Serious Case Review – Statement from the Chair of Bradford Safeguarding Children Board (BSCB)

My name is Professor Nick Frost. I am Professor of Social Work at Leeds Met University. As Independent Chair of the Bradford Safeguarding Children Board (BSCB) I am responsible for overseeing review processes following the death of a child or after other serious incidents. The role is established by government regulations and this ensures my independence from all the agencies in Bradford. I have 35 years experience in practice, policy and research in children's services issues.

I wish to express my sincere regrets and sorrow about the death of Hamzah and the subsequent events.

The death of any child is a tragedy and the fact that Hamzah's body was undiscovered for a long period makes his death even more tragic. It is imperative that all agencies with safeguarding responsibilities, in Bradford and nationally, learn any lessons from his death and the fact that it was undiscovered for so long afterwards.

The BSCB decided to initiate a Serious Case Review (SCR) following Government guidance as soon as possible following the events surrounding the discovery of Hamzah's body. In accordance with the guidance I appointed an experienced person to independently Chair the SCR process (Nancy Palmer) and a well-qualified independent author to produce the report. Nancy is here today and will speak about the process of undertaking the review and she will outline the primary findings.

BSCB has published three documents: the SCR, an Executive Summary of the SCR and a Learning and Improvement report produced by the BCSB.

The SCR details significant events during Hamzah's short life. The main aim of the report is to learn lessons from these unfortunate events so that professionals can change and improve their systems.

The SCR is very clear that Hamzah's death could not have been predicted but finds that systems, many of them national systems, let Hamzah down both before and following his death.

It is my responsibility, as Independent Chair, to ensure that lessons are learnt. Very sadly I cannot give any assurances that a tragedy like this will never happen again in our country - as we can't control or predict the behaviour of all parents, the vast majority of whom are doing their very best to care for their children. However, I can assure you that at this stage I am satisfied each agency is responding adequately: but this is an on-going process which requires constant monitoring.

No child should go through what Hamzah experienced. I am satisfied that systems are in place today that minimise the chance of a situation such as this ever being repeated in Bradford.

In this statement I wish to make a number of points.

It is clear from the trial and the judge's remarks that only one person is responsible for Hamzah's death: that person is Amanda Hutton, Hamzah's mother. At the trial, Judge Roger Thomas QC addressed how the mother had kept the death of her son a secret saying: "Your

deviousness was to keep various agencies away from you and your children." The serious case review states: "Hamzah died because he was neglected by his mother."

Having established this accountability we need to know what the agencies in Bradford need to learn from the events. In my 35 years of involvement in children's services I have never come across a case that can even be compared to this one. As the SCR establishes this was a unique combination of events: a mother who was determined not to co-operate even with the most necessary and essential services. She managed to mislead professionals and relatives about the whereabouts of Hamzah.

Thus the SCR asks how a child could disappear 'from the radar' of the services. Certainly there was insufficient information and no evidence that would have allowed any agency to take statutory action to safeguard Hamzah. The SCR states that 'there is nothing in the information examined by the panel to suggest that Hamzah's death was predictable'.

The SCR helps us to see how issues could have been handled more helpfully. For example, no thorough multi-agency assessment was undertaken - this is the usual way in which professionals build a full picture of what is happening in a household. Such an assessment may have given a comprehensive picture of circumstances in the household and should have led to a multi-agency meeting.

One of Hamzah's siblings could have been listened to more carefully on the two occasions where it was mentioned that all was not well in the family. However, when questioned about their home life at school the children appeared to be content. We have a duty to listen to children and young people.

The SCR also finds that remarkably the siblings appeared well and cared for – but sometimes they did not. This inconsistency could have been explored more fully.

Further mother was inconsistent in her stories about where Hamzah was following his death. Again some of her statements could have been followed up more fully.

Now the system has been reformed fundamentally: to avoid children in the district disappearing from view all Bradford births are now notified to children's centres by a health visitor – unless the parent explicitly opts out from this process. Additionally since Hamzah's death, and drawing on research, the assessment process has been fundamentally reformed and involves a range of professionals working together.

My independent view of services in Bradford has been they are good and sometimes excellent. This personal assessment was re-enforced by the Ofsted inspection of 2012 which is available on the Ofsted website.

But lessons must and will be learnt and action will follow. Personally I will do all in my power to ensure that the contents of the Learning and Improvement document are fully followed through. I know I have the total commitment of all the agencies involved in the SCR to do this.