THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Child Safeguarding Practice Review Panel

Webinar slides

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

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The Child Safeguarding Practice Review Panel

The national Child Safeguarding Practice Review Panel is an independent body that was set up to identify, commission and oversee reviews of serious child safeguarding cases.

It brings together experts from social care, policing, health, education and the third sector to provide a multi-agency view on cases which they believe raise issues that are complex, or of national importance.

Methodology and context of the review

Arthur Labinjo-Hughes:

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

Star Hobson:

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

National review phases of work:

Phase 1 :

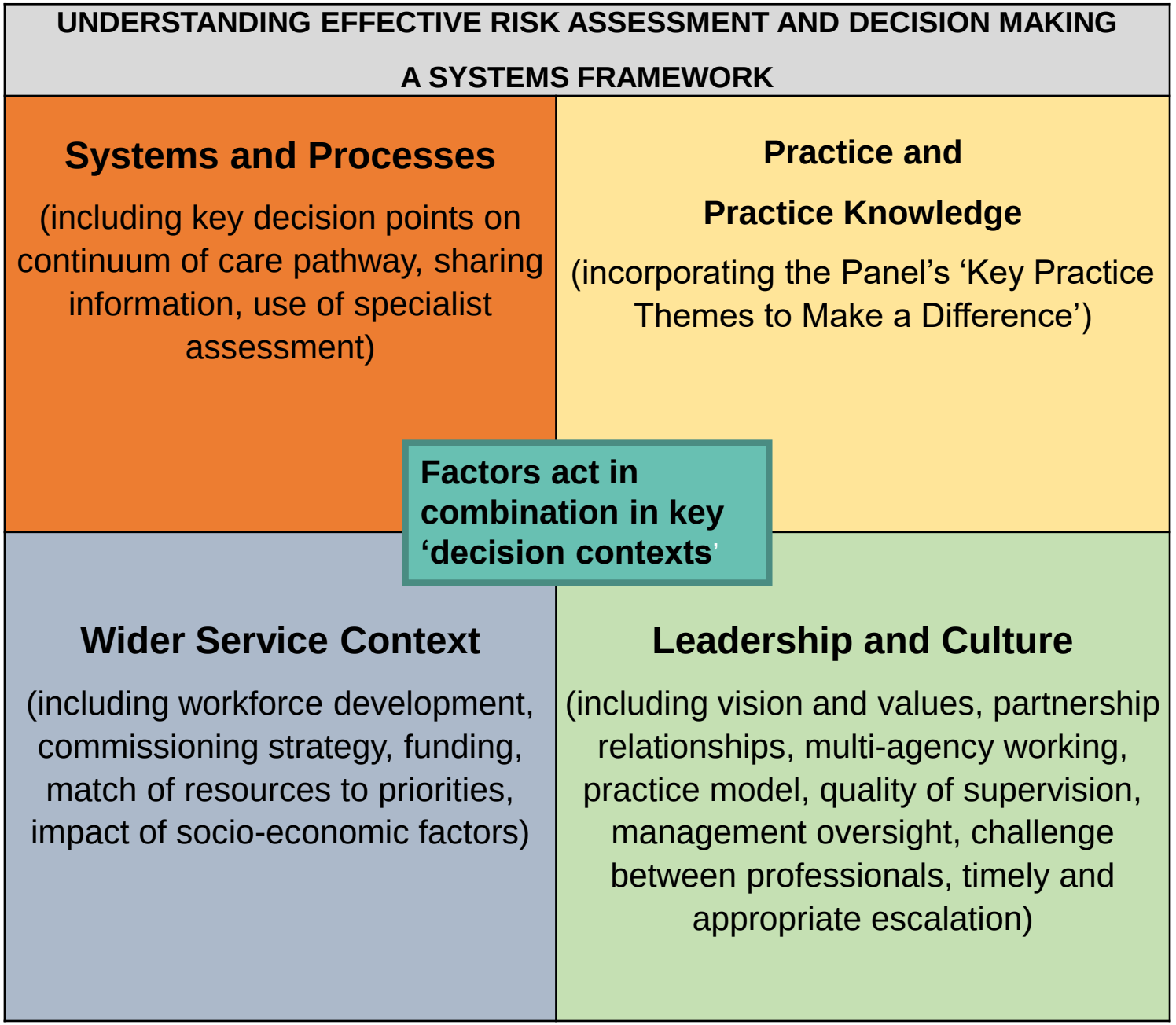
- Chronology
- Significant events and 'Key Practice Episodes'

Phase 2 :

- Interviews and reflective conversations inc. with family members and professionals
- Wider evidence and data: rapid reviews, wider research and data analysis
- Risk assessment and decision making review
- Challenge group and behavioural insights work
- Engaging stakeholders

Phase 3 :

- Recommendations and report development


UNDERSTANDING EFFECTIVE RISK ASSESSMENT AND DECISION MAKING
A SYSTEMS FRAMEWORK
Systems and Processes
(including key decision points on continuum of care pathway, sharing information, use of specialist assessment)
Practice and
Practice Knowledge
(incorporating the Panel's 'Key Practice Themes to Make a Difference')
Factors act in combination in key 'decision contexts'
Wider Service Context
(including workforce development, commissioning strategy, funding, match of resources to priorities, impact of socio-economic factors)
Leadership and Culture
(including vision and values, partnership relationships, multi-agency working, practice model, quality of supervision, management oversight, challenge between professionals, timely and appropriate escalation)

Key findings

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

Key findings – why do these issues persist?

- Protecting children from abuse is intrinsically complex and challenging work.
- 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.
- Skill in blending 'care' and 'control' functions.
- Asking professionals to get to the truth of what life is like for children.

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.

There is a need to strengthen national and local frameworks and systems

The review process (lessons learned)

- Diverse team of reviewers
- KPE approach
- Utilising a system framework
- Six-month timeframe

Engagement with families

- Highly sensitive
- Building on family engagement in LCSPR
- Formal written invitation and in person interviews – panel member and reviewer
- Focus on perspective about services
- Engagement with perpetrators through MoJ and prison governors provided unique insight

Interviews with professionals

- Professional interviews - frontline professionals, former employees and a range of other colleagues
- Largely individual but some group conversations –no longer than an hour, undertaken on ‘Teams’
- Framed as conversation with a purpose - not witness statements

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

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

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 leadership.

National recommendations

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.

Thank you!

Communications:

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