

Arthur



National Review Briefing

- The Child Safeguarding Practice Review Panel is an independent body who oversee all statutory case review activity
- Given the similarity of the cases, the severity of harm and the death of both children, and because they happened so close together, the panel decided to undertake a national safeguarding practice review
- The purpose of the review was to analyse the circumstances leading up to Arthur's and Star's deaths and to explore why the safeguarding processes designed to keep them safe, failed
- The review identified that the experiences of Arthur and Star in their short lives were not unusual and therefore made a number of local and national recommendations

[Link to the National review into the murders of Arthur Labinjo-Hughes and Star Hobson - GOV.UK \(www.gov.uk\)](#)



Star

- Star was just 16 months old when she was murdered by her mother's partner in September 2020. Her mother began a relationship with Savannah Brockhill in October 2019. Savannah was a known perpetrator of domestic abuse
- Concerns were raised by professionals in January 2020 about the relationship and physical chastisement of Star. The case was closed
- Family members described Star as looking sad and depressed and made a referral to children's social care. another referral followed in response to a video showing Star with bruising
- Star's mother and Savannah acted to prevent professionals from seeing Star
- At the time of her death Star had numerous injuries including a fracture to her skull

- Arthur was just six years old when he died in June 2020 as a result of injuries sustained from abuse by his father's partner
- Prior to his death no significant concerns had been raised by professionals. His mother was imprisoned in 2019 for the manslaughter of her partner and Arthur lived with his father
- In 2019 Arthur's father began a relationship with Emma Tustin
- Arthur's grandparents contacted services with concerns about bruising to Arthur
- On 16 June 2020 emergency services attended the family home and found Arthur with bruising. He later died of his injuries

Key Findings

- Professionals only had a limited understanding of what daily life was like for Arthur and his voice was not heard
- Arthur's father was seen as a protective factor, and this view did not change because too many assessments relied on his view
- no proper consideration was given about the risks to Arthur arising from the move to live with Emma Tustin
- Arthur's wider family were not listened to
- Child protection procedures did not include practice guidance about allegations of physical abuse
- The lack of multi-agency strategy discussion undermined the response to concerns about bruising to Arthur
- Joint working and joint decision making were both very poor which led to poor assessments and ineffective multi-agency working



Key Findings

- Professionals only had a limited understanding of what daily life was like for Star
- Decision making reflected the volume of activity rather than information sharing
- Assessments did not explore the family context
- Star's wider family members were not listened to
- Children's social care was beset with structural and workforce issues
 - Domestic abuse was not considered as part of single assessments and therefore was not understood
 - Assessments within children's social care were not fit for purpose and did not enable the identification of risks to Star
 - The response to referrals were weakened by a lack of formal processes, particularly strategy discussions