Arthur and Star 7 Minute Briefing

This 7-minute briefing is information taken from the Child Safeguarding Practice Review.
The structure is designed as a reminder to think about 'application to practice'

The briefing does not have all the answers, it is a tool to enable practitioners to reflect on their practice and systems

1. Introduction

Arthur, 6 and Star, 16 months were two children tragically murdered by their caregivers in 2020. The children lived in different parts of the country but both cases were heavily reported in the media at the same time, causing national outrage in December 2021. Both children had suffered significant abuse and neglect, been surrounded by professionals and family members yet the safeguarding system had been unable to keep them safe

2. National Review

In January 2022, the Child Safeguarding Practice Review Panel were commissioned to undertake a review into the circumstances leading up to the deaths of Arthur and Star whilst recognising that their experiences were not unusual. The national context is sadly one where on average, one child is killed every week across the UK with children under the age of 1 being the most at risk. In the majority of cases, children are killed by their own parent though in Arthur and Star's cases, it was their parent's partner that caused them harm. The national panel published their findings in May 2022 and have made a number of recommendations for the child protection system across England and Wales.

3. Systems and Process

Agencies should work together to develop a shared understanding of what is happening to children and families over time. There should be clear processes in place to support information sharing and information seeking, within and between agencies. There is a need to develop critical thinking and challenge within and between agencies.

4. Practice and Knowledge

The views and concerns of wider family members and those who know the child well can be too easily dismissed as malicious. Practitioners should appreciate the speed at which life can change and recognise the impact of change in a short space of time. Investigating allegations and understanding nuance when families are reluctant to engage requires great skill. Practitioners should sensitively support diverse communities where understanding is evolving and challenge bias –same sex couples and parenting. Practitioners should address the impact of domestic abuse and understand the needs of children whose parents are in prison.

5. Leadership and Culture

Leaders have a responsibility to create working conditions to support complex work.
There is a need to ensure: clarity of vision, responsibilities, and resource, robust governance and a culture of learning, improvement and challenge.
There should be clear management oversight of complex safeguarding work, supported by reflective supervision for practitioners.

6. Wider Service Context

A failure to trigger statutory, multi-agency child protection processes.

A rapidly evolving safeguarding agenda has overshadowed the need for sharper, specialist child protection skills and expertise.

There is a need to refocus on child protection through an expert led, multi-agency model for child protection investigations, planning, interventions and review

7. Reflections for Health

Reinforce the use of chronologies and genograms as safeguarding assessment tools- how can we support this through use of clinical records? Recognise the value of reflective practice and safeguarding supervision within and between agencies- how can we introduce multi-agency reflective practice to the way we work?

Working together-what are the barriers to information sharing? Who can we seek information from when there are gaps in our understanding? Child protection-Are we clear on the distinction between safeguarding and child protection

How to use this briefing:

7 minute briefings should be delivered face to face to promote discussions and not included with other day to day issues, to ensure impact. Please consider these 3 questions alongside the briefings:

What are your key thoughts and reflections?

How can we ensure the learning is embedded and how will we know this?

How can we integrate the learning into team or service improvement plans?