priorities are agreed,

2. To 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
    - 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

3. To 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

4. To 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.
5. To 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.
6. To 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.

2.13 National Recommendations

The review also identified eight national recommendations which are being shared for action with all local authorities

1. A new expert-led, multi-agency model for child protection investigation, planning, intervention, and review.
2. Establishing National Multi-Agency Practice Standards for Child Protection.
3. Strengthening the local Safeguarding Partners to ensure proper co-ordination and involvement of all agencies.

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

2.14 Action in Bradford

Action has already been taken by the partners in Bradford to address issues identified in relation to the death of Star Hobson. These are set out below. The Partnership are working at pace to update the action plan to include the full set of recommendations from the national panel.

2.15 Partnership actions already undertaken.

2.16 Since the criminal trial and the Children`s Commissioners report, Children Services, West Yorkshire Police and Health Care services have taken action to respond to recommendations and to provide for the wellbeing and safety children in Bradford.

2.17 Bradford is working alongside the Government appointed Children's Commissioner to make significant changes in how social workers work in the district. Bradford is in the process of setting up a Children's Trust which will deliver further changes needed to make at pace to make sure children in our district are safe.

2.18 The Safeguarding Partnership, the Children's Commissioner and Chair of the improvement board are reviewing arrangements including governance and performance to ensure actions are taken and that agencies are held to account.

2.19 Development of Bradford`s Early Help Offer has been accelerated and training has been delivered to frontline practitioners. Five locality based Early Help Hubs in which statutory partners and commissioned services will be co-located with a specific remit of ensuring a safety net of early interventions is in place

2.20 Focussed work is underway to revise protocols and train staff in relation to assessing risk, sharing information and provide quality supervision of social workers. Review and action is being taken on all statutory multi-agency processes used to keep children safe including child protection medicals, strategy discussions and Section 47 enquiries.

2.21 Bradford District Care NHS Foundation Trust (BDCFT) and Airedale NHS Foundation Trust (ANHSFT) have introduced new process, guidance and training for Pre-birth, maternity and antenatal safeguarding. This includes ensuring that the offer of Early Help assessment is considered at any stage in pregnancy and that routine enquiry in relation to domestic abuse is embedded. Alongside this, additional bespoke training is being developed for General Practitioners.

2.22 All agencies are progressing training for staff in relation to disguised compliance and professional curiosity. The programme includes mandatory training for all children`s social care staff.

2.23 Systems, process and training have been reviewed and refreshed by CSC to ensure all agency staff can complete chronologies or prior concerns.

2.24 Specific training has been delivered to the CSC and Health care staff on coercive and

controlling behaviours in relationships and the impact on children learning, hidden partners and diversity.

2.25 Within CSC guidance has been provided to all managers about the oversight of key points in a child`s journey and an audit is being used to focus on improvement.

2.26 West Yorkshire Police has undertaken a review of Safeguarding and is in the process of delivering the key recommendations. This includes uplifting resources within the Safeguarding Units and taking action around training and accreditation.

2.27 New referrals processes adopted by Bradford Police in February 2022 are live across the other four policing areas (Calderdale, Leeds, Kirklees & Wakefield) in respect of child protection.

2.28 West Yorkshire Police have introduced a Neglect toolkit which can be drawn upon by practitioners from all agencies to identify and effectively respond to cases of neglect.

2.29 West Yorkshire Police Safeguarding specialist functions has increased the implementation of Digital Media Investigators. Digital media was a significant source of information during the investigation of Star`s murder.

3. OTHER CONSIDERATIONS

3.1 There are no other considerations.

4. FINANCIAL & RESOURCE APPRAISAL

4.1 Additional investments have been agreed for Children's Services.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

5.1 The protection of Children is the highest priority for the Council and its partners when considering the implications of abuse, as is the provision of services to support those who are victims of this abuse. Failure to protect and provide appropriate services significantly increases the risk to children in the district. It would lead to significantly reduced public confidence in Bradford Council, West Yorkshire Police, the Health economy and other partners, as has been demonstrated nationally.

6. LEGAL APPRAISAL

6.1 There are no direct legal implications arising from this report, in that it does not impose any additional legal duties or obligations on the Council. Rather, it provides recommendations for improvement of services, many of which have either already been adopted by agencies, or which will be incorporated into the future working practices of those agencies in the exercise of their statutory duties.

7. OTHER IMPLICATIONS

None

7.1.1 SUSTAINABILITY IMPLICATIONS

7.11 None

7.1.2 GREENHOUSE GAS EMISSIONS IMPACTS

7.21 None.

7.1.3 COMMUNITY SAFETY IMPLICATIONS

. Community concern in relation to the death of Star has been significant.

7.1.4 HUMAN RIGHTS ACT

7.41 Sexual and Criminal Exploitation is a violation of the rights of the child/adult under the Human Rights Act. The multi-agency partnership arrangements are intended to prevent the rights of the child/adult being violated in this way

7.5.1 TRADE UNION

7.51 None

7.5.2 WARD IMPLICATIONS
None

7.7 AREA COMMITTEE ACTION PLAN IMPLICATIONS
(for reports to Area Committees only)

N/A

7.8 IMPLICATIONS FOR CHILDREN AND YOUNG PEOPLE

The recommendations of this review all relate to children and young people and will be actioned at pace as part of a revised action plan. This review will be shared with the Corporate Parenting Panel, who will look at the implications of the recommendations in relation to children who are looked after. This will include looking in detail at the recommendations about care leavers and pregnancy pathways for teen parents.

7.9 ISSUES ARISING FROM PRIVACY IMPACT ASSESMENT

7.10 The nature of child protection work requires partners to manage confidential matters and data under GDPR regulations in accordance with individual agency guidelines. There is no sensitive data included in this report that requires a Privacy Impact Assessment None.

8. NOT FOR PUBLICATION DOCUMENTS

None

9. OPTIONS

9.1 None

10. RECOMMENDATIONS

10.1 There is nothing more important than getting services right for children young people in the district.

The Council Executive commit to working closely with the partners to deliver on every one of the recommendations within the developmental action plan, and progressing at pace the extensive wider work underway across the partnership.

11. APPENDICES

The National Panel Review

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1078488/ALH_SH_National_Review_26-5-22.pdf