Arthur Labinjo Hughes

A Focused Review of Local Practice

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Foreword

It is important to acknowledge that without the persistence of Arthur's paternal grandmother, Joanne Hughes, and the leadership of Paul Johnson, the CEO of Solihull Council, this focused review would not have been commissioned.

It is one of several reviews that have been undertaken and whilst it provides new perspectives on the sequence of events involving Arthur, it neither minimises nor detracts from where the ultimate responsibility for his death lies. That rests firmly with Arthur's stepmother, Emma Tustin and his father, Thomas Hughes.

At the outset, it is also important to recognise the changes that have been made since Arthur's death. Ofsted's most recent monitoring visit to Solihull's Children's Services in January 2024[1] found that social work practice had improved and that strong governance arrangements continue to support progress. This is positive, evidencing that lessons are being applied and that the social work arrangements to help and protect children are more secure. From a police perspective, there is less confidence. The PEEL inspection of West Midlands Police published in December 2023[2] made no judgements of good or above, with the force's 'response to investigating crime' and 'protecting vulnerable people' both found to be inadequate. There remains work to be done.

On reflection, it remains both easy and true to state that Arthur's murder was shocking. This is simply because it was. His needless death was not the result of a one-off incident, but the culmination of a period of torture and maltreatment, so severe that is hard to comprehend what his lived experience must have been like. The feelings of shock in this case are exacerbated

[1] https://files.ofsted.gov.uk/v1/file/50240034
[2] https://assets-hmicfrs.justiceinspectorates.gov.uk/uploads/peel-assessment-2023-25-west-midlands.pdf

when knowing that the harm Arthur suffered was caused by those who were meant to love, care for and protect him.

Unfortunately, whilst the child protection system in the UK is one of the most developed, cases such as Arthur's and others, where children suffer significant harm, are not as rare as we would wish them to be. Not all end in murder, but many children will be living in homes today where they are being neglected, maltreated and abused. They are often hidden in plain sight, coercively controlled, bullied and manipulated. This can make abuse and neglect hard to spot.

This is why it is important that when people see, hear or suspect something is not right, that they come forward and seek help, for the child who cannot. Perpetrators of these crimes manipulate and deceive, blame others and when engaged by authorities, disguise who they really are and what they are doing. In this context, it can be difficult for practitioners in statutory agencies to achieve a line of sight on factors that justify intervention. Sadly, in some cases when opportunities do arise, they are missed. This is one such case.

Introduction

1.1 Arthur Labinjo-Hughes suffered a horrific and tragic death on 17 June 2020. His father, Thomas Hughes, was convicted of his manslaughter and his then partner, Emma Tustin, of his murder.

1.2 The aftermath of this case prompted significant reflection about how safeguarding and child protection systems could be improved to prevent such tragedies in the future. This included a Joint Targeted Area Inspection, involving the oversight bodies for children's social care, police, health and probation, an IOPC investigation into the police response and a national review led by the Child Safeguarding Practice Review Panel.

1.3 The national review identified several key issues, including but not limited to, a failure in information sharing practice, partnership working, and an absence of critical thinking and challenge within and across agencies and of families who disguise their behaviours.

1.4 My report does not seek to revisit areas previously covered, nor does it address national issues. It provides an evidence-based opinion on whether the actions of practitioners were reasonable and proportionate in the context of what was known by them at the time, and consistent with the law, statutory guidance (non-statutory guidance where relevant) and local procedures. In considering these questions, alongside the broader terms of reference, my report focuses on a very specific time period between 15 April 2020 and 27 April 2020. The latter date is when Arthur's case was closed by children's social care - nearly two months before his murder.

1.5 I have also considered why an earlier intervention was not made by key statutory agencies, why the home visit failed to discover the injuries (that would likely have led to more decisive action) and why, following the receipt of a photograph of Arthur with evidence of him having sustained substantial physical injuries, the case was closed.

1.6 The photograph itself, taken by Arthur's paternal grandmother, is central to many of these

questions. Much has been said about it, the ambiguity of its timeline and for those who saw it, disbelief that the practitioners who visited Arthur didn't see the injuries it graphically depicted. Each of these issues is addressed in the body of the report.

1.7 The terms of reference are attached at Appendix A.

Background and Context

2.1 Arthur was born on 4 January 2014. His short life was marked by some significant challenges. During contact with the family, his father, Thomas, was seen by children's social care and the police as a protective factor. He was anything but. He was reported to have been a loner at school and only had one known girlfriend prior to meeting Olivia Labinjo-Halcrow, Arthur's mother. Reports indicate that he may have been easily manipulated, with Olivia being absent for periods of time, or not returning home leaving Thomas to look after Arthur.

2.2 When Arthur was about one year old, Thomas and Olivia separated. As a toddler, Arthur lived with Olivia and her then new partner Gary Cunningham. Their relationship was reported as being troubled and abusive. In February 2019, Olivia stabbed Gary to death. She was subsequently convicted of manslaughter and sentenced to twelve years imprisonment.

2.3 With his mother incarcerated, Arthur and his father went to live with his paternal grandparents Joanne and Christopher Hughes. This was an important period given the adverse experiences that Arthur had previously been exposed to. Living here provided Arthur with stability and a supportive family network, who clearly loved and cared for him.

2.4 In the Autumn of 2019, Thomas began a relationship with Emma Tustin and soon thereafter moved into her home with Arthur. Emma was known to children's social care because of issues related to her own children and allegations regarding domestic abuse. She was reportedly both a victim and perpetrator. At the time that Thomas and Arthur moved in, Emma had two of her children living with her. The relationship, which could at times be turbulent, appears to have been controlled or significantly influenced by Emma.

2.5 We now know that by April 2020, Arthur was suffering increasing levels of abusive behaviour from Emma, behaviour that at times was either tolerated, mimicked, or ignored by Arthur's father.

That said, in or around 14 April 2020, tension escalated between Thomas and Emma. This culminated in a heated argument between them, resulting in Emma going missing and Thomas and Arthur moving back to the home of his paternal grandparents.

2.6 The following day, 15 April 2020, Thomas reported Emma missing. He feared that in the aftermath of their argument she might self-harm. The police responded, calling at Thomas's mother's address, where they saw Arthur and his paternal grandparents. Thomas was at work.

2.7 Following Emma's return the police called to carry out a '*safe and well check'*. Given that Emma had gone missing at a time when there was a concern that she might self-harm, this check was focused on her health and wellbeing. The officer in attendance spoke to Emma and Thomas, saw Arthur, and left with no concerns being identified for further action.

2.8 Mrs Hughes had previously noted the bruising on Arthur's back. When challenged, Thomas told her that Arthur had been involved in a fight with Emma's son. Not content with the explanation, she took photographs of the marks and bruises on 16 April 2020. Her anxiety was heightened when Thomas and Arthur returned to Emma later that day. In response, Mrs Hughes contacted children's social care. Her call was taken by the Emergency Duty Team (EDT).

2.9 Recognising the previous discussions about the place, date, and time the photographs of Arthur were taken, I saw the area in the grandparents' home where these were captured. The décor and furniture are identical to that in the photographs and an examination of the device on which it was taken revealed them to be in sequential date order. There is no doubt about the location and the police have confirmed they were taken on the day in question.

The actions and decisions of Solihull's EDT on 16 April 2020, following contact by Mrs Hughes

3.1 The handwritten notes of the EDT Social Worker (SMBC1), who received the phone call, referenced the bruising to Arthur, mentioned that Mrs Hughes was very worried and that she considered it too risky to wait until the morning to check on her grandson. They also recorded Mrs Hughes's offer that she could look after Arthur at her home if needed.

3.2 There is no mention of photographs in these notes or in any of the officially recorded reports made by SMBC1 on this date. That said, Mrs Hughes was unequivocal that she did mention the photographs in her conversation with SMBC1, but that they were not requested.

3.3 At 20.16hrs, the police records show that SMBC1 contacted them via the 999 system. This was done to avoid the queue on the 101 number. It is reasonable to infer from this that SMBC1 was taking the call seriously. SMBC1's notes indicate that they passed on the information and concerns raised by Mrs Hughes and requested a welfare check that evening. The police call handler explained that they would prioritise the call and the police would go to the address that evening, although they could not say exactly when this would be. SMBC1 explained that Mrs Hughes had said that she would care for Arthur if it was felt that he needed to be removed. It was agreed that following their visit, the police would contact Mrs Hughes and provide feedback to EDT.

3.4 At 20.30hrs, SMBC1 contacted Mrs Hughes to tell her that they had passed on her concerns to the police, that a welfare check had been requested and that following the visit, Mrs Hughes would be contacted by the police with an update.

3.5 Good practice was shown by SMBC1 in swiftly contacting the police with the concerns raised by Mrs Hughes. Their request for the police to undertake a welfare check was both reasonable and proportionate to the presenting issues. Decision making and actions at this point were

sound in the context of an out of hours response.

3.6 That said, the review has been unable to make any firm conclusions about whether SMBC1 was aware of the photographs of Arthur. Mrs Hughes was adamant in her recollection that she had told SMBC1 about them and confirmed this under oath at the criminal trial. SMBC1 had no such memory and made no mention of them in their handwritten notes.

3.7 Had the photographs been available to either EDT (or the police) on the night of 16 April 2020 or the morning of 17 April 2020, it is reasonable to conclude they could have provided the catalyst for triggering a more authoritative response beyond the request for a welfare check. That said, this conclusion is somewhat caveated by the fact that on their eventual receipt, no such action was taken.

The actions and decisions of the police in response to EDT's request for a welfare check on the evening of 16 April 2020

4.1 At 23.00hrs, police officer WMP1, contacted SMBC1 to inform them that police would not be attending that night. SMBC1's notes of the conversation state:

4.2 *"WMP1 rang to inform me that he had been, just been assigned to the incident and was involved with [the] incident yesterday involving Emma. He said that he had spent several hours with the family both at Grandmother's house and at Cranmore Road [Emma's home address] and felt that he had a fairly good understanding of the situation. He informed me that he was aware that Emma had had a mental health assessment yesterday at A&E following the incident and had been discharged.*

4.3 *He said that during his time with Tom yesterday he had come across as a very caring father and had on several occasions taken Arthur out of the room when things had become difficult with Emma and he was fairly sure he would do the same this evening if he felt Arthur was at risk from her. He said that during their conversation with Tom he had mentioned the argument Arthur had had with Emma's son and had not been evasive about this. WMP1 stated that he hadn't noticed any significant injuries at this point".*

4.4 The phrase - *no significant injury* - warranted further professional curiosity by SMBC1. What exactly did that mean, what injury was seen on Arthur and what made it insignificant? There is no evidence that this critical line of enquiry was properly explored with the police.

4.5 WMP1 went on to explain that a visit at that time, post 23.00hrs was likely to exacerbate issues and given the observations on the previous safe and well check, they would not attend.

4.6 *"WMP1 stated that during the visit to the house yesterday he had observed that the house was clean and that Arthur appeared to be being cared for appropriately. He said he had had no concerns with regards [to] his welfare and felt that although there were clearly concerns with*

regards to Emma's mental health and her relationship with Tom, Tom appeared to be able to prioritise Arthur's welfare over his. WMP1 felt that a visit to the house at this time of night may exacerbate any potential difficulties between Tom and Emma, would not serve any purpose, and could inadvertently place Arthur and Emma's son at more risk".

4.7 Contact with the police by SMBC1 was to share details of an alleged physical assault on Arthur. The context of the visit on the 15 April 2020 was for a fundamentally different purpose. In this respect, it was unreasonable for WMP1 to rely on this outcome of this visit to assuage concerns about possible physical harm. The police had not spoken to Arthur on his own, examined him or posed questions to his carers about the allegations. The fact the house was clean and there was an 'appearance' of Arthur's care being positive were snapshot observations that would never have been able to determine whether Arthur had been injured or not. This is reinforced by the fact that Arthur's bruises were, in the main, beneath his clothing and not visible.

4.8 In short, there was no way for anyone to establish Arthur's immediate safety that night without seeing him. The additional context provided by Mrs Hughes's concerns should have been afforded greater priority by the police. In hindsight, it is also evident that Thomas's behaviour during the previous visit by the police was disguising the reality of the situation and the risk that Arthur faced. That said, in my opinion, there was sufficient information available to the police and a check should have been undertaken.

4.9 On being contacted by the police and advised of their decision not to visit, Mrs Hughes contacted SMBC1 the same evening, stressing her disappointment at the police response. Mrs Hughes reiterated her ongoing concerns about Arthur's safety whilst in the presence of Emma Tustin. SMBC1's notes reflect that Mrs Hughes did not consider Thomas to be a protective factor. SMBC1 advised Mrs Hughes that they would pass on her concerns to the MASH team in the

morning, at which time they would consider the case as a priority.

4.10 On reflection this could have been an opportunity for SMBC1 to have another conversation with the police and challenge the decision of WMP1 not to visit. Whilst the response by SMBC1 was not unreasonable (given the established position of the police), Mrs Hughes had shared additional details querying Thomas's capacity as a protective adult.

The actions and decisions of the Solihull MASH on 17 April 2020 in response to EDT's referral

5.1 On the morning of 17 April 2020, Solihull's MASH was informed of the phone call. SMBC2, the MASH assistant team manager noted in their record, "*the bruises could have been caused since that visit was carried out' (referring to the police visit on 15/4/20).*

5.2 SMBC2 directed that the duty social worker 'screen the history' of the family and contact Thomas to arrange a home visit to see Arthur. This *Threshold Visit* to Arthur at Emma Tustin's home was carried out later that day by SMBC3 and SMBC4.

5.3 At this time, Solihull children's social care operated an approach that involved duty social workers in the MASH undertaking home visits to establish whether the threshold for a social work assessment had been met. Such visits were carried out in circumstances where children were not considered to be at immediate risk and where more information was required by managers for them to decide about next steps.

5.4 Whilst it can be argued there was a logic to the process of Threshold Visits (and equally argued against), it was the wrong response for Arthur. The context of the concerns shared by Mrs Hughes, alongside the known history, were sufficient in seriousness to trigger a multi-agency strategy discussion. As already articulated in other reviews, this is likely to have been a catalyst for more robust information sharing and coordinated planning across partner agencies.

5.5 In this respect, notwithstanding the fact that the West Midland Child Protection procedures did not include practice guidance in relation to allegations of physical abuse, there was, in my opinion, sufficient guidance already available that should have resulted in a strategy discussion being convened.

5.6 For example, there were clear concerns being expressed about physical abuse from a source

close to the family and there was no indication these were malicious in nature. The additional information known about Emma Tustin's history, Arthur's mother's history and the recent incident on 14th/15th should have led MASH managers to the simple conclusion that partner agencies needed be engaged to find out more about the family circumstances.

5.7 The allegations of physical abuse and the family history were such that the local authority did have reasonable cause to suspect Arthur was suffering or likely to suffer significant harm. In this respect, the decision making by MASH was inappropriate in the context of the raised concerns and the application of the threshold to trigger a strategy discussion.

5.8 Furthermore, the very practice of Threshold Visits may have inadvertently influenced decision making in that it may have been seen as an easier, more rapid way of 'finding out more'. Planning with partners by way of a strategy discussion would have been the reasonable and proportionate response.

The actions and decisions of the Local Authority social worker and Family Support Worker during and after the home visit to Arthur on 17 April 2020

6.1 Arthur's death occurred in the immediate aftermath of the first national lockdown in response to COVID 19. To their credit, when asked about the difficulties arising from the changing operational environment, SMBC3 and SMBC4 were pragmatic. Whilst they felt that the entire service was under resourced and under pressure, they continued to carry out visits when they could. In fact, SMBC3 had volunteered to go on the call.

6.2 During this visit, one of Emma's children was present together with Emma, Thomas, and Arthur. When spoken to by SMBC3, Thomas stated that *'his mum does not want him and Arthur living with Emma',* advising that things were raw with his parents because they had reported them to children's social care.

6.3 It is fair to reflect on the level of disinformation that Thomas was feeding into the system to create or reinforce a view that this was more to do with difficult family relationships than anything else. He painted a picture of Emma and him being victims and made a report to the police that he was being harassed by his family.

6.4 SMBC3 observed that the children were playing and getting along well during the home visit. In order to establish what had happened, they separated Arthur and Emma's young son, from Emma and Thomas. Both boys reflected a version of events that related to them 'play fighting' and that during this time, Arthur was accidently knocked back onto the stairs resulting in the light bruising on the centre of his back.

6.5 The boys acted out their story and when asked, Arthur lifted his shirt to allow a visual examination of his back. SMBC3 recorded that there was a faded bruise on Arthur's back and a scratch on his face. Their judgment at that time was that the light bruising and scratch were consistent with the explanation given by the two children and SMBC3 recommended level 3

family support for Arthur.

6.6 The fact that the children had been 'coached' in their accounts as part of Thomas and Emma's efforts to deceive professionals is well documented in other reviews and is clear in the transcript of the criminal trial. Therefore, these issues are not revisited here. What is considered in detail is why SMBC3 and SMBC4 did not see the full extent of Arthur's injuries during the home visit.

6.7 In the aftermath of Arthur's murder this has remained an unresolved question. It was the subject of much debate, not least in the media when the photograph was published. In fact, the level of negative attention resulted in one of the involved practitioners having to move out of their home for a period of time. The failure to identify the injuries was also the subject of considerable focus during the criminal trial, in which neither SMBC3 nor SMBC4 had representation, given their status as witnesses.

6.8 Despite all of this, SMBC3 and SMBC4 remained resolute in their position that they had not seen the injuries depicted in the photographs. Several theories have been propagated to explain why this might be. One suggested that the photographs were not of Arthur, another that they were not taken on the date suggested and must have referred to a different time, or that make up had been used to camouflage the bruising.

6.9 As already outlined in this report, the photographs were taken at the time claimed (notwithstanding some confusion caused when the maternal grandmother mistakenly suggested it was taken at an earlier date). However, the fact remains that even if they had been taken at another time, the nature of the injuries depicted warranted investigation.

6.10 In considering the response of SMBC3 and SMBC4, it is important to clarify that neither had

seen the photographs of Arthur, nor were they aware of their existence. Furthermore, the brief provided to them did not set out a detailed description of Arthur's injuries but referred to the presence of bruising on his back, a scratch on his face and concern that he was not safe with Emma. In this respect, engaging with the children away from Thomas and Emma, establishing their versions about what had happened and facilitating an opportunity to examine Arthur's back were all reasonable actions to undertake.

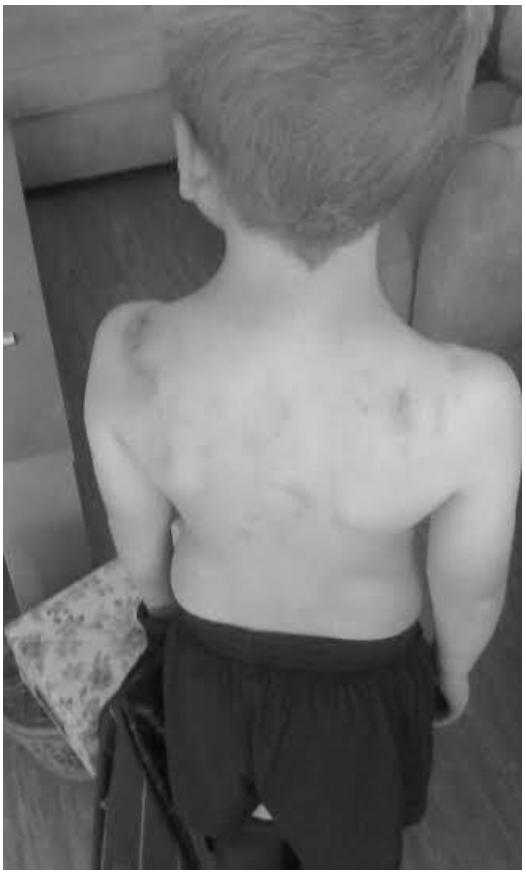
6.11 On the morning of the visit, SMBC3 had completed background checks and SMBC4 was tasked to accompany and support them. SMBC4 was known to Emma, who reportedly had a poor relationship with and did not trust social workers. This was good practice and reflects a level of thoughtful planning.

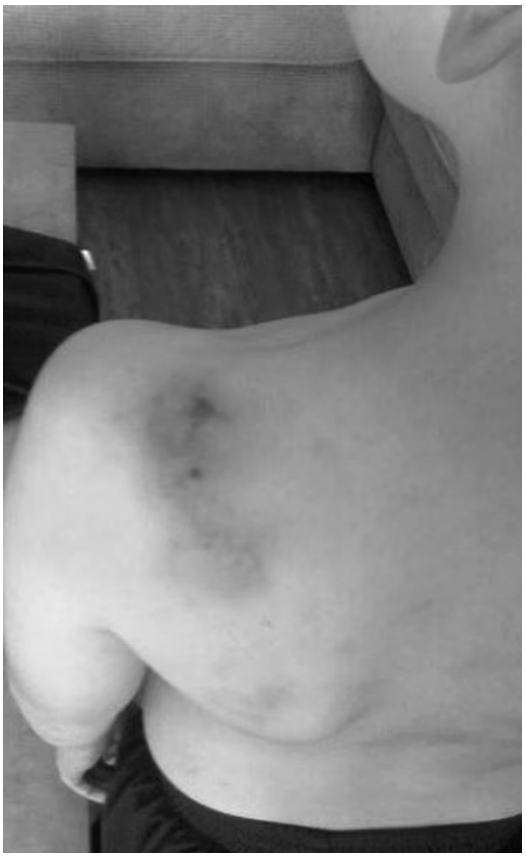
6.12 Having spoken with Thomas and Emma, SMBC3 and SMBC4 engaged the two children and questioned them about the incident which was being used as the reason for Arthur's reported injuries. Whilst the children were seen and spoken to away from the adults, they were not seen and spoken to individually. Whilst there is no certainty that the children's accounts would have been different, talking to the children on their own would have reflected best practice and been in line with the statutory guidance at the time, Working Together 2018.

6.13 SMBC3 stated that the light in the room, was relatively good, the blinds were open, and they were confident that their visual examination of Arthur's back was not significantly diminished or obstructed.

6.14 Given the limits of what they could do at that time, based on the information available to them, they asked Arthur to show them his injuries on his back. Other material seen by the review corroborates that Arthur did just that.

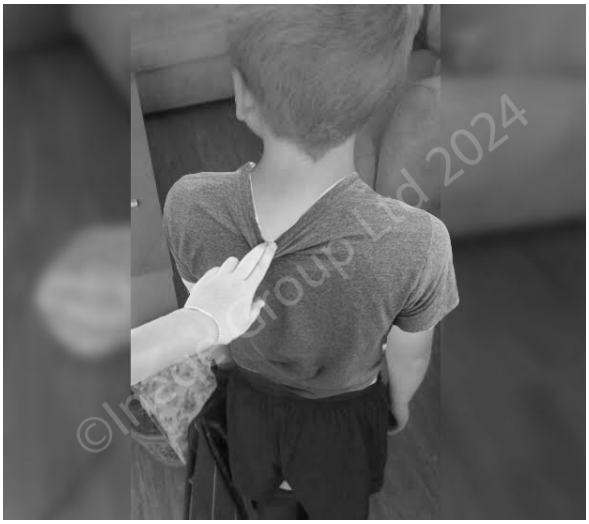
6.15 Exercising professional curiosity is a balanced judgement for practitioners. It is easy to second guess such judgements when you are not present, especially when reports are written with the gift of hindsight. Much of the reporting on this aspect of the case has been driven by reflecting on the inability of SMBC3 or SMBC4 to identify injuries, by those who had already seen the photographs. The two key photographs are included below.

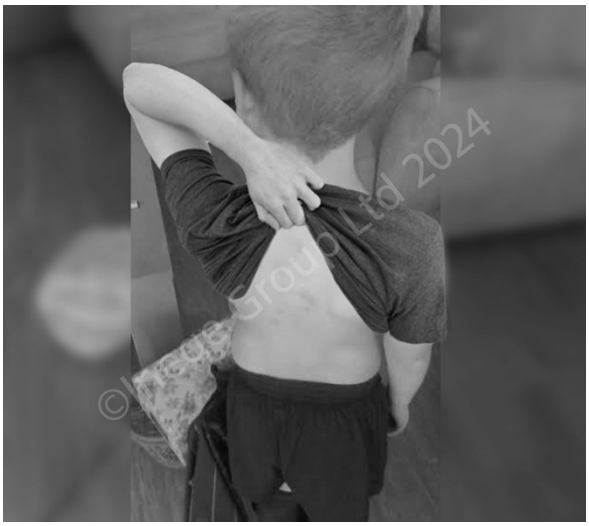




The question is how these injuries, visible in a photograph taken the day before, could have been missed. The answer may be in the context of what he was wearing and the extent to which SMBC3 and SMBC4 could act, based on the briefing that Arthur had bruising on his back. During their visit, Arthur was wearing a football top. He lifted it to facilitate the examination and that framed what SMBC3 and SMBC4 saw.

Reconstruction with clothing





7.1 The above images are recreated using the initial photographs supplied by Mrs Hughes, with a top (potentially looser than Arthur's football shirt). These simulate the way that Arthur's shoulders could have remained covered when he '*rolled-up*' his shirt to expose his back and how, even if Arthur had pulled the shirt to the bottom of his neck, SMBC3 and SMBC4 are unlikely to have seen the extensive bruising, abrasions, and finger marks on his shoulders.

7.2 On this basis, it is easier to understand why SMBC3 and SMBC4 responded on that day, with the information they had, in the way that they did.

7.3 However, I am equally alert to arguments that the thoroughness of the physical examination of Arthur, and the conclusions drawn from it were insufficient. Given hindsight bias, I am not wholly convinced by these, but recognise the important lessons for practitioners about professional curiosity and disguised compliance. Much in the same way that the Child Safeguarding Practice Review Panel has published a useful briefing paper on the management of bruising in non-mobile infants[3], it would be helpful for the Panel to develop guidance to cover its expectations for best practice with older children. This should include advice on the type and extent of any physical examination of a child at home by visiting practitioners.

7.4 Further to the visit by SMBC3 and SMBC4, others in the statutory system failed to capitalise on critical opportunities to intervene when additional details subsequently came to light. Indeed, on 20 April 2020, following the completion of the Threshold Visit (and in the absence of sight of the photographs), SMBC2 decided that Level 3 family support was an appropriate response and should be put in place. However, on the same date, children's social care records show that the maternal grandmother made contact with them (SMBC1). She explained that she had been communicating with the paternal grandmother and had seen photographs of injuries to Arthur's back.

7.5 She went into detail regarding old and new bruises, finger-marks on Arthur's right shoulder and a black bruise on his left shoulder. The record includes a note *"I explained to her that two workers had visited Arthur on Friday the 17th April 2020 and did not observe the injuries she has described in the photographs".* A further note on the entry state, *"I reassured her [MGM] that Arthur had been seen and no safeguarding concerns were identified".*

[3] https://assets.publishing.service.gov.uk/media/632d9724d3bf7f56794d4467/14.155_DFE_Child_safeguarding_Bruising_PB1_v3_Final_PDFA.pdf

7.6 It is clear from these entries that the response by children's social care was being driven by the outcome of the Threshold Visit, which itself was compromised by the acceptance of an untrue version of events. Awareness of this photograph should have prompted further action, by way of immediately seeking it. Assuming it had no relevance or that it did not warrant further scrutiny was an error of judgement and a missed opportunity to re-engage. That said, given subsequent decision making, it is arguably unlikely that managers would have changed their minds. On its eventual receipt, no further authoritative action was triggered by way of child protection procedures.

The actions and decisions of the police on receipt of the photographs of bruising to Arthur

8.1 On 18 April, Thomas's brother, concerned for Arthur's wellbeing and the mental health of Thomas contacted the police. He told them that he was very worried as he had seen a picture of injuries on Arthur's back. He was called back about 45 minutes later by a police officer. Thomas's brother stated that this officer explained that he had seen Arthur [during the safe and well check regarding Emma] emphasising that he had no concerns. Thomas's brother then highlighted the existence of the photographs, which the officer asked him to share, making a commitment to get back to him once he did. The photograph was shared via email and whilst I can confirm it was received by the police they did not respond as promised. This is the first known time that the photographs were shared.

8.2 Two days later, Arthur's maternal grandmother also contacted the police expressing her concern regarding the injuries seen in the photographs, as well as her anxiety about Arthur remaining with Emma and Thomas. I found no evidence of further action being taken in response to her call. The maternal grandmother was simply told that social services were involved.

8.3 Given the nature of the injuries depicted in the photograph, which include a range of fresh and older bruises and abrasions, some of which mirror finger markings, it is difficult to understand why the police did not take further action. In my opinion, the injuries provide (at the very least) reasonable grounds to suspect that a child was a victim of actual bodily harm.

8.4 Had the police, as is their duty, investigated to discover whether an offence had been committed and by whom, it is reasonable to suggest that Arthur could have been removed from those who represented a critical risk to him.

8.5 This was not the only opportunity to intervene, but it was a crucial one. I have seen no evidence to indicate that the police sought to trigger a multi-agency child protection response in line with

statutory guidance and local procedure. In fact, I have seen no evidence that they pursued any lines of enquiry at all regarding the photograph.

8.6 Reasonable and proportionate practice would have involved immediate information sharing with appropriate partners (via a referral to the MASH), a strategy discussion and an agreement regarding a course of action. This was a serious crime and as part of the multi-agency arrangements in place to safeguard children, responsibility to investigate it lay firmly with the police.

The actions and decisions of the Solihull MASH on receipt of the photographs on 24 April 2020

9.1 On 24 April 2020, as concerns about Arthur's safety grew within the family circle the maternal grandmother forwarded the photographs of Arthur's injuries to Solihull's MASH. This should have triggered professional reflection and an immediate response. The situation was complicated by the fact that the maternal grandmother had mistakenly identified the wrong date with regard to when the photographs were taken (she initially stated 7 April 2020, rather than the actual date 16 April 2020). Whilst this was quickly corrected through a phone call made by SMBC3 to the paternal grandmother, this added to ongoing confusion and the over-reliance on the outcome of the Threshold Visit. Practitioners ultimately failed to reconsider their position after receiving this critical new evidence. This should have prompted an immediate strategy discussion, the triggering of a section 47 enquiry and a rapid re-assessment of Arthur's safety.

9.2 Shortly after the email containing the photographs arrived, SMBC3 received a phone call from SMBC5 (manager). Her recollection of the call was that SMBC5 said, *"Some photos have come in, I am just going to email them over to you, can you have a look at them".* She reflected that she thought SMBC5 went on to say, *"Phone Dad and clarify some of the things in the photo".*

9.3 SMBC3 told the review that they believed the photographs were emailed to them whilst still on the phone with SMBC5. On seeing the photographs, SMBC3 recalled, *'My jaw hit the floor. I was absolutely gobsmacked…my first reaction was like, that's not the child I [saw]".* The subsequent telephone call made by SMBC3 to Thomas provided no further clarity. On being told about the severe bruising in the photographs, he repeated the account of the children fighting.

9.4 I am told that SMBC5 consulted with another manager and made the following entry when stepping the case down to level three family support.

9.5 *"The photos shared today by MGM are very concerning and indicate significant bruising [to]*

Arthur's shoulders and back. The email sent by MGM indicated that these injuries could have happened on the 7th of April, which does not fit in with the timeline shared by the family when they explored the concerns last week. However, following SW1's enquiries today PGM has confirmed that these photos were taken on the 16th of April. I remain concerned that when the SW's saw the boys on the 17th of April, and they looked at their backs, the injuries were not seen to be this severe and it is unlikely that a day later they would have healed. The children have however, been seen to be safe and well, and [have] not shared any concerns about being intentionally harmed and the injuries could be consistent with the explanation given about a play fight. Had we seen these pictures on the day they were taken, consideration may have been given to a CP medical, this is now not applicable a week later. I do not feel any further investigation is needed in relation to this and agree with the recommendation for level three, it is hoped the family will consent to work with SMBC4 and [they] can monitor and escalate if concerns of this nature are raised in the future".

9.6 It is hard to understand the rationale behind SMBC5's decision making following receipt of the photographs, both in terms of the instruction to call Arthur's father and later, that no further investigation was required. Given this new information and the conflicting positions in the supervisor's commentary, I am of the clear opinion that Arthur's circumstances at home could and should have been explored further. The decision not to investigate further was a failure of both professional judgment and management oversight. It was not a reasonable conclusion to infer that the substantial bruising seen in the photographs could have been caused by play fighting (without further assessment). Furthermore, it was inappropriate to rule out a child protection medical in the absence of either seeing Arthur again or seeking the advice of health practitioners.

9.7 The supervisor's decision for ongoing monitoring failed to recognise the seriousness of both the

allegations and the evidence in the photographs. Even if these had been taken weeks before, the extent of the bruising alongside their location on Arthur's body (in areas indicative of possible non-accidental injury) should have been recognised as concerns by any competent manager.

9.8 The decision for monitoring was also weak in that there was no contingency built in for non-engagement, with the plan being predicated on the commitment from Thomas to participate. When he changed his mind and refused the support, there was no challenge or escalation. On the 27 April 2020, records reveal that when approached by SMBC4, Thomas declined the level three support that he had previously agreed, stating that, *"he wants things to calm down, and currently any work with Arthur may upset and unsettle him. They've now moved in with Emma and want to start working as a family".*

9.9 Later that day, SMBC4's supervisor agreed to close the case to Family support level 3. There is no evidence that any discussion took place with SMBC5 concerning the photographs or the fact that Thomas had rejected further support . When SMBC4's supervisor was asked if they had read SMBC5's comments regarding the case (an entry immediately before theirs) they could not remember. In fact, when pressed during interview they could remember very little.

Conclusion

10.1 Beyond those areas of learning addressed in other reviews, the criticism of the two practitioners who carried out the Threshold Visit has attracted significant focus in the context of Arthur's case. In the eyes of so many, they failed to identify the nature and extent of Arthur's injuries captured in the photographs taken by his paternal grandmother the day before. Looking at these images, people could not understand why he wasn't removed from the house and taken to a place of safety. Whilst perhaps an understandable perception, it is wrong.

10.2 Context is key, and in this regard, the context of the Threshold Visit on the 17 April 2020, was not informed by the graphic photographs of Arthur's injuries. It was solely informed by the EDT notes from the previous night (which made no mention of photographs), information that there was bruising on Arthur's back and a view from a police *safe and well* check, triggered a day before, by concerns for Emma Tustin and her potential to self-harm.

10.3 Notwithstanding the points I make about professional curiosity, disguised compliance and the future benefits of sharper guidance, they spoke to Arthur away from the adults, established his version of events and got him to lift his shirt so they could examine his back.

10.4 Whilst viewing Arthur's unclothed torso in the photograph, it is hard to imagine how his injuries weren't immediately apparent. However, when framed by the limits of a lifted shirt, it is reasonable to conclude that the extent of his injuries (that were located around his shoulders) would neither have been visible nor obvious.

10.5 Whilst the Threshold Visit was an inappropriate and ultimately unhelpful course of action to take, I do not believe that SMBC3 and SMBC4 ignored Arthur's injuries. They are experienced practitioners and I have found no reason why either would have intentionally chosen to minimise what they had seen or would have failed to recognise the gravity of harm had they seen it. In

keeping with the outcome of the other reviews, Thomas and Emma were manipulative and controlling. They coached their children to reflect a version of events that suited their aim. That was to disguise what they had done to Arthur and what they were continuing to do.

10.6 That said, the failure to engage in a strategy discussion and objectively consider all of the available information (including the history of those involved) was a missed opportunity to apply a collective analysis of information and possibilities. This failure was repeated when it became clear that photographs of injuries existed.

10.7 In my opinion, there were three critical opportunities where had practice been sharper, outcomes could have been different. Whilst acknowledging hindsight, the first relates to the police response to EDT's request for a welfare check on Arthur on the night of 16 April 2020. The over-reliance on the previous contact by the police with Arthur was ill-informed. The concerns related to a direct allegation of physical abuse and there was sufficient justification for the police to have responded immediately.

10.8 The second relates to the failure by the police to address the evidence in the photograph they received on 18 April 2020. The photograph depicted injuries consistent with the crime of Actual Bodily Harm. Even if the police had shared it with their partners in children's social care (and there is no evidence that they did), it would have still warranted and required a proper police investigation. In the opinion of the review, had the police chosen to investigate what was a credible allegation of a serious assault against a child, it is possible that Arthur may have been removed from the pathway to harm that he was ultimately on.

10.9 The third critical opportunity was triggered when the photographs were shared with children's social care on 24 April 2020. At this point it is reasonable to suggest that the supervisor(s)

should have re-evaluated their position, demonstrated professional curiosity and revisited their approach. They did not.

10.10 I find no good reason that the case was closed and that no one involved with the case or the oversight of it, paused to seriously reflect on the fact that Arthur had been injured in this way and to consider how they could help and protect him. Whilst acknowledging learning about optimism, disguised compliance and the wider challenges of child protection, it is hard not to draw conclusions about the levels of basic competence in decision making on what was a relatively straightforward allegation of physical abuse, supported by photographic evidence and insight from the extended family.

10.11 Finally, and for the purpose of clarity, whilst I was told on many occasions that there was uncertainty about when the photographs had been taken, from a child protection point of view, this is irrelevant. Regardless of when they were taken, and they were taken on the day before the Threshold Visit, they evidenced the fact that Arthur had been subjected to a brutal assault. Their possession by statutory agencies could and should have changed the course of this case. It is therefore not possible to rule out the likelihood that an appropriate intervention may have prevented Arthur's murder.

Appendices

Appendix A – Terms of reference

Provide an evidence-based opinion on whether the actions of practitioners were consistent with the law, statutory guidance (non-statutory guidance where relevant) and local procedures.

Provide an evidence-based opinion on whether the actions of practitioners were reasonable and proportionate in the context of what was known by them at the time.

The practice episode will cover, but not be limited to the following:

The actions and decisions of Solihull's Emergency Duty Team (EDT) on 16 April 2020, following contact by ALH's paternal grandmother.

The actions and decisions of the police in response to EDT's request for a welfare check on the evening of 16 April 2020.

The actions and decisions of the Solihull MASH on 17 April 2020 in response to EDT's referral.

The actions and decisions of the Local Authority social worker involved and their line manager(s) during and after the home visit to ALH on 17 April 2020.

The actions and decisions of the police on receipt of the photographs of bruising to ALH's back (taken by paternal grandmother).

The actions and decisions of the Solihull MASH on receipt of the photographs from ALH's paternal grandmother on 24 April 2020.

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