Education and Children's Social Care Overview and Scrutiny Committee

Date of meeting:	14 September 2022
Title of Report:	**National Review into the murders of Arthur Labinjo-Hughes and Star Hobson, National Panel**
Lead Member:	Councillor Charlotte Carlyle (Cabinet Member for Education, Skills and Children and Young People)
Lead Strategic Director:	Sharon Muldoon (Director for Childrens Services)
Author:	Karl Knill and Jean Kelly
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Your Reference:	Click here to enter text.
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
This briefing summarises key learning from the National Review into the murders of Arthur Labinjo-Hughes and Star Hobson and reflections on the actions taking in Plymouth to consider and implement key learning.

Recommendations and Reasons

For information and discussion

Alternative options considered and rejected
Not applicable, for information

Relevance to the Corporate Plan and/or the Plymouth Plan
For information

Implications for the Medium Term Financial Plan and Resource Implications:
Not applicable

Financial Risks

Not applicable, for information

Carbon Footprint (Environmental) Implications:
Not applicable, for information

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:

** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*

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Appendices

**Add rows as required to box below*

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	**2**	**3**	**4**	**5**	**6**	**7**
A	Briefing report title							
B	Equalities Impact Assessment (if applicable)							

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are unpublished works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	**2**	**3**	**4**	**5**	**6**	**7**

Sign off:

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Originating Senior Leadership Team member: Jean Kelly

Please confirm the Strategic Director(s) has agreed the report? Yes

Date agreed: 03/09/2022

Cabinet Member approval: *Councillor Charlotte Carlyle*

Date approved: 05/09/2022

Introduction

Following the high-profile deaths of Arthur Labinjo-Hughes and Star Hobson, the government requested that the National Child Safeguarding Practice Review Panel (National Panel) undertake a review of those deaths and more broadly, of the way we undertake Child Protection in England.

The full report can be found here - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1078488/ALH_SH_National_Review_26-5-22.pdf.

Findings

The report was published in May 2022 and identified a number of issues within Solihull and Bradford as well as broader, national issues for consideration by other safeguarding children partnerships and the government. These concerns included:

- Poor information sharing within and between agencies – for example, social care and health colleagues not sharing concerns between them, meaning nobody had 'the full picture' of concerns for a particular child.
- Lack of robust critical thinking and challenge within and between agencies – for example, where an agency disagrees with a decision by children's social care not to assess a child, they should be formally offering and recording that challenge, in the spirit of getting it right for children.
- A failure to trigger statutory child protection processes at the appropriate time – for example, if a child has an injury that is suspected to have been caused by a parent/carer, there is a legal framework for the processes that should be initiated, however this isn't always happening.
- The need for specialist child protection skills and experience to support complex risk assessment and decision-making – for example, it may be that all colleagues involved in child protection decision making should be qualified for a certain period of time, such as five years.
- Challenges in working with reluctant parents – for example, are colleagues as creative as they could be around support parents to engage with services and do they take robust action where, despite best efforts, this still has not been possible.
- Not understanding the lived experience of children – for example, relying on the self-reporting of parents/carers without undertaking direct work with children themselves.
- Poor understanding and response to domestic abuse – for example, not fully understanding the nature of coercive control and therefore the impact that will have on a parent's ability to act in the best interests of a child.
- Leaders needing to create the right organisational conditions for undertaking complex child protection work – for example, having regular, protected and reflective supervision that enables colleagues to explore what they see, hear and feel in a particular family.

The report noted that many of these are recurring themes, within national and local reviews, across the country and over an extended period.

Seeking assurance

The report noted some key messages for local safeguarding children partnerships to seek assurance on from each partner agency within the partnership:

- Are strategy meetings always being held when they should be? Strategy meetings are the forum for professionals involved with the family, to share information and make a decision about the risk of harm to a child, including the development of an immediate safety plan. These meetings are chaired by children's social care.
- Are sufficient resources in place to allow for multi-agency engagement in child protection processes (strategy meetings, section 47 enquires, child protection conferences)?
- Is there a robust information sharing arrangement in place across the Partnership?
- Are 'malicious' referrals considered fully, including making contact with the person making the referral?

Following the publication of this report, the Plymouth Safeguarding Children Partnership board meeting considered the findings and agreed that it would be a timely opportunity for the Partnership to review its arrangements and identify any changes that might be needed to ensure the most effective safeguarding arrangements are in place.

In September, the Partnership Board members will be meeting again to discuss and agree an assurance plan that has been put together and proposed by the three statutory partners (local authority, police and health). The assurance plan lists a range of potential concerns or risks and seeks to understand if it is a concern or risk for us here, in Plymouth. Any concerns or risks identified will then have actions to resolve them and provide assurance. We anticipate that a number of elements will promptly have assurance provided and need no further action. Other elements are likely to require further action to achieve that assurance. An extra-ordinary Partnership Board meeting is being proposed for late October or early November, in order to ensure rapid action is taken to make the necessary improvements.

We are undertaking this work with the assurance plan, with urgency, to provide confidence that we are all working together as effectively as possible to keep children safe and that we are able to evidence this, to ourselves and others.

Awaiting a government response

Within the report, there are some proposals for a much larger change to the way child protection is undertaken in England. These changes include:

- A new model of multi-agency child protection to investigate, assess, plan and intervene where children are at risk of significant harm. This is to include new multi-agency teams alongside a new framework for child protection and multi-agency practice standards.
- Improvements to the way MASH (multi-agency safeguarding hubs) operate to improve the quality and consistency of them across the country.
- Improvements to the way local safeguarding children partnerships are structured, including improved involvement of education colleagues and ensuring the partnership takes a leadership role in developing child protection practice in its local area.
- Ensure that national inspectorates, such as OFSTED, pay greater attention to multi-agency partnership working when undertaking inspections.
- National Panel to have a greater role in driving practice improvements across safeguarding partnerships.

- A national child protection board to be established to ensure effective cross-government working that provides stronger leadership and support to safeguarding arrangements.
- A review of how data could be better used to protect children.
- For domestic abuse to have specific attention, in terms of guidance, training and the commissioning of domestic abuse services.

These changes would require the support of national government and legislative changes. The government has said it intends to respond to these recommendations by the end of the year.

Recent changes in Plymouth

Working Together to Safeguard Children (2018) set out the changes from local safeguarding children boards to a different, partnership arrangement. The Plymouth Safeguarding Children Partnership was formed in late 2019 (originally a joint arrangement with Torbay) with the expectation that the arrangements would be regularly reviewed and adapted as we and others learnt what worked and what didn't, locally and nationally. Within a few months of the partnership forming, the Covid-19 pandemic resulted in all agencies, focusing on emergency planning to work together to provide some very immediate support to children and families. Over the past year, as we've emerged from that emergency phase and moved back to something that is closer to business as usual, we've taken the opportunity to review the arrangements in place and have already begun making changes, a number of which link to the National Panel recommendations, including:

Education – we identified in late 2021 that education colleagues needed a stronger voice within the partnership to ensure they were heard as well as ensuring appropriate support and challenge was offered to them, in their key role with children and families. This led to the establishment of the Safeguarding in Education Reference Group (SERG) and ensuring we have an education colleague on all subgroups. In recent months education colleagues have worked with other partners to think about how we better support children that are missing education or electively home educated. They have also been instrumental in developing the Adolescent Safety Framework.

We welcome the National Panel focus on how we can better involve education colleagues and ensure they are an equal partner in future safeguarding arrangements, taking into account the way much of education is now structured through multi-academy trusts.

Data – we identified in spring 2022 that that our multi-agency data set needed a refresh to be more priority focused and ensure it was enabling us to ask the right questions, at the right time. Work has recently concluded to update that scorecard and ensure partners can provide a prompt and coordinated response to identified trends. Going forward, the refreshed scorecard will be reviewed quarterly by the Practice Improvement and Development Group within the Partnership. That group will direct quality assurance activity accordingly as well as highlighting to the Partnership Board, any emerging issues or concerns that become apparent within the data.

MASH – we identified in summer 2022 that our oversight of the MASH (multi-agency safeguarding hub) could be strengthened and as a result have agreed to move the strategic governance of it into our partnership safeguarding arrangements. Children's social care colleagues have undertaken a full review

of the ‘front door’, keeping partners updated and appropriately involved. A change to the way the ‘front door’ looks and will be implemented over the coming months.

Updates

By the time of the Scrutiny committee in September, we will have held the next Plymouth Safeguarding Children Partnership Board meeting. We anticipate actions will arise from that meeting and we will update the scrutiny committee on the 14th September.