Bradford Safeguarding Children Board

A Serious Case Review

Hamzah Khan

The Executive Summary

November 2013

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1.1 Introduction

1. Hamzah died on the 15th December 2009 but his body was not discovered until September 2011. He died because he was neglected by his mother, Amanda Hutton. She was convicted of manslaughter and child cruelty in October 2013.

2. The death of any child, whatever the circumstances is a traumatic and shocking experience and Hamzah's is profoundly disturbing. Hamzah had been starved and neglected and this was not known about until the evidence was laid before a judge and jury in the autumn of 2013 following an extensive criminal investigation.

3. The circumstances under which Hamzah's dead body had remained hidden have shocked professionals and the wider community. The trial also revealed other significant information about the family and the circumstances of the children that had not been known until then.

4. It was not possible whilst preparing this SCR to establish an exact date for Hamzah's death. However, it became apparent during the court hearing that he died on 15.12.2009. Information provided through statements and from the post mortem examination indicates that Hamzah's death may have occurred in late 2009 when Hamzah would have been aged four years old. The circumstances and cause of Hamzah's death was the subject of separate and parallel inquiries by the police and the coroner. The review does not investigate why or how the death of Hamzah was not disclosed by any member of the family.

5. A theme in this review is the extent to which Hamzah was unknown and invisible to services throughout his short life. The circumstances that caused mother in particular to withdraw increasingly from any contact with services are complex. A contributory factor appears to be the degree of domestic violence she suffered and the social isolation she felt. Associated with this was the reaction from some people in the community to a relationship that involved partners from different cultures and religions. Hamzah was invisible to services largely because neither of his parents participated in the routine processes such as ensuring he saw health professionals on a regular basis or was enrolled for early years to educational provision.

6. Although Amanda Hutton had become a criminally neglectful parent she had not always been such an inadequate mother. She had become pregnant as a teenager with a teenaged boyfriend at a time when there was little specialist support available. It was a relationship that became abusive and violent.

7. Little is known or recorded about the first pregnancies but the limited agency information from health visiting records for example and accounts from some of her family indicate that Amanda Hutton had applied herself to parenting her older children. She had cared for members of her extended family. By the time she had neglected Hamzah to such an extent that Hamzah died having been subjected to cruel treatment, her circumstances had entirely changed as had her ability to function as an adequate parent as a consequence of her chronic dependency upon alcohol that had such appalling consequences.

8. Hamzah's body was discovered by police officers during a search of the house in September 2011. The police were at the house following up concerns about anti-social behaviour and the very poor conditions in the home and were also trying to establish the whereabouts of the younger children who had not been seen for some time.

9. The review coincided with major changes to national guidance and frameworks for safeguarding children. These changes have included how for example the assessment of children should be undertaken. Some of the problems and issues highlighted by Professor Eileen Munro in her national review of safeguarding were factors in this case and are discussed in the overview report. There have also been changes to guidance and law in regard to domestic violence. There have also been changes to the way that serious case reviews are undertaken.

10. The review had to be completed using the previous frameworks for a serious case review but has taken account of the severe limitations that traditional reports have had. It is for this reason that the review has used an adaptation of systems learning for the findings from the unusual and tragic circumstances that occurred in this case and to consider what the implications are for safeguarding practice and service more generally. Account has also been given to the severe limitations that traditional recommendations have in transferring learning from a review into professional practice. It is for that reason that although there are agency recommendations made by individual services, the overview report provides a series of challenges to the BSCB rather than setting out specific recommendations.

11. Those challenges and reflections emphasise that working with troubled families and vulnerable children is complex and has to take account of how there is always an inter play of many different and often contradictory factors that are not helpfully addressed through rigid or SMART recommendations and action plans that tend to rely on additional rules, protocols or procedures.

12. The overview report analyses the implications for how MARAC functions and has provided a focus for improvement to assessment frameworks and practice locally. Changes have been made to how the education service is notified about children born in the district as well as acknowledging that areas such as Bradford have a mobile population. The review also highlights the implications for contracting and compliance arrangements for the delivery of services such as GPs.

13. Helping children to talk about their worries and concerns, giving people working in schools, health, police and social care settings the capacity to talk with and listen to children's accounts, being mindful of how issues such as domestic abuse and depression erode the capacity of victims to access or engage with help and the implications that has for how professionals plan and act. The findings of the review also address the challenge of dealing with issues such as neglect. Hamzah did not die as a result of a single and devastating act of harm but died as a result of persistent and longer term lack of nutrition.

1.2 Rationale for conducting the serious case review

14. The reason for commissioning the review was that the circumstances under which Hamzah had died and the fact that the death had not been reported was indicative of

Hamzah having been neglected. The information about the very significant impairment of physical growth was not known until the trial.

15. The overall purpose of the review is to establish if lessons are learned from the case through a detailed examination of events, decision-making and action. In identifying what those lessons are, to improve inter-agency working and to better safeguard and promote the welfare of children in Bradford.

1.3 Communication and contact with the family subject of the review

16. Amanda Hutton and the children's father were made aware of this serious case review at the outset. In view of the separate investigation by the police as well as the coroner's enquiry, the serious case review panel had to ensure that all contact with the family was the subject of appropriate consultation and advice. The panel used the national guidance agreed between the Association of Chief Police Officers (ACPO), the Crown Prosecution Service (CPS) and the Directors of Children's Services in England.

17. Both parents had initially confirmed that they wished to provide information for the review and agreed to speak with the independent chair of the panel. The chair of the panel and the BSCB manager each made several efforts to contact both parents by letter, telephone and text. The panel chair had a brief discussion with Amanda Hutton on the telephone and although a meeting was planned Amanda Hutton did not keep the appointment.

18. Following the trial the children's father did meet with the manager of the BSCB. During that discussion he made clear that he had been unaware that Hamzah had not been registered with a GP and had not had any immunisations.

1.4 The methodology of the serious case review

19. The serious case review was completed using the methodology and requirements set out in the national guidance (*Working Together to Safeguard Children 2010)* that applied at the time of the review being commissioned and completed. That guidance was extensively revised in March 2013 following the publication of Professor Eileen Munro's final report in 2011.

20. The analysis in the final chapter of this report uses some of the framework developed by SCIE (Social Care Institute for Excellence) to present key learning within the context of local systems. This was in anticipation of the changes to serious case reviews. This also took account of recent work that had suggested that an approach of developing over prescriptive and SMART recommendations had limited impact and value in complex work such as safeguarding children.

21. A serious case review panel was convened of senior and specialist agency representatives to oversee the conduct of the review. The panel was chaired by an independent and experienced person who is also the independent chair of a LSCB in another part of northern England. An experienced and independent person has provided this overview report.

22. The panel agreed case specific terms of reference that provided the key lines of enquiry for the review and were additional to the terms of reference described in national guidance. The panel established the identity of services in contact with the family during the time frame agreed for the review. For services that had significant involvement they were required to provide an independent management review and are listed in the overview report.

23. An overview of the health agencies was provided in a comprehensive health overview report. Health overviews are no longer a requirement for SCRs.

1.5 Details of the timescale and conduct of the serious case review

24. The serious case review was commissioned by Professor Nick Frost, the independent chair of the BSCB, on the 28th November 2011. A serious case review panel was convened and was chaired by Nancy Palmer who is independent of all services involved and is also a chair of a local safeguarding children board in another area. The panel members are listed below. In addition to the senior and experienced local people drawn from relevant local services the panel had the benefit of additional challenge from a senior manager in a neighbouring authority who acted as a 'critical friend'.

25. There is an expectation that serious case reviews are completed within six months of being commissioned. A short extension to the timescale was agreed by the independent chair of the BSCB. This occurred as a result of several IMR authors and panel representatives being required to give priority to their participation in the statutory inspection of children's services that took place in Bradford in May 2012.

Position	Organisation
Professional Development Manager	Bradford Metropolitan District Council (BMDC) Adult Services
Designated Nurse	Bradford and Airedale Teaching PCT
BSCB Manager	BSCB
Medical Director	Bradford and Airedale Teaching PCT
Detective Chief Inspector	West Yorkshire Police
Manager	Youth Offending Team
Group Service Manager	BMDC Children's Specialist Services
Assistant Director Access & Inclusion	BMDC Access and Inclusion
Independent 'critical friend' (Assistant Director Performance, Planning & Resources, Children's Services Department)	Bolton Council
Head of Midwifery	Bradford Teaching Hospital Foundation Trust

26. The following agencies had contact with the family at various times. They all conducted management reviews of their agency's actions and decision making which contributed to the overview report's analysis and findings;

a) Health services that include:
    - Bradford and District Care Trust (BDCT)
    - Bradford Teaching Hospitals NHS Foundation Trust
    - Bradford and Airedale Teaching Primary Care Trust (PCT)
    - Yorkshire Ambulance Service;
b) Bradford Children & Young People's Specialist Services commissioned the IMR on behalf of Children's Social Care Services (CSC)
c) Bradford Early Years Children's Services (children's centre)
d) Bradford Education and Early Childhood Service commissioned separate IMRs in respect of education support services, school admissions and from schools the children attended during the period under review.
e) Bradford MARAC (multi agency risk assessment conferences)[1]
f) Bradford Youth Offending Team (YOT)
g) Staying Put
h) West Yorkshire Police
i) West Yorkshire Probation Service

27. Bradford Metropolitan District Council had been made subject to a statutory direction to outsource its education services in July 2001; that direction was lifted from July 2011. This means that for the period that is the focus of this review, the provision of services was through an arrangement with Education Bradford, an independent provider.

28. Information was also received from CAFCASS (children and families court advisory support service), the West Yorkshire Ambulance Service (WYAS), the Bradford Registrar and the Home Hunter service. Checks were also made with services in the east and south of England regarding information provided at various times by the family regarding the whereabouts of specific children. These checks confirmed that the children have always lived in the Bradford area.

29. In compliance with national guidance an overview report was provided on behalf of the various health services that contributed to the review. The overview report for the entire serious case review was completed by Peter Maddocks who attended every meeting of the case review panel. He is independent of all the services involved and he presented the overview report to the Bradford Local Safeguarding Children Board in December 2011. This complied with national requirements for the completion of a serious case review in England.

30. All of the report authors, together with the overview author, were required to collate information and provide analysis in response to several key lines of enquiry identified by the panel and agreed by the BSCB. The key lines of enquiry, which are additional to the terms of reference set out in national '*Working Together'* guidance were;

<u>Recognition</u>

i. To what extent were any vulnerabilities or needs of Amanda Hutton recognised and taken into account in terms of any potential risks they posed for Hamzah and his siblings including any information about depression, domestic violence, social or

[1] The MARAC is not an agency but is a multi agency framework for sharing information and action in response to identified risk; in this case it relates to incidents of domestic abuse. Although the abuse began in 1996 the MARAC was not established in Bradford until 2008.

family involvement or the use of alcohol or drugs; to comment in particular on any action taken to ascertain whether there were any issues of learning or other disability or impairment relevant to agency involvement, and comment on the extent to which any barriers may have contributed to Amanda Hutton's reluctance to accept help or advice.

ii. Provide information about any concerns that were reported by any member of the family and comment, where appropriate, on any action taken in response to such information.

iii. Identify any opportunity for enquiring into the whereabouts and well being of Hamzah between June 2005 and September 2011.

Assessment and Decision Making

iv. The extent to which relevant historical information was sought, understood and considered in work with Hamzah and his family; IMR authors should include a summary of any relevant information known to their service about the parents or family that they judge relevant to the serious case review.

v. The quality and timeliness of any assessments and the extent to which they took account of relevant family history, the cultural, ethnic and religious identity of the family, the needs of Hamzah and his siblings and the capacity of the parents (acknowledging they were separated) to meet the needs of their children; this should include comment about any extended family or others and their role and impact in promoting the safety, well being and knowledge of Hamzah prior to the discovery of his death.

vi. Consider and comment whether there were opportunities to use any arrangements such as the common assessment framework, team around the child or children going missing protocols to co-ordinate information and help at any stage.

vii. Comment on the quality of judgments and decision making and the extent to which it reflected a focus on the needs of Hamzah and his siblings and represented appropriate professional standards and a competent understanding of any relevant theoretical and/or legal frameworks; particular attention should be given to how any evidence of neglect or impaired capacity to parent was collated and analysed.

Using and Sharing Information

viii. Identify whether information in respect of the family was shared among agencies to the best effect so as to inform appropriate help and interventions; in particular to identify when practitioners in contact with the family saw Hamzah and/or his siblings and recognised any evidence of neglect or other concerns and comment on what action was taken to protect him or a sibling.

ix. To comment on the quality of reports and information provided for interagency enquiries and analysis including information provided in meetings of MARAC or the conduct of statutory assessments or for the purpose of identifying and tracing children who have gone missing.

Engagement and acceptance of help and advice

x. To what extent did either parent accept contact, advice or help from professionals in contact with the family between June 2005 and September 2011?

xi. Was there any other action that could have been taken to achieve a better level of contact and engagement with the family?

Planning and Help

xii. Comment on the clarity and appropriateness of plans and actions undertaken made as a result of the discussion at MARAC, information about siblings missing from school or as a result of any statutory assessment.

xiii. Identify what opportunities were taken to seek the views, wishes and feelings of any of the children and comment upon the extent to which the children may have felt inhibited to seek advice, information or help.

Practice Support and Supervision

xiv. Consider whether all relevant single agency and multi-agency procedures were followed and comment on the extent to which procedures helped or inhibited appropriate judgments and action at the time.

xv. Consider whether the policy, procedural, management and resource infrastructure that surrounded each agency's involvement with Hamzah and his family promoted appropriate decision making; this should include evaluating the training, knowledge and experience of people working with Hamzah and his family, workloads and organisational stability; comment should also be made about whether any shortfall in resources were an impediment.

xvi. Consider whether professionals working with Hamzah's family had sufficient and appropriate supervision commensurate with their role and responsibilities, and the extent to which the case was subject to appropriate and effective managerial oversight and enabled critical reflection.

Learning from SCRs and other review processes

xvii. Consider relevant research or evidence from previous serious case reviews conducted by the Bradford Safeguarding Children Board; consideration may also be given to evidence from other LSCBs or evaluations of SCRs. Take into account any common themes and actions arising from that research and those SCRs that are relevant to the circumstances of this case and comment on what impact they had in this case.

xviii. Consider previous reviews of single agency practice. Take into account any common themes and actions arising from those reviews that are relevant to the circumstances of this case and comment on what impact they had in this case.

Agency specific key lines of enquiry

xix. Police and children's social care; report and comment on what information was shared and the actions taken between 12th September 2011 and the 21st September 2011 and whether there was opportunity to have discovered the body of Hamzah at an earlier stage in those enquiries.

xx. Education and early childhood services; report and comment on the extent to which any of the children were missing from education or early years provision and the appropriateness of actions taken to ascertain the children's whereabouts and attendance at school and other provision.

1.6 Summary of the serious case review

31. Several examples of good practice were identified by the review. These examples included;

a) The police took prompt action when one of the children asked for help because of the domestic violence; this included ensuring CSC became involved;
b) The Registrar made a home visit to register Sibling 3's birth when she was made aware of Amanda Hutton's difficulty in being able to attend the office;
c) The police officer who gained the trust of Amanda Hutton tried to secure effective help and support in response to the domestic violence which included referral to housing and specialist advice services;
d) The ambulance crew ensured that their concerns about the welfare of children was reported to CSC when they were called to the house;
e) The health visitor sought advice from specialist advisors when she was failing to get contact with Amanda Hutton and her babies in 2005;
f) The discussion at the Primary Health Care Team about the concerns about the children not being seen by health professionals involved the health visiting and GP service;
g) The school nurse tried to make a home visit when she was concerned about lack of contact;
h) When Sibling 8 attended with the injury to his thigh the A&E staff provided a place of safety and ensured that other services were contacted and continued to provide care and treatment while consultation and plans were made;
i) The midwifery service arranged ante-natal home visits in one of the pregnancies in recognition of Amanda Hutton's difficulty with attending hospital;
j) The early childhood service secured access to the home after being asked to provide advice; this contrasted with the lack of success achieved by other services;
k) The PCSO (police community support officer) demonstrated very considerable persistence in gaining access to the house in 2011; she sought advice about the concerns she had and did not let the matter drop.

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32. Agencies have identified areas for improvement and these are incorporated in the 'Learning and Improvement' document published at the same time and in response to the Serious Case Review.

1.7 The summary of the events examined by the review

33. Hamzah's mother, Amanda Hutton, is white British and father is Asian British Pakistani. Both parents speak English. Amanda Hutton became pregnant with her first child (Sibling 8) 18 months after she had met father when she was aged 16 in the mid 1980's. The parents stopped sharing a house in late 2008 after the children's father was arrested following an assault on Amanda Hutton and he was made the subject of a non-molestation order. It is apparent that Amanda Hutton had tried to leave the relationship on previous occasions and was referring to the children's father as an ex-partner as early as February 2007. With the exception of the two eldest children who were adults at the time of Hamzah's death, all of the siblings lived with the Amanda Hutton.

34. From the first pregnancy there was a pattern of avoiding contact with health services; the late notification of pregnancies had an impact on the planning of ante natal care. Amanda Hutton experienced low mood and depression with all of the pregnancies.

35. The first report of domestic violence was made in 1996. Amanda Hutton declined to make a formal complaint to the police; this was to be a repeated pattern and is a common feature for women in abusive relationships. Further episodes of violence occurred and nine reports had been made to police between 1996 and 2008. On at least one of those occasions it was one of the children who reported the violence and further information about domestic violence was provided by one of the children when he asked for help in 2007. It is likely from information provided to the review as well as other evidence from research that indicates that domestic abuse is an under reported crime that not all the incidents of violence were reported to services. Around the same time there were incidents in the community; some of these appear to relate to the parents being from different racial and cultural communities although the children's father says this was not an issue.

36. With all of the children there were problems for the health visiting service and GP in seeing the children (or parents). This became even more of a problem with the later pregnancies.

37. There was contact between services and consultation with safeguarding advisors in the health visiting service. By 2005 it was noted that there was some evidence of Amanda Hutton using alcohol to cope with her circumstances.

38. In 2006 one of the children went to the police to talk about the situation at home and their distress about the domestic violence. The police used their powers of protection to try to arrange accommodation with CSC who returned the child home.

39. Shortly after this there was a further incident when Amanda Hutton asked for police help although by the time they had arrived father had left the house. In February 2007 Amanda Hutton was at A&E with bruises and chest pains following an assault at home. She said that she had separated from father. There were further attendances at A&E

one of which was via an ambulance that had been called to the house by one of the children.

40. In 2007 one of the children was injured having fallen when running away from his father. The child went to A&E and whilst there asked for help to live away from his family. This led to involvement by CSC as well as the police. The child did not make a formal complaint and no further action was taken by either of the services at that time.

41. By the summer of 2007 Amanda Hutton was asking for help to find alternative accommodation away from father. Several services became involved in trying to help; this included YOT, the police as well as specialist services. In spite of Amanda Hutton asking for help, she was unable to take up appointments that were made for her. Further incidents of violence occurred later in the year.

42. There was further contact in 2008 from Amanda Hutton with the police; on one occasion one of the children had gone missing from home. In April 2008 Amanda Hutton asked to meet with a specific police officer who had provided support in 2007. By the time the officer was able to contact Amanda Hutton she did not want to meet.

43. In 2008 there was a discussion at MARAC. In December 2008 there was a further incident at home when father forced an entry to the property and assaulted Amanda Hutton. He was prosecuted and received a community sentence with a requirement to attend sessions of a domestic abuse programme designed to help men to change their behaviour. He was asked to leave the group due to his disruptive behaviour and lack of cooperation.

44. In April 2009 three of the children were not collected from their primary school at the end of the school day. The police made a welfare visit that included checking all of the rooms in the house. One of the children did not have a bed and for another the arrangements were not clear. Amanda Hutton appeared to be under the influence of some unknown substance. The police sent information to CSC to suggest that a follow up visit by a social worker might be required.

45. In October 2009 the children and Amanda Hutton were removed from the register of the GP practice. This followed a protracted period when Amanda Hutton had been asked to bring the children for routine health and developmental checks and immunisations and was after warnings of the intention to remove them from the practice list unless health professionals were able to see the children.

46. During 2010 there was correspondence between health visitors, education and early childhood services and CSC which centred on the difficulties in seeing the children. The health visitor had realised that the younger children had not been in contact with health services and were not registered with a GP. It was in response to the enquiries that Amanda Hutton sought to misdirect further local contact by insisting that the younger children were living with relatives in the south of England. The school were noticing that at least one of the children who was attending the school was looking more neglected. Father told his offender manager at probation that the two eldest children were living with him.

47. There was an anonymous referral in March 2011 about the children. This did not involve any home visit following consultation with education services and the school. In July

2011 the school attendance officer began inquiries with the police about four of the children; this included Hamzah who had never been enrolled for education. Amanda Hutton wanted all of the services to believe that the children were living outside Bradford with relatives. Various places in the south of England were mentioned and inquiries were made with another local authority that had no information; the children were never living outside Bradford.

48. In September 2011 there was a further referral. Over a period of several days a police community support officer (PCSO) made persistent attempts to see Amanda Hutton and the children without success. The PCSO made a child protection referral to CSC who requested a uniformed police officer to visit the property when Amanda Hutton had refused access to the PCSO. When the police gained access to the house Hamzah's body was discovered.

1.8 Key themes from the review

49. The agency reviews identify themes that have implications for policy development and staff training that applies to all services working with children. Chapter 3 of the overview report provides a summary. Important messages for learning from this review include:

    a) The importance of encouraging children to talk about their concerns, feelings or worries;
    b) Troubled families and parents who are suspicious or unwelcoming of contact from sources of help and support are also the most at risk of becoming isolated and invisible;
    c) Using phrases such as 'safe and well' to describe children's circumstances based on short or superficial contact can create optimistic mindsets that can also influence how further information is processed;
    d) Ensuring that assessment practice is based on a thorough foundation of theoretical understanding and can show rigour in triangulating evidence from direct observation of children and what they say; previous history and chronology; and thorough and reflective enquiry with relevant third parties or professionals;
    e) Thorough and reflective practice requires people having time and capacity to spend time with children and for talking with each other in enough detail;
    f) Children need to be the focus of professional contact with vulnerable adults who may be reluctant to accept help or support; what emerged in the court case was that coercion can be applied by adults determined to keep information secret;
    g) Concepts such as vulnerability and neglect do not reflect one off events or single behaviours; they represent a longer process of multi layered issues and patterns that will not be obvious through limited contact, observation, recording or partial sharing of information;
    h) Helping professionals to 'Think Family' and to see adult behaviour in terms of implications for their children;
    i) Workload pressure and contractual or commissioning arrangements can influence the capacity and focus of professional's ability to respond to information or lack of engagement;
    j) Ensuring that procedures and processes that support the seeking and exchange of information in important areas such as identifying whether children are missing are not seen as substitutes for appropriate and curious professional enquiry;

k) The importance of primary health professionals in maintaining contact and oversight of pre-school children that extends further than administration of routine health care;
l) The interplay of alcohol dependency, depression and domestic abuse increase the likelihood of child neglect and increase the risk of other abuse but does not predict such abuse; it therefore requires appropriately curious and proactive enquiry and assessment;
m) Short cuts to systems and processes that may help ameliorate short term workload pressures may undermine the integrity and quality of critical activity such as assessment and information exchange and recording;
n) Professionals are effected by the physical and emotional demands of their work that can be exacerbated by other temporary crises or difficulties that effect their performance such as the bereavement for one of the professionals in this case;
o) Children may not feel able to articulate emotional and psychological distress and can face emotional and psychological barriers in providing full disclosure of information out of loyalty to their family or to other significant people in their lives;
p) Emergency services such as the ambulance service (and by implication the fire and rescue services who are not involved in this case) may have significant information about families relevant to agency enquiries or MARAC discussions that is not routinely sought;
q) Women who suffer domestic violence will face varied difficulties and barriers in being able to ask for and then use help and assistance; professionals need to be aware of relevant research as well as being empathetic;
r) Men remain largely invisible to services that work with vulnerable children even when their behaviour as in this case is one of the sources of concern and risk for children;
s) Responding to older children when they ask for help can present challenges to professional and agency orthodoxies; a teenager describing their home life as intolerable may not be describing the tensions associated with adolescent development but rather is describing harmful abuse.

50. The recommendations developed in response to the IMRs and health overview report set out a detailed response to support learning and improvement. The final chapter of the overview report provides critical challenges for the BSCB that provide an opportunity for further work on developing the systems in response to the insights that the case provides about general patterns rather than addressing the specific issues highlighted from this case.

1.9 Priorities for learning and change as a result of the review

51. Each agency has identified areas for improvement; these are set out in the 'Learning and Improvement document'. The review also acknowledges that some of the shortfalls that are highlighted for example in how domestic violence was handled have been the subject of improved training and practice.

52. This is an unusual case and the review panel have focussed on identifying lessons that help to continue with the development of effective systems and practice rather than trying to address the unique features of one particular case. It is for these reasons that the panel have not made traditional interagency recommendations but have instead provided a series of reflections and challenges for local services in regard to the learning from the case; these are placed within a context of systems learning.

53. The most important points of learning from the review are;

a) Cognitive influence and human biases: developing mindsets that are open to fresh or different information; repeated exposure of professionals to intractable and long term problems contributing to a normalisation in the response; understanding the significance of deviant or risky parental behaviour.
b) Family and professional contact and interaction; putting children's needs, views and wishes at the forefront of interaction and enquiry; achieving balance in how vulnerable parents are helped; recognition of barriers that inhibit engagement and implications for practice.
c) Responses to incidents and information; viewing individual incidents or crises in isolation; identification and clarification of patterns or inconsistencies that could represent significant harm to children.
d) Longer term work with vulnerable children and troubled families; recognition of long term behaviours and changes to circumstances; multi agency understanding about what constitutes good enough parenting; systems that rely on parents doing the right thing.
e) Tools to support professional judgement and practice; availability and use of tools for collating, sharing and analysing information; promoting analytical discussion and revealing underlying and long term patterns such as neglect.
f) Management systems; improving the local arrangements to use information about vulnerability to promote the well being of children (especially pre-school); developing models of help and support; moving to more assertive forms of help when required.

1.10 Critical challenge for future development of safeguarding in Bradford

54. Having considered the overview report, the Bradford Safeguarding Children Board and the local agencies have agreed to consider the following issues to improve future practice. This is in addition to the recommendations being implemented by services as a result of their individual management reviews.

Influence of human biases

1) Is the support for professionals from different professional backgrounds sufficiently rigorous and challenging to prevent inappropriate erosion of concerns especially in regard to older children?

2) Can professionals distinguish with sufficient clarity between indicators of neglect and other factor such as social disadvantage?

3) What is the capacity in terms of skills, knowledge and organisational capacity for services in being able to work effectively with resistant adults?

Family and professional contact and interaction

1) How can professionals maintain an appropriate focus on the needs and risk for children when working with adults who have longstanding difficulties that can include depression, substance misuse or domestic abuse?

2) How can professionals identify evidence of inappropriate resistance?

3) How can professionals satisfy themselves that relevant children's views, wishes and feelings are considered and influence judgements and decisions?

4) How can the revised arrangements such as Think Family be evaluated for their effectiveness and are there particular issues for children of multiple births?

5) How can professionals ensure that frameworks for responding to domestic violence recognise the barriers to effective help and what are the implications for offence management and social support and intervention?

Response to incidents and information

1) How do the arrangements for responding to individual incidents or crises provide sufficient opportunity to place them within a context of previous history and to identify emerging patterns or dissonance/inconsistency?

2) How does the training and support provided to practitioners equip them to understand the importance of and have the capacity to identify underlying patterns such as emotional neglect as a result of issues such as alcohol dependence or domestic violence?

3) How does professional interaction in regard to contact, sharing information and making referrals consistently identify underlying concerns or patterns relevant to the development or vulnerability of a child over and above information about a specific incident?

4) How do practitioners have the guidance, confidence and skills to overcome the resistance of adults who may wish to divert or redirect professional focus or concern (that might include disguised compliance)?

Longer term work with vulnerable children and troubled families

1) Is the apparent level of uncertainty amongst different professionals about what constitutes 'not good enough' parenting acceptable?

2) Are local systems for ensuring children have access to appropriate health care and education (including pre-school) robust enough to compensate when parents are unable or unwilling to act in the interests of their children?

3) Are the increased rates of babies known to the early year's service leading to improved access for the most isolated and vulnerable of children?

Tools to support professional judgment and practice

1) To what extent is local assessment practice a reflection of a child focussed, professionally controlled activity rather than being driven by local and national bureaucracy?

2) Are the tools for collecting and recording information about children and their families adequate and able to promote sufficient interagency assessment?

3) How does the training and development of professionals undertaking assessments across all services provide sufficient understanding about child development and childhood vulnerability?

Management systems

1) Do professionals require written protocols and procedures to understand whether their action is appropriate and sufficient when enquiring into the whereabouts of a child?

2) How do professionals undertaking complex work that is subject to a great deal of primary legislation and regulation secure and maintain an appropriate level of knowledge and understanding?

3) Are there particular issues in a cosmopolitan city such as Bradford regarding how the community is kept informed about arrangements and agreements to look after children outside of their immediate family?

4) Are the current arrangements for permitting a child to be removed from a GP practice list appropriate?

5) Are the current arrangements for identifying any child living in the city not registered for school or for a pre-school service appropriate?

6) Does the BSCB have sufficient confidence in current arrangements for identifying children who are missing from home, education or health care and oversight?

55. A formal response will be published by the BSCB. Progress will be overseen by the Bradford Safeguarding Children Board. The serious case review has been submitted to the Department of Education. The serious case review will not be the subject of a formal evaluation by Ofsted; that arrangement was ended in July 2012. The serious case review and the associated responses will be examined as part of the unannounced inspection of arrangements to protect children that takes place in all English local authority areas with children's social care responsibilities.