



## **A Serious Case Review**

**Hamzah Khan**

**The Overview Report**

**November 2013**



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## **1 Introduction and context of the review**

1. The serious case review examines, for the purpose of professional learning and service improvement, the involvement of agencies with Hamzah Khan who died as a result of the criminal neglect by his mother, Amanda Hutton who 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 over a number of months. The full extent of his treatment was not known about until the evidence was laid before a judge and jury in the autumn of 2013 following an extensive criminal investigation. This detailed information was not available to the overview panel at the time that the serious case review was underway. The trial also revealed other significant information about the family and the circumstances of the children that had not been known until then.
3. The review examines what was known and understood by the different services at the time of events and considers what the tragic story of Hamzah represents for professional learning and future policy. In doing this, the review is focussed on how people doing difficult work, often as in this case with adults who are reluctant or unwilling to have help, can best be encouraged and supported in continuing to improve the opportunities and quality of contact with troubled families and vulnerable children. Simply saying that with hindsight, and if people had known what we all know now, they probably would have made some different decisions does not help with promoting effective improvement and learning.
4. One of the most singular aspects of this case is the degree to which there is very little recorded information about the children and particularly in respect of what they were thinking, feeling or saying at critical points such as the incidents of domestic violence. Hamzah together with some of his other siblings who had not ever got to school literally disappeared from the view of their extended family and community as well as from the view of universal services such as education and health.
5. When one of the children, then an adolescent, did speak out about his unhappiness it was heard and probably misunderstood as being solely symptomatic of adolescent and parent conflict and tension.
6. An important question from this review that is wider than just for the circumstances of one city and the local safeguarding children board is how children can be encouraged to talk about their home circumstances and for such information to be heard with sufficient curiosity, empathy and understanding that takes account of children's overall well-being by people and organisations that have the capacity to do this.
7. Attention to collating information, showing thoughtfulness and reflecting on the significance of information is less likely to occur in conditions where workload, information systems and frameworks are not conducive to this and measures of what is satisfactory practice is not focussed on the experience and outcomes for vulnerable children.
8. It is now known that five children lived with awful physical and emotional conditions for many months as their mother's emotional and mental well-being

was severely impaired and deteriorated. How can children living with such conditions have the confidence to talk with a trusted adult especially if they have been withdrawn from contact with services such as health visitors, GPs, early year's services or school? These are not issues that are addressed through procedures or complex action plans.

9. Whether it is the professionals and other people who knew the family, the participants in the process of the criminal investigation and trial or the general public who have doubtless been very distressed by the information that has now been revealed about Hamzah's circumstances, all will share a sense of anger, bewilderment and shock that a child can be so neglected as to die and then can be left undiscovered for almost two years whilst living in a major city in a country with one of the most developed systems for safeguarding children in the world.
10. The fact that Hamzah had been withdrawn from the usual and universal services such as early years, education and health and was therefore invisible for almost a lifetime is a significant factor. The overview panel received no information that suggested that there was one opportunity for a single individual to have done something to have saved this child. The information considered does not point to single acts or omissions but rather a constellation of factors that contributed to the circumstances.
11. Although some individual judgments with the benefit of hindsight can be seen to have been made without enough information or analysis, the invisibility of Hamzah is far more a reflection about how universal as well as specialist systems of help are delivered to vulnerable children and troubled families.
12. There is a danger in such a highly charged and emotional case such as this, that with the crude application of hindsight any genuine and more honest learning will be lost. Reliance on hindsight can wrongly infer that wrong personal or professional judgments were made rather than looking at what was known at the time and analyse how and why information was being processed by all of the relevant people (family and professional) and the reasons for it. Unless there is some understanding about how and why both professionals and families behave and act there will continue to be a preoccupation with looking at the wrong evidence and information that has limited value for improvement and learning in some of the most complex human and professional activity.
13. It is for this reason that the review examines for example whether there was sufficient understanding about the history and significance of domestic abuse, why assessments were approached in the way that they were rather than just stating that they could have been more effective, examining the impact and influence of contracting arrangements for GP services rather than just concluding the children should not have been taken off a GP register, the way in which people use and follow protocols for example in regard to finding children missing from education, the way in which enrolment of children with universal services such as school have been reliant on parents doing the right thing for their children and exploring issues such as why women who are emotionally and physically abused are so often unwilling and unable to co-operate or engage with help.
14. The person who could have prevented this death was Amanda Hutton who had the day-to-day responsibility for Hamzah and other siblings. She had become so overwhelmed with her own problems and needs that she was incapable of

adequately caring for herself let alone any dependent children. Nobody, save for the children who were living with her, will know when those conditions became so extreme and were in stark contrast to the conditions that were recorded by a succession of different services until some months before Hamzah's body was discovered. However, Amanda Hutton was not always such an inadequate or a dangerous parent.

15. Amanda Hutton had first become pregnant as a teenager at a time when support for such young mothers was not as developed as it is now. There were not the specialist midwives working with teenage parents, there were not Sure Start or Children's Centre services. There would now be a far more active and informed approach to working with teenaged parents under current arrangements compared to the position over 20 years ago.
16. Little is known or recorded about the first pregnancies but the limited agency information from health visiting records for example and accounts from her family indicate that Amanda Hutton had applied herself with commitment and provided appropriate parental care for her older children; this is borne out by professional recording as well as the statements from different family members. She had cared for her step father after he had an operation.
17. Amanda Hutton had been capable of empathy and care to others. By the time she had neglected Hamzah to such an extent that Hamzah died having been denied nourishment, 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.
18. That chronic dependency was not recognised or known about in the services that had been in contact with the family although there had been knowledge about drinking. Amanda even consulted her GP on at least one occasion in 2007 although the extent and degree of the dependency was not apparently as severe as became apparent in the later months of Hamzah's life; some of that might indicate a minimisation on Amanda Hutton's part as much as possibly a historical tolerance that is viewed differently by today's knowledge and understanding about substance misuse and the impact it has on parents' emotional and physical care of children. It also appears to be the case that for many years Amanda Hutton was able to maintain a better level of care that did not warrant more intrusive or assertive intervention when help was generally being declined.
19. The extent to which Amanda Hutton became isolated especially after the death of her mother was not properly understood and in truth was not disclosed either to the trial or in the agency information provided to the SCR. It simply was not known about. It is apparent that she was prone to depression and in 1999 had made threats to self harm.
20. It can now be seen that there was an effective and serious misdirection of services that had begun to make enquiries about the whereabouts of Hamzah and the other young siblings but this was after Hamzah had already died in December 2009. Amanda Hutton, with the apparent coercion of the children, had persuaded services such as education and health that they were living in an entirely different part of the country. What the trial established was that Amanda Hutton had been determined to keep the fact of Hamzah's death a secret. Those threats that the trial were told about were sufficient to prevent Hamzah's siblings from speaking out.

21. Although there were efforts to check information when for example a health visitor had become concerned in 2010 about the lack of contact with health services and subsequently both the enquiries by health, education and CSC as well as a referral that was made in early 2011 relied primarily on what the family said rather than getting to a point where Hamzah or the siblings who were subject of the inquiries had been seen. There was not a visit to the home because at the time it had not been regarded as necessary. It is one of the examples of where a decision has different significance with hindsight and knowledge about what the true picture was.
22. These events highlight the dangers of any decision making that relies on impressions of children being 'safe and well' rather than undertaking more inquisitive and reflective enquiries, either through a CAF (common assessment framework) or certainly when making enquiries and assessments in regard to whether a child is in need or at risk of significant harm<sup>1</sup>. People who are dealing with heavy workloads and have competing demands for their attention will have more limited opportunity to be curious, inquisitive and enquiring.
23. Neither the trial nor the SCR has satisfactorily reconciled how and why Hamzah's disappearance for almost two years was not a matter of curiosity or inquiry for the father or any other adults in Hamzah's family.
24. This SCR has considered the domestic abuse that occurred over very many years and probably predates the first recorded incident in 1996. The SCR also refers to Amanda Hutton's history of depression and the traumatic isolation that she felt following the death of her much loved mother and the disintegration of her relationship with the children's father over several years.
25. Some people will ask why help was not provided. Help was provided on several occasions and sometimes with great sensitivity and persistence. However, as will become clear through the report, that help faced many and significant barriers. These barriers included the extent to which neither parent felt able to acknowledge problems for much of the time and the emotional and psychological impairment that leads victims of abuse to refuse help partly because of concerns about exacerbating the situation. In addition, professionals faced problems of collating information from disparate sources.
26. The timeframe for when matters had got so entirely out of control or how some of the children were able to engage in Amanda Hutton's account that Hamzah had gone to live with relatives are still not entirely clear although the trial heard evidence of coercion and threats of violence. It is also not clear why Amanda Hutton's parenting of Hamzah was especially poor over and above observing that Hamzah appeared to have been a more difficult eater than the other siblings and this coincided with the escalating collapse of Amanda Hutton's relationship, the escalating impairment of her ability to care for herself, her children or her home after she eventually left the abusive relationship. With hindsight it can be seen that this was the time when Amanda Hutton withdrew from community and professional contact.

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<sup>1</sup> The review analyses and comments on the lack of use of the CAF as well as the way statutory assessments were dealt with in later sections.

27. There has been reluctance from within the family to disclose or discuss information over and above what has been given in court and under oath. One of those witnesses had to be compelled to appear. Amanda Hutton was unwilling and unable to give a full account of how and why her life had been so transformed for the worse either to the trial or to the SCR. Amanda Hutton has chosen to have no contact with the SCR process. The trial established guilt for neglect and cruelty but not the reasons for it. What the trial and this SCR describe is a family where nobody was able to tell any service about the appalling conditions that had become prevalent by the time of the child's death.
28. The non-molestation order that the children's father was subject to from 2009 meant that he did not visit the property where Hamzah died although he continued to have full and shared parental responsibility with Amanda Hutton for his children. The case raises additional questions for how fathers who have been abusive or violent to their partners are able to have a role in the lives and upbringing of their children.
29. The only evidence that the children's father disclosed a concern about the care of any children was when he had been taken into custody for assaulting Amanda Hutton. Although he was advised to tell CSC if he had concerns there is no record of this ever being done. The police did not have other direct evidence to support heightened concerns at that stage about the children.
30. This overview report gives an account of the detailed examination of several agencies knowledge of and contact with the family. The review acknowledges that some of those contacts could have been handled differently and explores why and the implications for learning by looking at the various contributory factors that influenced judgments, decisions and action of both professionals and other people as far as is possible.
31. The SCR examines the contact that took place at different times between the family and several agencies; this was primarily in regard to incidents of domestic violence. For the most part, Amanda and father were both resistant to professional contact. This is behaviour that will now be familiar to most professionals and services working with domestic violence and substance misuse and is explored in the analysis and findings of the report.
32. An account is also provided in the comment and analysis within the report about how the work of reviews such as this can contribute to the development of better informed practice as well as describing for example legislative changes in regard to domestic abuse being properly seen as causing significant harm to very young children in particular and the introduction of measures such as Domestic Violence Prevention Notices (DVPN) that are less reliant on victims co-operating with services such as the police. These are changes and developments that have occurred since the tragic death of Hamzah in 2009.
33. The case has raised important issues about how much responsibility is left to parents for example to register their children with health services or to ensure that they are enrolled for universal services such as education. The review considers for example issues such as the perverse incentives associated with primary health care patient contacts that create a disincentive to keeping reluctant or resistant people on GP register.
34. The SCR has coincided with a watershed in how reviews such as this have to better address the learning and improvement that needs to come from such

cases. The review has resisted a reliance on hindsight to judge the action and behaviour of all the parties, professional or others, to this tragic case.

35. The review has set out to understand what was happening and why and to explore the various influences and contributory factors. For example, mention is made in later sections of the report about how the aftermath of the “Baby P” case had very significant consequences in the increased level of contacts and referrals and how some of the measures designed to help ameliorate workload pressures had consequences in how information was being recorded at the time and the capacity to follow up less urgent or unresolved information such as when Hamzah was first identified as missing from education and health services.
36. The review panel has also taken account of the evidence that overly forensic overview reports and multiple recommendations that result in complex action plans have very little impact on wider learning and improvement in regard to the complex interactions that a case such as this illustrate.
37. It is for this reason that all agencies have considered what they need to change and do differently. However this overview report has not made recommendations but has instead provided a series of challenges and reflections for the Bradford Safeguarding Children Board (BSCB) to address in respect of the learning to be achieved from this review. Nobody should be under any illusion that by using such an approach it offers a far more substantial and onerous responsibility to the BSCB in responding to this tragic case than ratifying a set of recommendations and actions.
38. A significant theme in this review and for the trial was the extent to which Hamzah along with the younger siblings was unknown and invisible to services throughout his short life. The circumstances that caused Amanda Hutton in particular to withdraw increasingly from any contact with services are complex. A significant 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 although the children’s father is less persuaded that this was a factor.
39. 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 had been enrolled for early years or local educational provision.
40. The case has already prompted changes to the way in which services can be more proactive in looking for children who may be missing from such universal services although in the absence of an all embracing and comprehensive information system that records and tracks a child from birth, the primary reliance continues to rest on parents being responsible and enrolling their children where they retain sole parental responsibility (there is no statutory involvement through a care order for example).
41. There are important questions for local and national policy in regard to how many of the systems for the universal health care and education of children rely on parents registering their children for such routine services. Although this review describes the action already taken in Bradford to be more rigorous in identifying the children who either are not known at all or as in this case are

effectively withdrawn from view, is it realistically impossible to guarantee that a child will not remain hidden from universal or specialist services such as children's social work services under current statutory arrangements.

42. The reflections and critical challenge are designed to provoke more enduring learning and improvement that applies across a wider range of services and children rather than being confined to the highly unusual circumstances of this one tragic case.
43. Regrettably, domestic abuse, child neglect, substance misuse and mental illness are the background to very many children's lives. The work of a review such as this can only hope to inform and support the continued development of professional practice in a country where internationally, the UK is a bench mark for learning and improvement.

### **1.1 Circumstances leading to the serious case review**

44. Hamzah (the index child for the review) had seven siblings, five of whom were living in the same household. The two eldest siblings lived independently. There was one other child (Sibling 3) who was younger. Hamzah's body was discovered by police officers during a search of the house in September 2011.
45. The police were at the house following up concerns about anti-social behaviour and reports about very poor conditions in the home. The police were also trying to establish the whereabouts of several of the children who had not been seen for some time. Several visits had previously been made to the property by a police community support officer (PCSO) with a request for Amanda Hutton to make contact. During a visit earlier in the afternoon to the property Amanda Hutton had answered the door but had refused access to the house although the PCSO had noted the presence of a strong smell and the evidence of many flies.
46. It was the PCSO who showed great persistence in seeking further support from fully warranted officers and eventually secured access to the property that led to the discovery of Hamzah's body. The action of that officer was commended by the judge and is also highlighted as one of the examples of good practice in this review.
47. It had not been possible to establish an exact date for Hamzah's death when the SCR was being conducted in 2012 although as a result of the evidence given in the trial, it has now been established that Hamzah died on the 15<sup>th</sup> December 2009. Information provided through statements to the SCR and from the post mortem examination had indicated that Hamzah's death might have occurred in December 2009 when Hamzah was aged four years old. The SCR panel was not told about the discovery of his body in a babygro for a child aged less than 12 months old; this was clear evidence that his physical growth had been severely impaired given the more definite date of death established by the criminal trial.
48. The parents had separated in October 2009. With the exception of the second eldest child (Sibling 6) who was 18 at the time of Hamzah's death, all of the siblings were then living with Amanda Hutton. Sibling 7 was aged 19 at the estimated time of death. After the discovery of Hamzah's body all of the children under 18 became the subjects of care proceedings initiated by the local authority and were placed with carers outside of the family.

49. The serious case review was commissioned on the 28<sup>th</sup> November 2011 by the independent chair of the Bradford Safeguarding Children Board. Work began on compiling a chronology in December 2011, which coincided with the appointment of the independent chair of the serious case review panel and of the independent author of this overview report. The panel chair has worked in Bradford but moved to other employment in 1993. The overview author has not worked for any of the services contributing to this serious case review. Further information about their relevant experience and knowledge is provided in section 1.11.

## **1.2 Rationale for conducting a serious case review**

50. Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires a Local Safeguarding Children Board (LSCB) to undertake a review of a serious case in accordance with procedures set out in chapter 8 of *Working Together to Safeguard Children (2010)*.
51. The LSCB should always undertake a serious case review when a child dies and abuse or neglect is either known or is suspected to be a factor in their death.

## **1.3 Reasons for the review and terms of reference**

52. 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. There had been historical concerns including domestic violence and use of alcohol. The home conditions in which Hamzah and the siblings were living when the body was discovered were very poor.
53. The serious case review panel at their first meeting on the 10<sup>th</sup> January 2012 confirmed the scope and overall terms of reference for the review and established a timeline for the completion of work. The panel postponed agreeing case specific key lines of enquiry pending the receipt of the chronology and first drafts of narrative information from the authors of the individual management reviews (IMR) at the meeting of the panel in February 2012.
54. The overall purpose of the review is to establish the opportunities for learning and improvement from the case through a detailed examination of events, decision-making and action. In identifying what that learning and improvement is, to improve inter-agency working and to better safeguard and promote the welfare of children in Bradford.

## **1.4 The methodology of the serious case review**

55. 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<sup>2</sup>. The government had indicated that it supported the changes being recommended by Professor Munro that future serious case reviews should be conducted using systems based learning methodology; details about what that methodology and framework had not been agreed when the review was completed<sup>3</sup>. The BSCB was already working on how future serious case reviews in Bradford should be developed in order to provide a more informed inquiry into the local systems for safeguarding and protecting children<sup>4</sup>.

56. The analysis in the final chapter of this report uses some of the framework developed by SCIE (Social Care Institute for Excellence) in anticipation of the changes to serious case reviews to present key learning within the context of local systems. 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<sup>5</sup>. The final chapter of the review for example explores the influence of family and professional interactions, the responses to incidents and crises and the tools that are used by professionals. The report also recognises that this is a very unusual case concerning the death of a child that was not discovered for several months.
57. This is not a review that has used systems methodology to collect and analyse the information from the people who had contact with the family, but the panel have worked to place the evidence that has been analysed within individual agency reports into a framework that begins to explore how the local systems both promote and in some circumstances inhibit professional practice and decision making.
58. The individual agency management review authors were briefed and encouraged to examine professional practice within the context of local systems operating at the time of the events that were being examined. A systems based review would have provided greater opportunity for the practitioners to be central to the process of the review in terms of collating information and helping to develop the analysis and collective understanding about why the case

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<sup>2</sup> Munro review of child protection: final report - a child-centred system; May 2011

<sup>3</sup> The government started a three month consultation on the 12<sup>th</sup> June 2012 regarding the revised guidance for learning and service improvement that would change arrangements for the conduct of serious case reviews as well as abolishing much of the national guidance in Working Together and the arrangements for assessment of children in need. The revised national guidance was published in March 2013.

<sup>4</sup> Analysis of clinical incidents; providing a window on the system not a search for root causes. CA Vincent; *Quality and Safety in Health Care*, 2004. The article argues that incident reports by themselves tell comparatively little about causes and prevention, a fact which has long been understood in aviation for example and is the basis of developing a systems learning approach to serious case reviews in England.

<sup>5</sup> *A study of recommendations arising from serious case reviews 2009-2010*, Brandon, M et al, Department of Education, September 2011. The study calls for a curbing of 'self perpetuating and proliferation' of recommendations. Current debate about how the learning from serious case reviews can be most effectively achieved is encouraging a lighter touch on making recommendations for implementation through over complex action plans. SMART refers to strategic, measurable, achievable, realistic and timely.

developed in the way that it did. The revised national guidance gives greater freedom to LSCBs in regard to the methodology they choose to conduct a SCR.

59. 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. Further information about their respective experience is provided in section 1.11.
60. 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 following section 1.4). These reports were completed by suitably experienced people who had no direct involvement or responsibility for the services provided to the children and their parents.
61. 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 The scope of the serious case review**

62. The period of the review was from the beginning of Amanda Hutton's known pregnancy with Hamzah to the discovery of Hamzah's body in September 2011. All information known to a service providing an IMR was reviewed. Any information regarding involvement prior to the period of the detailed chronology and analysis was summarised in the IMR and in the overview report.
63. All agency chronologies include detailed information about when the children were seen, spoken to or observations made about them.
64. Agencies that identified significant background histories on family members pre-dating the scope of the review have provided a brief summary account of that significant history.
65. Reviews of all records and materials that have been examined include;
  - a) Electronic records
  - b) Paper records and files
  - c) Patient or family held records.
66. Individual management reviews were completed using the template provided by the Bradford Safeguarding Children Board (BSCB), and were quality assured and approved by the most senior officer of the reviewing agency.
67. The following agencies have provided an individual management review that was to be completed in accordance with *Working Together to Safeguard Children (2010)*, Chapter 8 and the associated BSCB guidance and relevant procedures.
  - a) Health services that include:
    - o Bradford and District Care Trust (BDCT and provided health visiting services)

- Bradford Teaching Hospitals NHS Foundation Trust
  - Bradford and Airedale Teaching Primary Care Trust (PCT); general practitioner services and the Health Overview Report (HOR)
  - 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)<sup>6</sup>
  - f) Bradford Youth Offending Team (YOT)
  - g) Voluntary organisations (Home Start, Hope Project and Staying Put<sup>7</sup>)
  - h) West Yorkshire Police
  - i) West Yorkshire Probation Service.
68. 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 of education services in the city.
69. 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 all of those children had always lived in the Bradford area.

### **1.6 The terms of reference as described in national guidance**

- I. Keep under consideration if further information becomes available as work is undertaken that indicates other agencies should carry out individual management reviews.
- II. To establish a factual chronology of the action taken by each agency;
- III. Assess whether decisions and action taken in the case comply with the policy and procedures of the Bradford Safeguarding Children Board;
- IV. To determine whether appropriate services were provided in relation to the decisions and actions in the case;
- V. To recommend appropriate inter-agency action in light of the findings;

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<sup>6</sup> 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.

<sup>7</sup> Staying Put is a local domestic violence/abuse charity that helps up to 1,400 women and children every year across the Bradford District to stay in their own homes. Staying Put provided their IMR when the SCR panel had already prepared a draft overview report when the extent of the agency's involvement was identified.

- VI. To assess whether other action is needed in any agency;
- VII. To examine inter-agency working and service provision for the children;
- VIII. To establish whether interagency and single agency policies adequately supported the management of this case;
- IX. Consider how and what contribution is sought from the family members;
- X. To develop a clear multi agency action plan from the overview report.

### **1.7 Particular issues identified for further investigation by the individual management reviews<sup>8</sup>: the key lines of analytical enquiry**

70. In addition to analysing individual and organisational practice, the individual management reviews should focus on:

#### **Recognition**

- i. **To what extent were any vulnerabilities or needs of mother 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 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 mother'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**

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<sup>8</sup> These are the detailed issues that are analysed by the IMRs and in the detailed analysis in chapter five of this report.

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 12<sup>th</sup> September 2011 and the 21<sup>st</sup> 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.

### **1.8 The terms of reference for the health overview report**

71. The health overview report provided an overview of the information and analysis provided by all health services for the serious case review. In particular it addressed the following:
  - i. Comment on the quality of information and analysis and identify significant themes and areas for learning;
  - ii. Comment on any specialist referrals or assessments undertaken and the extent to which these contributed to appropriate decision making;
  - iii. Provide comment on the extent to which evidence about neglect was identified and acted upon by various health services;
  - iv. Comment on the extent to which the reports provided by health services have identified appropriate learning and have provided sufficiently informed analysis;
  - v. Give particular regard to any implications for the likely reform of health arrangements in Bradford identified through the review regarding the capacity of primary health professionals to identify and follow up of children not presented for routine health advice or treatment;
  - vi. The quality of action already taken in response to the serious case review and the recommendations and action proposed by the health IMR reports;
  - vii. Identify any further themes to be explored within the overview report;
  - viii. Make recommendations necessary to ensure appropriate implementation of learning across the health service in Bradford.

### **1.9 The terms of reference for the overview report**

72. Provide a multi agency overview report in accordance with the national guidance in *Working Together to Safeguard Children*.
73. In addition to the requirements of *Working Together to Safeguard Children (2010)* and taking into account the specific issues identified above, the overview report author:
  - I. Commented on whether the individual management reviews have addressed the terms of reference and all relevant issues;
  - II. Examined the inter agency working and communication between all involved agencies;
  - III. Determined whether services which were provided, actions taken and decisions made were in accordance with current policies, procedures and government guidance;
  - IV. Considered whether different decisions or actions may have led to a different course of events;
  - V. Provided an executive summary on behalf of the BSCB.

### 1.10 Membership of the case review panel and access to expert advice

74. An independent person was appointed to chair the case review panel from the outset;
75. The case review panel that oversaw this review comprised the following people and organisations;

<b>Position</b>	<b>Organisation</b>
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

76. The independent author of the overview report attended every meeting of the panel;
77. The panel had access to legal advice from a solicitor in the council's legal service;
78. Written minutes of the panel meeting discussions and decisions were recorded by a member of the BSCB staff team.

### 1.11 Independent chair of the serious case review panel and independent author of the overview report

79. Nancy Palmer was appointed as the independent chair of the serious case review panel. Nancy is a psychology graduate and qualified social worker with a long career history in children's services including the roles of child protection co-ordinator and service manager for child protection. Although she has worked mainly in the public sector she has also spent time in the voluntary sector and developed a career of increasing seniority in children's services delivery and regulation. Alongside her employed role, she has also undertaken independent work chairing serious case and serious incident reviews, and delivering training on child protection and safeguarding. Following six years as a senior civil servant in the role of divisional manager with Ofsted, where she was instrumental in setting up and subsequently managing early years and children's services regulation for the north of England, Nancy went on to spend 18 months as a government advisor on children's services before becoming the Operational Director for the north of England with Cafcass. In July 2009 she

took the decision not to continue working full time and now holds a part time portfolio of work including the role of independent LSCB chair and other ad hoc work mainly in relation to children's safeguarding.

80. Peter Maddocks was commissioned in December 2011 as the independent author for this overview report. He has over thirty-five years experience of social care services the majority of which has been concerned with services for children and families. He has experience of working as a practitioner and senior manager in local and national government services and the voluntary sector. He has a professional social work qualification and MA and was registered with the General Social Care Council now superseded by the Health and Social Professions Council (HSPC). He undertakes work as an independent consultant and trainer and has led or contributed to several service reviews and inspections in relation to safeguarding children. He has undertaken agency reviews and provided overview reports to several LSCBs in England and Wales. He has undertaken training in regard to systems learning and its application to serious case reviews.

### **1.12 Parental and family contribution to the serious case review**

81. Amanda Hutton and 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 any 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<sup>9</sup>.
82. Both parents initially confirmed that they wished to provide information for the review and had agreed to speak with the independent chair of the panel. Regrettably, in spite of several attempts to contact both parents it was not possible to speak with either of them during the course of the SCR apart from a brief conversation between the BSCB manager and Amanda Hutton that confirmed she was willing to speak with the panel chair. 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 to that appointment.
83. Following the trial the children's father agreed to meet with the manager of the BSCB. During that discussion the father made clear that he had been unaware that Hamzah had not been registered with a GP and had not had any immunisations. The children's father denies responsibility for domestic abuse to Amanda Hutton although does acknowledge the conviction. He refutes that he was resistant to help for example in regard to the domestic abuse. The children's father believes that although he has been subjected to racist attitudes he does not believe that his relationship with Amanda Hutton was a source of difficulty or hostility for some people in the community. The children's father has expressed his surprise about the degree of resistance that Amanda Hutton had to offers of help. The children's father has expressed his surprise that people

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<sup>9</sup> A Guide for the Police and the Crown Prosecution Service and Local Safeguarding Children Boards to assist with liaison and the exchange of information when there are simultaneous chapter 8 serious case reviews and criminal proceedings; April 2011.

did not contact him when there were concerns for example about the attendance of children at school.

### **1.13 Time scale for completing the serious case review**

84. The case review panel met on seven occasions between January 2012 and September 2012. The initial chronology of services involvement was completed by January 2012. The first draft of the narrative agency reviews were completed in February 2012 although final drafts including agency analysis were finalised in March 2012. The first draft of the health overview report was completed in June 2012. The final report was presented to an extraordinary meeting of the BSCB on the 3<sup>rd</sup> October 2012.
85. 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.
86. Following the completion of the trial in October 2013, the chair of the BSCB arranged for a further examination of the information revealed during the trial prior to finalising the overview report for publication. That review involved the author of this report, the chair of the SCR panel and the BSCB manager reviewing what additional or new information that had become available through the trial with the assistance of a senior police officer. It was decided not to reconvene the full SCR panel to avoid undue delay to the publication of the overview report and executive summary.

### **1.14 Status and ownership of the overview report**

87. The overview report is the property of the Bradford Safeguarding Children Board (BSCB) as the commissioning safeguarding board. Since June 2010, all overview reports provided to LSCBs in England are expected to be published. In view of the level of public interest that the case represents and the extent of the media coverage already given during the trial, the names of Hamzah and of the mother Amanda Hutton are used.
88. The overview report is primarily written with the intention of addressing professionals involved with the design, oversight or delivery of multi agency safeguarding services although it should also provide accountability and information to other interested parties. The executive summary provides a more accessible and shorter account of the key findings from the review.
89. The review aims to build on the considerable knowledge and expertise that has developed in relation to the safeguarding of children in the UK. In doing this work, the panel are mindful about how complex or opaque some of the information and events may have looked to practitioners at the time of the events.
90. The BSCB will determine how and what further information is provided to the family at the conclusion of the review and following the submission of the overview report and executive summary to the Department of Education.
91. 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 action plans 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.

### **1.15 Previous serious case reviews**

92. The LSCB in Bradford has published executive summaries of four serious case reviews undertaken between 2006 and 2010<sup>10</sup>.
93. Reference is made to these previous serious case reviews by several IMR authors and is also referenced where relevant in this overview report. The purpose of this is to highlight where similar issues or themes have been identified in previous reviews. This ensures that any action already recommended is not unnecessarily repeated. Themes relevant to this review include poor school attendance, domestic violence, the resistance of some families to professional help and support and the role of primary health professionals such as GPs in collating information and recognising safeguarding concerns.
94. There is evidence from other serious case reviews nationally that demonstrate a significance of injury to children from larger sibling groups.
95. Chapters four and five of this review describe in greater detail the specific lessons to emerge from a detailed analysis of this serious case review and include comments on how learning from previous reviews has been used.

### **1.16 Inspections of services for children in Bradford**

96. All children's services in England are subject to inspections. The local authority was subject along with all other local authorities in England to a Comprehensive Annual Assessment (CAA)<sup>11</sup>; in 2010 and 2011 the CAA annual rating given to children's services in Bradford was adequate<sup>12</sup>. This meant that services were meeting minimum national standards.
97. The annual unannounced visit<sup>13</sup> of inspection of contact, referral and duty arrangements for children that took place in late 2010 and 2011 judged

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<sup>10</sup> The coalition government's notice issued on the 10<sup>th</sup> June 2010 under section 16(2) of the Children Act 2004 which amended the previous national guidance in *Working Together to Safeguard Children* requires that both the executive summary and the overview report with suitable redaction to provide confidentiality are published. The coalition government ended the formal evaluation of SCRs from the 5<sup>th</sup> July 2012.

<sup>11</sup> The coalition government abolished the CAA from 2010.

<sup>12</sup> This profile includes findings from across Ofsted's inspection and regulation of services and settings for which the council has strategic or operational responsibilities, either alone or in partnership with others, together with data from the relevant Every Child Matters indicators in the new National Indicator Set (NIS). Every Child Matters was not continued as a policy framework by the coalition government.

<sup>13</sup> The inspection was carried out under section 138 of the Education and Inspections Act 2006. It contributes to Ofsted's annual review of the performance of the authority's children's services, for which Ofsted will award a rating later in the year, subject to any changes that the coalition government may introduce. The inspections are part of a national programme of enhanced inspection of children's services introduced in 2009 following the death of Peter Connolly (Baby P) and the two subsequent serious case reviews in Haringey.

services to be adequate. That inspection reported that there were effective arrangements in place to refer and respond to concerns about children. The inspectors noted that the number of domestic violence notifications sent to social care by the police resulted in a higher than necessary workload for assessment teams and both of the services recognised the need to streamline this process so that referrals were clearly differentiated from notifications sent through only for information purposes.

98. Bradford's children's services were judged to be 'good' with 'outstanding' partnership working, following a two-week investigation carried out in May 2012 into how children in care, foster children and those leaving care are being looked after and how safeguarding services were working across the district to protect vulnerable children from abuse and exploitation.

### **1.17 Synopsis and summary conclusion of the review panel**

99. Several aspects make this a most unusual case and therefore care has to be exercised in distinguishing between any lessons that are simply an application of hindsight with this one specific case and the more general areas of learning about how local systems for safeguarding children can be developed further.
100. A compelling aspect of the case for general learning is the extent to which none of the various organisations that came into contact with this family had enough information to form a view about what life was really like for any of the children in this household especially during the last few years.
101. The lack of focus on the needs, wishes and feelings of children is a consistent theme in serious case reviews. In this case there were specific occasions when some of the children expressed clear views and wishes that were given different inference by key services. One of the older children had been very unhappy although at the time it was interpreted as being the teenage angst of an adolescent rather than something more serious.
102. Information known to the various agencies at the time of the events that have been examined and analysed by the panel does not suggest that Hamzah's death was a predictable event. Preventing his malnourishment required Hamzah to have been seen by professionals who could monitor his well-being.. Such monitoring should have resulted in his malnourishment and neglect being identified and would have been a cause to make referrals under the safeguarding protocols to CSC and the police.
103. The fact that Hamzah was not registered with a GP practice in the city had been noticed by a health visitor in 2010, who initiated enquiries into his whereabouts, and those of 2 other young siblings. However, this was after Hamzah had died.
104. The subsequent enquiries by health, CSC and education services did not establish as a matter of verifiable fact where Hamzah and the younger siblings were living, having been misdirected by Amanda Hutton. This extraordinary case will cause local and national agencies to consider how a child such as Hamzah can be kept in view of their community and local services.
105. The misdirection required Amanda Hutton to convince her older children about the account of the younger siblings staying with relatives in other parts of the country. The fact that the locations stated varied may have been a lack of

consistency in the story being told or the recording and sharing of the information by professionals. The ability to persuade several services that the younger children including Hamzah were no longer living in the city and had effectively disappeared will require thoughtful reflection in regard to the prevention of children going missing at local and national levels.

106. Hamzah's absence from health visiting and GP services was being followed up in the summer of 2010 and advice was sought from the specialist safeguarding advisor. It was the health visitor's enquiries that initiated the missing from education protocol in October 2010 when the health visitor was enquiring about the whereabouts of the youngest children. It is of course known now that Hamzah had already died and his death had not been reported by Amanda Hutton.
107. The pattern of Amanda Hutton avoiding health care professionals had been a longstanding pattern of behaviour that had she put down to being afraid of doctors. The reasons for Amanda's reluctance to use health services were not explored at the time; at least there is no recorded evidence. The fact that she was a reluctant user of primary health care services was identified and was pursued by the GP and the health visitor for several months although the last time that the GP saw Amanda Hutton was in September 2006, although she had a telephone conversation with a GP in July 2007.
108. The fact that Hamzah was entirely "off the radar" of services for so much of his life was an indicator of concern although was not recognised until 2010 partly because nobody had a complete overview about the situation. The usual procedure for routine health care surveillance was undermined by Amanda Hutton's complete withdrawal from every service. The extent to which the younger children were never seen by any health professional after the first birth contact is quite out of the ordinary.
109. A reluctance or lack of engagement with professionals such as midwives, health visiting and GP services are now more likely to be regarded as indicators of concern because these are some of the patterns that are increasingly understood to be contributory to a child's safety and emotional well being (and was a factor in the health visitor initiating inquiries in 2010).
110. The GP practice had removed Amanda Hutton and the children from the register in October 2009 due to her persistent lack of response to appointments to have the children seen and to have the opportunity for routine care such as immunisations. If Hamzah had for example been seen by a GP prior to being removed from the register it would of course have been an opportunity for evidence about the extent of malnourishment that contributed to the death in December 2009 to be diagnosed. It is not a requirement for a GP to see a child before they are removed from the register. Hamzah had never received any of the routine immunisations which in itself was an indicator of concern.
111. There was a telephone contact with services in March 2011 which is analysed in greater detail in later sections that was also made after Hamzah had already been dead for several months. The checks made in response to the phone call relied on conversations with the older children at school. The checks that were made as a result of the phone call did not raise new or heightened concerns although if a home visit had been completed it would have clearly been an opportunity to check on the physical conditions within the home.

112. If the extent to which there was such a marked decline in the parenting provided by Amanda Hutton had been known, this would have provided a more focussed and concerning context for enquiry and assessment particularly by CSC or the police. Although the older children's attendance at school was not consistent and they appeared neglected on occasions this was not a consistent pattern. There was contact with CSC again in July 2011 which reported the filthy conditions although as before in March there was an incorrect assumption that the youngest children were not living at the house.
113. There was one occasion when Hamzah's father had expressed concerns about Amanda's care of the children although this occurred after he had been arrested for assaulting her. He was advised to report his concerns to CSC but there is no record of this being done.
114. The evidence of domestic violence and the reluctance to engage with primary health care services were seen in isolation in large part because no single agency had a lead responsibility either by initiating a CAF (common assessment framework) or by a statutory route such as child in need (CIN). The lack of focus on what the children were saying or could have been encouraged to discuss more is also commented upon in other parts of the review. Matters are complicated in this case in as far as Amanda Hutton appears to have been a more caring parent at the outset with her older children but had clearly developed a chronic neglect in regard to the younger children.
115. Later chapters of the report provide the context for why the information that was reported and looked at was processed in the way that it was and considers what factors contributed. This takes account for example of the inherent barriers that professionals face when trying to respond to victims of domestic abuse, deal with substance misuse as well as the acknowledged shortcomings in how for example assessments were structured and conducted at the time, locally and through national systems. There were workload pressures that led to shortcuts in some aspects of the work.
116. The true extent of need within the family was therefore insufficiently known and the barriers for accepting professional help were not understood well enough at the time. None of the children's views, wishes and feelings was given enough focus and priority even when some of the children explicitly sought help or came to the attention of support services.
117. Several professionals tried to offer help at different times although none were able to overcome the resistance that was exhibited by both of Hamzah's parents. In regard to Amanda Hutton the behaviour is characteristic of women who have experienced abuse and violence over many years and presents significant challenges for professional practice. In regard to the father, he was reluctant to acknowledge his abuse and violence and sought to minimise it even after conviction. Again this is behaviour that professionals working with both victims and perpetrators will recognise.
118. The extent to which both of the parents were unwilling to accept help or advice and presented barriers to various professionals has become more apparent through the detailed collation of extensive information for the review.
119. A feature identified in other reviews nationally is how mind-sets can prevent a fresh look at information that appears to resemble or be consistent with previous reports which on their own do not arouse higher levels of curiosity or

concern and especially in services that are already under significant workload pressure. The mind-set that prevailed here was that Amanda Hutton had problems but was not considered to be a risk to her children.

120. The impact of domestic abuse on the emotional health of adults and children is becoming much better understood and for example national guidance emphasises that it is a source of significant harm for children and requires an appropriate response in regard to enquiry, assessment and the help that is provided.
121. Different factors influenced decision making at key moments. For example changes to working arrangements, the impact of events such as Baby P on the workload of local services as well as a genuine desire to try and support a family dealing with what were seen at the time as the tensions between adolescent development and parental control.
122. The three youngest children (Hamzah, Sibling 2 and 3) were never enrolled for education (including any early year's provision<sup>14</sup>) and the primary health services had very limited contact. The implications of that are explored in the IMRs and the health overview report (HOR) and the later sections of this report.
123. When one of the children asked for help, this did not provide a clear enough opportunity to develop a better level of knowledge and understanding about the children's needs and circumstances. There were opportunities to explore inconsistencies; for example the children could arrive in school clean and well-dressed whilst at other times displayed symptoms of neglect, the most acute being the physical condition of one of the children observed by the school nurse in regard to tooth decay which is indicative of longer standing and more persistent neglect. There was the limited understanding about the barriers (especially for Amanda Hutton in regard to the domestic violence and abuse) to accepting help or advice. Domestic abuse has a corrosive and long term impact on the victim as well as being emotionally damaging for any children living in the same household.
124. Other complications arose because information was inaccurately recorded or poorly shared; for example one of the IMRs comments on the number of people dealing with enquiries about the youngest children missing from education and how that contributed to fundamental misunderstandings. The children's centre had wrong information about the age of Hamzah and Sibling 2 that contributed to them not having accurate reference points for judging the children's social and physical development on issues such as using their fingers rather than a spoon to feed themselves. Now that the extent of Hamzah's neglect has been revealed this takes on even greater significance.

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<sup>14</sup> The ESWS IMR explains that as Bradford adopts a rising fives admissions policy Hamzah and 2 would have been expected to start school in September 2009. By September 2010 Hamzah and 2 should legally have been in school. Sibling 3 would have been expected to start school in September 2010 but legally not required to be in school until September 2011.

125. The only multi agency discussion which was limited took place at MARAC<sup>15</sup> and this was focussed on the risk to Amanda Hutton and not upon her children. There is a far better understanding now about the significance and implications of domestic abuse on the emotional, psychological as well physical health of children that has been enshrined in law and national guidance regarding significant harm. That level of understanding was different in 2008.
126. Not all of the relevant services such as the GP were aware of the discussion at MARAC or the decisions; if they had been there may have been a different approach to the lack of contact with Amanda Hutton and the children. The MARAC had only recently been established and for example CSC did not have consistent representation at the time. Other agencies such as education and early childhood services were represented but the people attending the meeting did not communicate information within their own service and did not apparently implement the actions that had been agreed. Some of this reflected insufficient understanding about the purpose of MARAC as well as understanding the heightened risk of further abuse that is associated with making disclosures of domestic abuse or trying to leave a violent relationship.
127. Domestic violence, depression and substance misuse were persistent features that are now revealed far more clearly as a result of the detailed work of the review in collating information from different services. There was for example a significant level of involvement by Staying Put services with Amanda Hutton for over two years in regard to the domestic violence and abuse but was not integrated and shared with other services. The involvement of Staying Put was largely unknown to other services and therefore the detailed information disclosed to that service was not shared with other professionals.
128. The absence of clear disclosures or not seeing the information such as the failure to attend immunisations as a source of harmful behaviour rather than isolated incidents contributed to the lack of assertive and pro-active approach in the case.
129. Achieving a better understanding about prevalence and significance of domestic abuse, depression and substance misuse as being a considerable and detrimental feature of life for children in the family requires time and patient persistence and represent a complex challenge for professionals who need to have time as well as the appropriate skill and resilience to have more quality contact with vulnerable children and troubled families.
130. Much of the characteristic behaviour associated with domestic abuse both on the part of perpetrator and victim are exhibited in this case; the lack of acknowledgement and responsibility for the violence by the perpetrator and the difficulty for the victim in accepting help or leaving the violent relationship. The reluctance to access or accept help arise from a complex number of factors such as fear of repercussions, complications arising from responsibility for children, fear of losing housing and income as well as reconciling emotions and feelings for a partner. The impact of long term abuse and coercion on victims is explored in the final chapter of this report.

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<sup>15</sup> MARAC is focussed on cases of higher risk of domestic abuse with the purpose of developing strategies to help the victim to be protected; it is often a moment of heightened risk when the perpetrator of domestic abuse knows that the abuse is being disclosed.

131. The context within which the services operated at different times are also a feature explored through the review. For example the publicity of the “Baby P” case in London had a profound impact on some services such as CSC. They were dealing with a significant increase in referrals that coincided with difficulties in retaining sufficiently trained and experienced staff; it also coincided with the implementation of new systems of working and information management.
132. The education welfare service describes how it was moving from a traditional school absence service that relied on threats of prosecution to a service that seeks to balance enforcement with support and engagement with vulnerable families that have a range of complex needs.
133. Some of the IMR authors also describe the very real dilemmas that are presented when for example a key professional who is crucial in terms of their knowledge and relationship with a family becomes ill, experiences bereavement or leaves a job. The report describes how for example Amanda Hutton had great difficulty in developing trust in professionals with some notable exceptions for example in relation to PC8 who supported her following incidents of domestic abuse.
134. The GP IMR discusses the changes that have occurred in general medical practice; ensuring that GPs have information about MARAC discussions, the introduction of new safeguarding training and systems for identifying information about the welfare of children; the IMR acknowledges the challenges of GP consultations that are based on time limited ten minute consultations especially with patients who only present at a point of urgent need. The manner in which services such as primary health care are commissioned and contracted are discussed in both the HOR and the later chapters of this overview report; for example, there are perverse incentives that can lead to disengaged and reluctant families becoming even more isolated from core and universal services as happened in this case.
135. The reluctance of Amanda Hutton in particular to have contact with any service and the degree to which this was able to dominate the interaction with different services who were unable to manage or overcome the resistance; a clearer focus on how the children were being effected and the need for clearer impetus to a more assertive approach. This is where structured multi agency discussion and seeking legal advice can be helpful and is something that is far better understood now and is enshrined for example in the revised local assessment frameworks.
136. Some professionals demonstrated a better understanding about the barriers facing Amanda Hutton for example by getting help in regard to domestic violence, although this was not collectively understood and in any event none of the agencies were able to achieve an appreciable engagement by either of the parents. Underlying patterns such as Amanda Hutton’s readiness to accept practical help in regard to matters such as housing but her rejection of the contact that made demands upon her in respect of issues such as improving school attendance were not recognised at the time.
137. Amanda Hutton’s reluctance to accept help was poorly understood in terms of what the barriers might have been especially in relation to the domestic violence she suffered. There was insufficient attention given to the implications of factors such as domestic violence and substance misuse on the children and

their emotional as well as physical care and well being. Reports that the children seem 'safe and well' address only that the children do not appear to be physically at risk rather than offering clearer insight about the emotional and psychological impact. The review discusses the limitations of some of the tools and frameworks available to help professionals make appropriate judgments.

138. Great reliance was given to Amanda Hutton providing consent for different interventions or support when a more assertive approach would have given more explicit consideration to the needs of the children and probably sought to override parental objections including if it had been necessary and subject to legal advice, going to court for an appropriate order. Legal options were not considered because key services never believed that the children were suffering harm at the time.
139. Amanda Hutton's use of alcohol was not seen at the time as problematic and on some occasions there was an absence of certainty as to whether she was drinking or not. It was periodically observed when some agencies including the emergency services had access to the house or received third hand reports from members of the family including some of the children. The use of alcohol as well as the domestic abuse is a behaviour that adults will often want to disguise or keep hidden from view.
140. There are examples of good practice where for example individual professionals have sought to gain the confidence of Amanda Hutton and to offer considerable emotional and practical support far in excess of what would be expected from their professional or service remit, although this was not sufficiently coordinated across the different services that came into contact with the family.
141. Apart from the MARAC, there were no interagency meetings or formal discussions although there were discussions that took place over telephone or email or took place within single agencies; the consequence was that individual people and services were always dealing with incomplete information. When processes such as statutory assessments or the missing from education protocols were invoked they were not completed to the level of detail required; some of the factors that caused this have been referred to and are analysed in further detail later in the report.
142. The MARAC discussion was focussed on Amanda Hutton as a victim of domestic violence and there was insufficient account of the impact on her capacity to meet the needs of her children.
143. Safeguarding referrals that were made were then dealt with outside of the frameworks for strategy discussion and the information that was collated never triggered a threshold to convene a multi agency child protection conference. Recording of information was made using process logs rather than within needs assessment frameworks; some of this reflected taking procedural shortcuts to deal with workload demands.
144. When one of the children was physically assaulted and had sought help this led to a disagreement between the police and children's social care services about what action was required. The outcome was that the child returned home. It was managed as a parent and teenager conflict.

145. Opportunities to engage father in terms of his violent and abusive behaviour were largely undermined by his reluctance and inability to acknowledge and to take responsibility for his behaviour.
146. There is fundamental learning to emerge for example in regard to applying procedures and protocols with a greater level of curiosity and understanding. This is not making a point about bureaucratic compliance. An example is the degree to which the reports of the children missing were largely treated as administrative liaison arrangements between different services within Bradford and with other areas in southern England rather than providing a ladder to escalate the level of enquiries. It not the following of the procedure but rather what the information has revealed that has to be the focus for deciding an adequate outcome has been achieved.
147. The BSCB and its partners will want to reflect upon the manner in which vulnerable families can disappear from the purview of essential services such as primary health, education and early childhood services and the manner in which commissioning and contracting arrangements can create perverse incentives in relation to providing access to services for vulnerable families and children.
148. The Munro Review commissioned by the Coalition Government in 2010 has stressed the importance of looking at such information within the context of people's professional and organisational arrangements. Individual professionals are influenced and affected by the circumstances within which they work.
149. Such influences include the stability of the organisation they work in, the workload of individuals and their services, the quality of their training and knowledge, the clarity of working arrangements in matters such as how essential and relevant information is recorded and shared meaningfully. In this case there are specific issues such as how contracts are specified for the delivery of primary health services. There were the workload problems already referred to in some of the services that led to short term measures that contributed to insufficient analysis and collation of information. On a more limited scale there were also personal tragedies and difficulties that influenced the capacity of specific professionals.
150. Research and the evidence from other serious case reviews that is referenced in the IMRs and in later sections of this report shows that abuse is the product of several different factors and the complex interplay between them and the influence of family attitude and behaviour, professional reasoning and the action of all involved. Other serious case reviews identify the prevalence of depression, substance misuse and domestic violence as a background to many of the cases that involve the serious abuse or death of children<sup>16</sup>.
151. A more sceptical and enquiring approach combined with a predominant focus on the children creates an improved opportunity for better analysis about a

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<sup>16</sup> A national study in 2007 reported that domestic violence was a factor in 66 per cent of serious case reviews, substance misuse was a factor in 57 per cent and mental ill health was a factor in 55 per cent; overall over a third (34 per cent) featured all three factors combined and has been described as a 'toxic trio' by some commentators. *Understanding Serious Case Reviews and their Impact 2005-7: A Biennial Analysis of Serious Case Reviews 2005-7*, DCSF.

parent's decision making and the extent to which they are able to put her children's needs first.

152. Other serious case reviews locally and nationally also describe the extent to which help that is provided to vulnerable children or troubled families is delivered through a "silo" approach where individual people and services are focussed on their single agency issues, although there are instances in this case where individual professionals in the police and YOT for example tried hard to access other support from outside their own agency<sup>17</sup>.
153. Overcoming issues such as working in different agencies does require busy people having the capacity to talk with each other as much as doing their own core job. The factors are multi-faceted and includes over identification with the needs of Amanda Hutton, a lack of sufficient sceptical enquiry for example in regard to the disappearance of some of the children from health, education and social care systems, a reluctance to engage Amanda Hutton on anything more than a voluntary basis and an inability to identify the significance of the various and cumulative indicators of risk over time.
154. The importance of sharing information effectively and using it to think about what further enquiries should be made is highlighted in several of the IMRs. The majority of services had some knowledge of some indicators of potential risk and vulnerability but it did not lead to any further sustained concerted collective action.
155. Some of this reflected inadequate recording and gaps in information when practitioners were dealing with incidents. An example is one of the social workers not having full information about discussions at the MARAC; schools did not know about key decisions and the GPs were completely unaware.
156. There are other factors explored in the final chapter of this report in particular regarding the adequacy of tools that professionals have to make sense of opaque or contradictory information. Even when the assessment frameworks are used they represent considerable difficulty to practitioners in being able to describe and analyse risk. These frameworks have been abolished in national guidance since the death of Hamzah and work is already being completed on developing more appropriate single child assessment frameworks locally.
157. The only explicit risk assessments described in the IMRs was offence related; one was the OASys system<sup>18</sup> in probation that is primarily focussed on father as the offender and his offence. The YOT also completed an assessment in regard to the work with Sibling 8. The assessments did not achieve a complete picture of information about the family but were consistent with national standards and

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<sup>17</sup> The limitations imposed if professionals are not able to look at aspects of the children's needs outside of their own specific brief and is a significant theme identified in *Understanding Serious Case Reviews and their Impact A Biennial Analysis of Serious Case Reviews 2005-07DCSF*

<sup>18</sup> OASys is the abbreviated term for the Offender **Assessment System**, used in the England and Wales by Her Majesty's Prison Service and the National Probation Service from 2002 to measure the risks and needs of criminal offenders under their supervision.

requirements for offence related work. The importance of 'Thinking Family'<sup>19</sup> was discussed by the probation IMR author and is echoed in the reflections of other agency reports from education and other disciplines.

### **1.18 The family and other significant people**

158. Until the trial, very little information had been known about the history of Hamzah's family or of either parent's background and reflects the limited extent of enquiry, assessment and recording generally.
159. This had implications for aspects of practice and contact with the family. For example, the significance of the relationship between Amanda and her mother was not properly understood and therefore the traumatic sense of desolation and isolation that she felt particularly as the relationship with the children's father became even more estranged.
160. The first record of domestic violence had been in May 1996. It is thought that there had been previous incidents that were not reported and this would be consistent with research evidence that disclosures of abuse are usually made only after several incidents<sup>20</sup>. There were ten specific incidents recorded by the police between 1996 and 2008 although there had been other contacts where more generalised comments about domestic violence were disclosed.
161. Hamzah's mother is white British and father is Asian British Pakistani. Both parents speak English. They met as teenagers. It is believed that both had happy childhoods and they both have siblings. Father does not have any contact with any of his siblings.
162. Amanda Hutton became pregnant with her first child (Sibling 7) 18 months after she had met father outside a local night club when she was aged 16 in 1986. Amanda Hutton's mother had just married her stepfather who Amanda Hutton had known since she was 13 years old. Amanda Hutton came from a relatively comfortable family and had attended a local grammar school. Amanda left school before completing any "A" levels and moved out of the family home into a local flat. She worked briefly for a printing company, and also worked in the distribution department of a major retailer.
163. The maternal grandmother maintained contact with her daughter and was a significant source of emotional and practical support until her death in December 2007. Amanda was in daily contact with her mother until then, sometimes phoning three or more times during a day and having long conversations with each other.
164. Amanda Hutton's mother's death which occurred after a long illness was especially traumatic for Amanda Hutton and coincided with what appeared to be a marked deterioration in the relationship with the father of the children. It is significant that during a conversation with a health visitor in 2008 Amanda

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<sup>19</sup> Think Family was supported by a toolkit published by the previous government in 2009; it has been withdrawn by the coalition government.

<sup>20</sup> Research evidence shows that domestic violence has more repeat victims than any other crime; there will be on average 35 assaults before a victim calls the police.

Hutton stated that she had lost complete confidence in the health service when her mother died.

165. Although Amanda stayed in contact with her stepfather for a few months after the death of her mother, they gradually lost regular contact with each other.
166. According to third hand information from members of the family Amanda had been a typical teenager who had enjoyed music and had taken pride in her appearance. Although Amanda Hutton appears to have avoided health professionals for much of her life including ante-natal appointments she appeared to adapt to becoming a mother during her first pregnancies. Amanda's step father was nursed by Amanda for about three months following an operation and she was caring and considerate.
167. Amanda had started drinking alcohol when she was a teenager although it appears to have become far more problematic as the relationship with the children's father had deteriorated.
168. At the time of Hamzah's death, the parents had already been separated for about a year. Amanda Hutton had been granted a non-molestation order in December 2008<sup>21</sup>.
169. There had been concerns about domestic violence since 1996 although there had been several months between incidents being reported to the police. Significantly, the next incident reported after 1996 was in March 2003 when Amanda Hutton declined to make a statement and no further action was taken.
170. Professionals including specialist police officers will recognise that this is a common pattern of behaviour from women living with abuse who fear the repercussions of intervention although is behaviour that is less well understood by people who have less experience or specialist training and awareness.
171. Amanda was assaulted again in June 2003. In September 2004 Amanda Hutton was assaulted by father with a coin bag when there was no hot water for him to have a shower. Amanda Hutton again declined to make a statement or to accept help. Amanda Hutton made contact ten months later but not about specific incidents and also again in December 2005. There was a further incident in December 2006 when one of the children went missing.
172. In May 2007 one of the children complained that both parents assaulted them. In July 2007 there was a breach of the peace when Amanda Hutton stated that she felt trapped in the relationship, did not know how to get out and was described as very lacking in confidence. Amanda Hutton was unwilling to make any complaints to support a prosecution<sup>22</sup>. Amanda declined to go to a refuge

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<sup>21</sup> Reference is made in other parts of this report to other measure that have been introduced to help agencies such as the police deal with domestic abuse; an example is the use of domestic abuse prevention notices which were introduced this year.

<sup>22</sup> Reference is made in other parts of this report to changes that have and continue to be made in relation to domestic abuse; for example the introduction of Domestic Violence Prevention Notices are one of the new powers given to police to take action against perpetrators without having to go to court or have the cooperation of a victim of abuse and violence.

for fear of reprisals. Amanda agreed to have a referral made to a local organisation working with women in abusive and violent relationships and she was also referred to the housing service and registered with the house hunter service.

173. In December 2007 there was an assault on Amanda Hutton by the children's father in the family home. She provided contradictory information and the father denied assaulting Amanda Hutton. Amanda was contacted by a *Staying Put* worker who was told by Amanda Hutton that she was only allowed out of the house to do a brief shop of about 30 minutes each week and often had her telephone taken off her.
174. In February 2008 Amanda Hutton went to the police station to report that she had been physically assaulted. The domestic violence unit was unable to contact her subsequently because her phone was going to voicemail.
175. In May 2008 a police report refers to Amanda Hutton still living with her ex-partner when she reported being assaulted again at the house. Amanda Hutton was unwilling to speak to any police officer except to PC8 who had provided a response and support in previous contacts from as early as 2005 and had several contacts in the preceding months when Amanda Hutton had been unable to engage. That officer was not available.
176. The first referral to MARAC was made in July 2008 that collated information about 11 incidents since 2003<sup>23</sup>. A further discussion at the MARAC in August was attended by PC8 who had managed to secure Amanda's trust previously and told the MARAC that Amanda probably was at significant risk but was not disclosing information. At the end of November 2008 Amanda Hutton contacted PC8 saying that father was forcing her to leave the house. PC8 helped arrange interviews with housing services and encouraged Amanda Hutton to seek legal advice.
177. Under the arrangements that have been brought in now, the police would have the option of giving direction to the perpetrator and have powers to place restrictions on contact. Amanda Hutton was re-housed. Within 24 hours father broke into the property and assaulted Amanda Hutton as well as one of the children. Father was arrested and it was during the interview that he made comments about concerns regarding the children.
178. Father was subsequently convicted and a non-molestation order had imposed controls on him coming to house where Amanda Hutton lived. Father denies that there was domestic violence in the relationship in spite of the evidence from information such as police records. Although he attended meetings with his offender manager he was reluctant to acknowledge the domestic abuse and was disruptive when he did attend the integrated domestic abuse programme (IDAP).
179. For example, he attended the IDAP at the end of July 2010 and told everyone from the outset that he did not hit women as those men that do should go to prison. He blamed his partner and women in general because 'they get you into trouble'. He was given the option to leave at the beginning and then at the

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<sup>23</sup> CSC was not represented at the MARAC.

break but he decided to stay. He was very vocal and had to be asked to be quiet and to listen<sup>24</sup>.

180. The parents had some contact with each other after their separation. For example in September 2009 father's offender manager was told that Amanda Hutton had gone to father's property following telephone conversations earlier in the evening. Amanda Hutton was described as very stressed. Father talked to the offender manager how Amanda Hutton and he had discussed how destructive their relationship had become and father was unsure how to be involved with his children. This contact occurred less than three months before Hamzah died. Before that contact, in June 2009 father had talked with the same offender manager about being uncertain about arrangements for contact with his children.
181. The family was removed from the roll of the GP practice in October 2009 after persistent non attendance for routine health appointments and had failed to respond to letter and other contact.
182. Five of the children had been enrolled at Bradford schools and had histories of problematic attendance at school. The three youngest children (including Hamzah) had not been enrolled at school or with any early years provision. No applications had been made.
183. The education welfare service (EWS) was significantly involved in attempts to achieve improved levels of school attendance and to establish the whereabouts of the three youngest children after the health visitor initially identified that Hamzah was not registered with any GP.
184. There had been some indication that Amanda Hutton experienced depression and had some reliance on alcohol. She was resistant to the involvement of professionals and this increased over time.
185. During the investigation into the circumstances surrounding the death of Hamzah, one of the older children stated that life 'began to go downhill' after the birth of Sibling 6, and from aged 11 years there were issues with Amanda Hutton's use of alcohol and cannabis. He says that he was punched and slapped by his mother from the age of 12 years and that she drunkenly stabbed him with a kitchen knife when he was 13 years old, although this specific information about the use of a knife was not reported to the police at that time or to any other service.

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<sup>24</sup> He was suspended from IDAP because of the disruption and missed sessions. He was not happy about the suspension and thought he was being unfairly treated. Given the minimisation around the index offence of domestic abuse and the suspension, it was decided to take IDAP requirement back to court and have this removed which happened at the end of November 2010. The revocation application outlined the reasons for the request including the requirement being unworkable, owing to father's disruptive behaviour at IDAP session, his minimisation and continuing denial. The report outlined that work would be carried out on an individual basis. His attitude did not change and by the last individual session in May 2011 he continued to blame Amanda Hutton for putting him 'on probation'.

### **1.19 Cultural, ethnic, linguistic and religious identity of the family and their community**

186. Hamzah's father is British Asian and is Muslim. He has worked as a taxi driver and a mechanic. Amanda Hutton is white British. None of the agencies had information about any religious affiliation.
187. Just over 76 per cent of the population in Bradford is white compared to a national average of 97 per cent. Almost 34 per cent of 0 to 17 year olds are from black and minority ethnic backgrounds, the most significant group being of Pakistani heritage. Just over three per cent of the city's school population describe themselves as dual heritage.
188. Bradford is amongst the most deprived districts in the country. It ranks as the 32nd most deprived out of 354 local authority districts in England and is in the most deprived ten per cent of local authority districts nationally. 40 per cent of areas in the district fall into the most deprived 20 per cent of areas nationally and the variance in deprivation is wide ranging, with five per cent of areas falling into the most deprived one per cent of areas nationally and six per cent falling into the least deprived one per cent of areas nationally.
189. There are more children living in poverty in Bradford compared to the national average. A total of 61 per cent of children in the district live in low-income households, compared with 44 per cent nationally.
190. The uptake of formal pre-school childcare by low income families is lower in the Bradford district (14 per cent) than national (18 per cent) and is not increasing at an equivalent pace. Hamzah did not participate in any pre-school childcare.
191. The West Yorkshire Police deal with four incidents of domestic abuse every hour which cover other cities and towns as well as Bradford. The number of recorded domestic violence incidents in the Bradford district in the year to the end of April 2012 was 9,991, an increase of nearly 800 on the previous year. The police believe that is partly because victims feel more confident to report incidents.
192. 5,922 child referrals were made to Bradford Children's Social Care in 2010-11. This is a rate of 460.86 per 10,000 population under 18 and was significantly lower compared to 7,547 in 2009-10 (587.3 per 10,000), this went against the national trend of a slight increase. The majority of referrals were due to concerns around abuse and neglect (85%) whilst approximately a quarter of referrals were for children who had been previously referred.

## 2 Overview of events

193. 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 the same house in 2008; the children's father left the house after he was arrested for assaulting Amanda Hutton and he was made the subject of a non-molestation order although it clear from the information regarding the history of domestic abuse that has been summarised in section 1.18 that although they had been living in the same house they were effectively separated before then. With the exception of the two eldest children who were adults at the time of Hamzah's death, all of the siblings lived with Amanda Hutton.
194. 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. The children's father says that he was unaware of this<sup>25</sup>. By 2005 it was noted that there was some evidence of Amanda Hutton using alcohol to cope.
195. The first report of domestic violence was made in 1996; further detail of the domestic abuse that is already provided in 1.18 is not repeated in this summary. Amanda Hutton declined to make a formal complaint to the police; this was to be a repeated pattern. Further episodes of abuse and violence occurred. 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.
196. It is likely from information provided to the review that not all the incidents of violence were reported to services. Around the same time there were incidents in the community; the manner in which some of these were recorded and logged appeared to relate the parents being from different racial and cultural communities although the children's father disagrees that this was the case.
197. With all of the children there were problems for the health visiting service and the GP in seeing the children (or parents). This became even more of a problem with the later pregnancies (that included Hamzah).
198. In December 2006 one of the children went to the police to talk about the situation at home and his distress about the domestic violence. The police used their powers of protection to try to arrange accommodation with CSC who were unable to find a placement. The child returned home.
199. 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.

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<sup>25</sup> It is a consistent theme in reviews such as this that men are invisible to much professional practice and contact with vulnerable women or children. The lack of knowledge about Amanda Hutton's emotional and mental well being invites reflection about the degree of empathy between the parents.

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.

200. At the end of March 2007 Child 8 appeared in magistrates court on charges of theft and deception and was remanded 'as directed' and placed with specialist foster carers for two nights before being returned home. The YOT (youth offending team) became involved.
201. In May 2007 Child 8 was injured having fallen when running away from father. The child went to A&E and whilst there asked for help to live away from the family. This led to involvement by CSC as well as the police. Child 8 was referred to the homeless service and provided with emergency accommodation. Child 8 returned home before the end of May 2007.
202. 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.
203. It is known from information provided during the trial and from media information from members of the family that Amanda Hutton's mother died just before Christmas 2007 which coincided with the anniversary of the death of Hamzah's paternal grandmother.
204. There was further contact in 2008 from Amanda Hutton with the police; on more than one occasion one of the children had gone missing from home. In April 2008 Amanda Hutton asked to meet with a specific police officer (PC8) who had previously provided support. By the time the officer was able to contact Amanda Hutton she did not want to meet.
205. In July and August 2008 there was a discussion at the MARAC that had just been established<sup>26</sup>. 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. The children's father disputes that he was disruptive and states that he was assaulted by Amanda Hutton on occasions.
206. In March 2009 Amanda Hutton moved to a new property.
207. 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.

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<sup>26</sup> Further information is provided later about the Multi Agency Risk Assessment Conferences (MARAC) that is designed to focus on addressing the cases of highest risk of domestic abuse through a coordinated safety plan.

208. In June 2009 the children's father was convicted of an offence of battery in relation to his assault on Amanda Hutton in 2008. He was sentenced to a community order with a requirement to attend an integrated domestic abuse programme.
209. 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.
210. In late 2010 there was correspondence between health visitors, education and early childhood services and CSC which centred on the difficulties in seeing the children. By the end of 2010 and beginning of 2011 there were reports of some of the children living outside Bradford and 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.
211. There was an anonymous referral in March 2011 about the children. In July 2011 the school attendance service began making inquiries with the police about four of the children; this included Hamzah who had never been enrolled for education. Mother wanted services to believe that the children were living outside Bradford with relatives. Various places in the South of England were mentioned and inquiries made with another local authority that had no information; the children were never living outside Bradford.
212. In September 2011 there was a further referral to CSC. 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.

### **3 Synopsis of the learning and analysis from the individual management reviews.**

#### **3.1 Summary**

213. All of the individual management reviews were completed using *Working Together to Safeguard Children (2010)* which was also supported with additional local guidance provided on behalf of the BSCB.
214. Many of the services have already taken action or initiated action in response to improvements or areas of development identified through their individual review at the time that the SCR was being completed.

#### **3.2 Significant themes for learning that emerge from examining the IMRs**

215. The agency reviews identify themes that have implications for policy development and staff training that applies to all services working with children. In the summary of the review's finding provided in chapter one there is acknowledgement that some of the issues to come out of this review are reflected in the finding of national evaluation and research. 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; this means giving consideration to the influence, control and as in this case coercion that 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.

216. The remainder of this chapter summarises key evidence relating to the terms of reference established for the IMRs.

### **3.3 Good practice identified through the review**

217. To support the learning from the review the panel looked for examples of good practice. To constitute good practice, the panel looked for action or decision making that went beyond compliance with local and national policy, procedures and guidance.

218. Examples of good practice identified by the review include;

- a) The police took prompt action when Sibling 8 requested 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;
- 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 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 contrasts with the lack of success achieved by other services;
- k) The PCSO demonstrated very considerable persistence in gaining access to the house in 2011; they sought advice about the concerns they had and did not let the matter drop.

219. The remaining sections of this chapter summarise the most significant learning from the IMRs against each of the case specific terms of key lines of enquiry.

### **Recognition**

**To what extent were any vulnerabilities or needs of mother recognised and taken into account in terms of any potential risks they posed for Hamzah and his siblings and will include any information about depression, domestic violence, social or 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 mother's reluctance to accept help or advice.**

220. With hindsight, the HOR comments that it can now be seen that the domestic abuse and isolation and the mental health issues and alcohol misuse suffered by Amanda Hutton were barriers which contributed to the family's disengagement with services.

221. The MARAC report also refers to relevant research evidence about the severe impact of domestic violence on victims and the fact that in this case the known violence took place over more than 12 years. The MARAC author comments that 'Low self esteem and confidence, feelings of helplessness, of being trapped and of feeling unable or unwilling to change the situation. This will have contributed to the mother being reluctant to accept help and support'. The police IMR also referred to the research evidence about the very negative impact on children of witnessing domestic violence.

222. The HOR comments on the extent to which IMRs from the community services (BDCT) identified the vulnerabilities of Amanda Hutton; these included recorded information about the domestic abuse, mental health difficulties, debt, isolation and lack of support, misuse of alcohol, managing eight children, at times as a single parent, and the lack of acceptance in some of the community where they lived as a white woman with an Asian partner.
223. All of these issues were recorded in isolation as separate events and there was little chronology within agencies linking them to reveal the picture of overall vulnerability. The authors comment about the absence of evidence that would suggest any in-depth analysis of these issues or any action planning or linking of information that would have highlighted the potential risk to Hamzah and his siblings. The HOR refers to evidence from Ofsted evaluations of SCRs nationally that describe the extent to which the child's perspective is rarely evident and is reflected in this case.
224. Similar issues are identified with regard to the domestic abuse and possible post natal depression; there is no evidence that information was shared with other primary care professionals from midwives or that vulnerabilities were explored and help offered. The A&E department similarly appeared to take information about the assault of Amanda Hutton by a man in the street and at face value without any information gathering of family circumstances or referrals to other helping agencies or liaison with community staff.
225. In contrast to these issues the HOR points to the exceptional practice by YAS in 2007 when an ambulance crew remained with Amanda Hutton and her children for three hours after being called to help with a suspected drug overdose.
226. The author of the CSC IMR acknowledges that the information about Amanda Hutton's vulnerabilities in regard to depression, domestic abuse and alcohol dependency combined with looking after a large family of children could have been given a higher order of significance. It is theme highlighted by other authors such as probation although the OASys assessment completed in May 2009 contained relevant information.
227. The BDCT author describes how the health visitor also identified Amanda Hutton's vulnerabilities and that historical information had indicated a much higher level of post natal depression as far back as 2000. The high EPDS score was an indication that support was required. The issue of post natal depression was identified with the later births as well.
228. The BDCT author describes how a risk assessment was completed in 1998 and again in 2000 which both indicated low priority for support but was not updated when the evidence about depression and domestic abuse began to emerge.
229. The CSC author reflects upon how practice has changed in some important regards. For example, the significance of domestic violence and its impact on the emotional health as well as physical safety of children is better understood partly through the evidence and the learning generated through serious case reviews.
230. Although there was evidence about domestic violence going back to the 1990's, agencies such as CSC only became aware through the routine reports (rather than specific referrals) from the police of incidents from 2003 onwards. Given the number of incidents each year, the services rely on frameworks or

thresholds that identify when domestic abuse is a risk to children. This relies on the people who are completing the reports being sufficiently aware and confident to report relevant and significant information without overloading systems and people; it also requires those people who receive and monitor such information to have a sufficient awareness and capacity to identify and prioritise appropriately. It requires a degree of insight and understanding about the damaging impact of domestic abuse that can identify risk and need in the absence of direct and tangible injury to a child.

231. The author of the CSC IMR describes how viewing successive incidents in isolation inhibited the identification of any underlying patterns; the incidents on their own might not meet a threshold of significant harm and therefore merit formal enquiry and assessment but the cumulative impact especially on young children was a concern that was not identified with sufficient clarity and focus. Even the older child's report of physical assaults were not seen as having implications either for the child's own well being or for the younger and more dependant and vulnerable siblings.
232. The extent to which domestic violence was a factor when the parents were living together and the pervasiveness of alcohol and depression were not sufficiently enquired into. This reflects an insufficient understanding about how the emotional and physical capacity of a parent is crucial to a child's well being and safety. Without such understanding it is more likely that any help will be inadequate and insufficiently focussed.
233. Very little comment is made about how the different professionals interpreted Amanda Hutton's reluctance to accept help or advice. Police and social care in particular have to balance the rights and ethics of parents and families to privacy and declining help against the consideration as to whether declining such help has negative implications for a child.
234. Amanda Hutton articulated a deep distrust about health professionals from her very first pregnancy although this was apparently not well understood at the time; the distrust extended to other people who became involved at later stages although it is of note that for a period the YOT had a member of staff who seemed more able to overcome Amanda Hutton's reluctance to have contact with a professional. Amanda Hutton also developed particular trust in a specific police officer who tried to help her.
235. The IMR author for BTHT comments that maternity services recognised some of Amanda Hutton's vulnerabilities in regard to depression that was apparently attributed to 'baby blues'. There was no concerted exploration of Amanda Hutton's depression or other vulnerabilities for example in regard to her increasing family and there was no recorded evidence of discussion with health visiting services. Amanda Hutton was never asked about whether she experienced domestic abuse. The author describes the improved changes that have been implemented since 2005 that ensure domestic abuse is subject of more assertive and enquiring practice and with the flagging arrangements for example in the electronic patient record system.
236. When Amanda Hutton attended at A&E it was not established that she was the mother of eight children. The first occasion occurred as a result of an alleged assault in the street that was accepted at face value; the second occasion that was identified as a physical assault by father, no further enquiries were made by the A&E about other vulnerabilities that the IMR author points out are

documented. Like many other areas Bradford has invested in training and awareness about domestic abuse especially since 2007.

237. The GP only saw one of the children during the timeframe for the review in March 2008 when Sibling 8 who was then aged almost 17 consulted the GP about chest pains. He described how he was living away from home 'following difficult times'. This was a routine ten minute GP consultation and no further follow up was required. Sibling 8 did not raise any specific concerns about his own safety or well being or about his siblings. The IMR author comments that the introduction of the new Safeguarding Children SystemOne template<sup>27</sup> across the district would probably alert a GP to broader issues within the family that was not available in 2008. The system allows potential and actual safeguarding concerns to be 'flagged' and linked to the patient record.
238. The YAS author comments on how when their crew responded in April 2007 and recognised Amanda Hutton's mental health needs and radioed through to their communications centre for the number of the Crisis Team nobody had a contact number. This was overcome by contacting the police and CSC.
239. The MARAC in August 2008 provided a considerable history of domestic abuse. The MARAC was a new framework in Bradford in 2008 and the case was selected to help the police and other services improve responses to higher risk victims. The fact that the case was selected because of the history rather than as a result of a specific incident triggering a referral should have been an indication of vulnerability. The first meeting of the MARAC agreed that all services would research what information was known to each service and could have been an opportunity to have developed a more complete narrative of information and to have identified underlying patterns. CSC who had attended the first meeting was not at subsequent meetings.

**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.**

240. Evaluations of serious case reviews in England and Wales supported by evidence from inspections and research frequently comment on the extent to which the level of concern about a child is frequently linked to how old they are. In other words there is an unspoken measure that infers greater concern when information is linked to very young children and decreases as children become older.
241. Some of this no doubt reflects a 'common sense' approach that regards older children as less dependent and able to show higher degrees of resilience. Although not completely without validity, such an approach can represent additional vulnerability for older children.

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<sup>27</sup> SystemOne, is an electronic patient records system being implemented within the NHS, and in Bradford has been rolled out across some community health services including GPs, Accident & Emergency departments, Drugs and Alcohol Teams (January 2012). In the coming weeks it will continue to be rolled out and made available to further services including health visitors, school nurses. The introduction of the system has already improved information sharing and provided greater clarity about which services are being provided to a family and helps improve the interface between adult and children's services protecting children or vulnerable adults.

242. In this particular case Sibling 8 made very clear allegations of physical and emotional abuse in 2007. This was the only direct disclosure by a child. It is apparent that there was a difference of view between the police and CSC in particular about how best to respond. The approach taken by CSC and described in their IMR was to treat the incidents as a conflict between a teenager and his parents. The police were clearly not in agreement with this response.
243. The absence of significant injury to Sibling 8 combined with allowing the focus to remain on the behaviour of Sibling 8 rather than the parents and reluctance of Sibling 8 to pursue his allegations all contributed to CSC in particular not pursuing the matter as a safeguarding issue for Sibling 8 or the younger siblings.
244. Although the CSC IMR author does not refer to other factors, Sibling 8's age may also have been a contributory factor; there would probably be a reluctance to become involved in making arrangements to look after an older child. Such reluctance highlights the dilemmas when older children move from their families at a point of crisis. The outcomes for older children in particular tend to be more negative in terms of their ability to settle into placements or to secure longer term educational and work prospects. There are often difficulties in reuniting older children back into their families.
245. Finding the best way to respond to the needs of older children can be complex; in this case there is little evidence that any support was provided once a decision was made to neither invoke safeguarding procedures or to make arrangements for Sibling 8 to be looked after for more than a few days.
246. The probation IMR author comments on the extent to which the OM remained focussed on father to the exclusion of taking a more holistic overview of the family's overall situation. The OM was told by father of the late night visits to his property by Amanda Hutton between September 2009 and April 2011. The OM did not share this or related information with any other service either about the evidence of Amanda Hutton's consumption of alcohol reported by father or the fact that the children were left at home when Amanda Hutton went to visit father's home late at night. The focus on the domestic violence between Amanda Hutton and father did not appear to extend to a fuller consideration of the impact on the children.
247. The HOR points out that there was historical information in various health records about concerns that included the family's isolation from either white or Asian community, disclosures of longstanding domestic violence in 2004 and indications of Amanda Hutton's low mood and depression.

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

248. There were various contacts with the family over the six years. It is apparent with the benefit of hindsight and the collated evidence provided through such a detailed serious case review that Amanda Hutton in particular was both wary of contact and endeavoured to control any professional enquiries especially during the later timeline of this review and was generally proved effective up until September 2011.

249. The HOR comments that there were several opportunities where health staff could have been more proactive particularly when they received information from other services about issues such as domestic violence.
250. The GP service had made numerous attempts to contact the family by letter and by telephone; all of these contacts went unanswered. The GP made a home visit without success (this was not recorded in the children's records). There was discussion between the GPs and the health visiting service who were also trying without success to make contact with the family. The IMR author for the GP review makes the point that there are no local or national standards in regard to the absence of contact between GP and children. The GP IMR author reflects on the value that the SystmOne will provide to health professionals dealing with similar circumstances now and in the future.
251. It is possible to see that Hamzah had disappeared from the view of services such as health from a very early stage and that some other siblings had not arrived in other services such as education and early childhood services. The author of the admissions IMR describes how the service were not aware of Hamzah and Sibling 2 leading up to the 2009 admissions and even if they had been, then current arrangements that comply with national requirements and standards do not require a follow up when an admission form for starting education is not returned; the national system is based on the assumption that parents will exercise proper responsibility in making appropriate arrangements for their children's education. This assumption has implications in a city where there is a significant transient population of people not familiar with UK arrangements.
252. In October 2005 the nursery nurse attempted to make a home visit and was rebuffed by a hostile response from Amanda Hutton and an older sibling. The nursery nurse saw a child who looked pale and she consulted the health visitor. The BDCT author comments that this could have provided an opportunity to have inquired further and to have consulted other services at the time. CSC and the health visitor had discussed Amanda Hutton's disclosure of domestic abuse prior to Hamzah's birth in June.
253. The account in 2010 of the children going to stay with relatives was reported to various agencies with some variation about details such as location; Peterborough, Portsmouth and Southampton were variously referred to. Some embellishment was given for example in regard to plans for the whole family to relocate.
254. The fact that a child disappeared from routine health oversight and surveillance is an area of significant interest for the HOR and the IMR authors for those separate services.
255. CSC visited the home on four occasions between November 2006 and April 2007. On the first occasion SW1 saw Hamzah together with his siblings Sibling 2 and three; all three children were reported to be 'looking well'.
256. The IMR author makes an important observation that on the three first visits to the house the various staff only saw the living room. They never saw any child on their own and they never visited bedrooms. The same author highlights that expected practice and standards required practitioners to speak with children and to visit sleeping arrangements. It is unclear if Amanda Hutton prevented such enquiries or they were simply not done.

257. In 2009 when the children were not collected from school the police made a home visit and reported that home conditions were acceptable. The police reported that Hamzah, Sibling 2, 3, 4, 5 and 6 had all been seen and looked well.
258. In March 2011 a neighbour made an anonymous referral; it is not clear why the referrer was advised to contact the police if they had concerns about the welfare of a child. At the same time CSC became aware through ESW1 that Hamzah and Sibling 2 had been 'placed in Portsmouth'. CSC took reassurance from the ESW report that concerns did not appear substantiated; they made no enquiries of their own.
259. In July 2011 CSC were told of ESW4's concerns about the filthy home conditions. However this information was never passed to a social worker or to a manager; a misunderstanding by CA6 believed that she had consulted and agreed an outcome with an unspecified social worker.
260. The referrals in March and July 2011 were opportunities for CSC to have inquired into the whereabouts of Hamzah. If more inference had been given to the vulnerabilities in this family it is more likely that more follow up would have been given to the reports of the children moving out of the area. The more substantial issue of how children who go missing are managed is explored in more detail in the final chapter.
261. Even if there had been a different response, it would not have provided a different outcome for Hamzah at that stage.

### **Assessment and Decision Making**

**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.**

262. The extent to which information was known to any service about the wider family is very limited and reflects the fact that opportunities to make enquiries or conduct assessments were not sufficiently taken. Information that was known was generally accepted at face value.
263. The HOR reflects on the barriers in regard to accessing historical information in patient's records. Health records are all written in chronological order, but every organisation organises them differently. They can be very long and complicated and there is no requirement for each and every record to contain a critical incident or summary sheet, which would highlight the more serious concerns and provide a basic chronology.
264. The widespread introduction of the new recording tool (SystmOne the safeguarding template) attached to every child's electronic records will seek to improve this, as critical incidents which may indicate a child in need or at risk, and concerns and information about the child's welfare and any actions can be recorded chronologically and kept separate to the main body of records to provide quick and easy access to the most pertinent information relating to safeguarding.

265. The SystmOne will provide primary health professionals with improved information about family information although in this case father was not registered at the same GP practice as his family.
266. The GP's discussed the lack of contact with the practice and had meetings with the health visiting team. These discussions were not linked to the children's records and the absence of immunisations and general health oversight do not appear to have been linked to other information known about incidents of domestic violence and depression.
267. Reference has been made in the previous section about the consultation that took place between CSC and the health visitor regarding Amanda Hutton's disclosure of domestic violence prior to Hamzah's birth. In general there was a high reliance on 'agency checks' which by and large recycle existing information already known to the services and were limited in their scope and nature.
268. For services such as health visiting, the information that was known about the family was not subjected to sufficient critical analysis in terms of understanding implications for Hamzah and his siblings. The difficulties in getting access led to a preoccupation with establishing contact rather than understanding the possible implications for the children and for other services. Amanda Hutton's expressed reasons for not wanting contact with health professionals in general were taken at face value and were restricted to her feelings of distrust rather than what her children required.
269. The historical information held by the various services was not available as a unified source and even information held by individual services was not consistently and routinely accessed.
270. In December 2008 CSC updated their agency chronology records although the IMR author comments that this was largely confined to the episodes of domestic abuse. It was March 2011 when SW12 added a closing case note that referred to the 'worrying history of mother's ability to cope'. There was no further contact with the family until September 2011.
271. The CSC author observes that the reliance on routine agency checks left historical information largely unnoticed or unknown and therefore provided limited understanding regarding contemporary information and events. It is of note in the CSC report that for example agency checks with the health visiting service reported routinely that health visitors had not gained access to the home since 2005. Checks with the GP would have revealed that the GP had a similarly low level of contact with the children. The CSC author is struck by the absence of recorded consideration or analysis of historical information. Further analysis in later sections reveals that workload was an issue across the service and a contributory factor in how the enquiries were conducted and assessment was recorded.
272. The implications of such an approach is that unless a dramatic or tangible concern impels further enquiry or action, the vulnerabilities and risks for children remain largely unknown for example from the long and established pattern of domestic violence dating back to the 1990's.
273. In probation, the OM was aware of the historical safeguarding concerns although when father provided new information about concerns for example

relating to the late night visits by Amanda Hutton these did not appear to have been understood for their significance according to the probation author.

**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.**

274. The quality as well as timeliness of assessments has been a significant issue for exploration in serious case reviews, inspections and academic research relating to work with complex families and vulnerable children.
275. The Munro Review provided fundamental criticism of the format and the conduct of assessment and made recommendations about changing the national framework for assessment with children in need in England that have led to revisions to national guidance.
276. It is widely acknowledged and is a focus of the Munro Review's recommendations, that the national approach to assessment of children in need had become mechanistic and prescriptive with an unhelpful preoccupation with key performance indicators that have never really assisted in developing a better understanding about quality, relevance and outcomes to this important activity.
277. Recent studies have emphasised that although professionals such as social workers can be very effective at gathering information from a range of sources they face a far greater challenge in being able to identify ways to analyse the information for its relevance and significance in regard to risk and need for children, leaving assessment often to be 'slightly better than guessing' (Dorsey).
278. An evaluation of assessment tools by the Department of Education has identified and reviewed three systems of assessment tools. The study concludes that although there needs to be a move towards more structured analysis and decision making there is limited evidence about the effectiveness of available tools in child protection work<sup>28</sup>.
279. The extent to which fathers are absent from assessment and agency contact generally is another theme to emerge in national studies on a regular basis. Although father was sentenced to a community order for assaulting Amanda Hutton this did not overcome his reluctance to seek or accept help or advice.
280. This entire preamble is by way of providing some context for the analysis that is provided by the IMR authors and in the HOR. It would be surprising if the IMRs had been able to describe assessments that had achieved a proper balance of timeliness and scope.

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<sup>28</sup> Systematic review of models of analysing significant harm; Barlow J, Fisher JD and Jones D, Department for Education March 2012.

281. Although the lead responsibility for assessment within the context of work with children in need or at risk of significant harm will always rest with CSC and a qualified social worker, this does not remove the need for all the relevant services to have the capacity to both contribute meaningfully to formal assessments led by CSC as well as having frameworks to guide their staff in identifying and recognising need and risk appropriately.
282. Certain fundamental areas of knowledge are required across the whole community of services working with vulnerable children; these include for example appreciating the impact of domestic violence, substance misuse and mental health on the well being of children as well as of the adults concerned. It requires sensitivity to the cultural and religious traditions within which children are growing up. It requires an insight into why some families will have great difficulty trusting state services or organisations. It requires discrete areas of specialist expertise as it relates to professional disciplines for example in regard to children's development, their learning capacity and their physical health.
283. The probation author describes that although the OASys assessment provided a 'sound' platform of understanding about father's risk to known adults and children the assessment remained focused on the adults and on father in particular as an offender.
284. The CSC author describes the organisational arrangements in place particularly from August 2008 in regard to the implementation of the Integrated Children's System (ICS)<sup>29</sup> that was consistent with the national policies and frameworks in place prior to the election of a coalition government. The author summarises how the system creates the conditions within which key assessments as well as other tasks and activities are completed within a process that requires a managerial sign off; in other words if an assessment is required the case can only move forward even to closure once the assessment has been completed and authorised by a line manager.
285. The CSC author acknowledges the high reliance on third party checking with other agencies rather than taking more searching and direct enquiries characterised their approach. The same author also comments on the lack of use of the assessment templates for any of the information that was generally placed in case recording. Implied within the commentary is the fact that the structure of recording did not encourage or demand any degree of analysis. For example, Amanda Hutton's symptoms of depression are recorded but there is not any consideration about the impact that the depression could have on Amanda Hutton's capacity to meet the needs of four children all aged under three.
286. This process of relying on process case recording continued. Assessment was further inhibited by the absence of focussed attention on the children even to the extent of not seeing all rooms of the house or trying to speak with them. This contrasted with the police who did complete welfare checks that included checking all the bedrooms and other 'non-public spaces in the home and on more than one occasion had for example identified issues such as inadequate bedding for some of the children.

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<sup>29</sup> ICS has been the subject of particular criticism and challenge by Professor Munro.

287. Much of the contact by CSC was conducted through 'duty' arrangements; this appears to have also contributed to the limited recording of information, the narrow focus of contact and the lack of enquiry into historical information or identifying any patterns. The CSC author acknowledges that the needs of the children were insufficiently identified and therefore recorded. Even Sibling 8 who made specific allegations about being assaulted was unable to elicit more concerted assessment and enquiries.
288. The cultural and religious complexity of the family was not enquired into. This is surprising for a service working in a metropolitan district with a rich history and diversity of culture, religion and language. It is of some note that there are occasions when Amanda Hutton appears to be the victim of racial or cultural inspired violence. The BDCT author comments that Amanda Hutton was isolated from both the white and Asian communities.
289. Health services had generally limited opportunity to undertake assessment with the children. Some of this reflected the episodic nature of services such as A&E or the YAS. Services such as midwifery faced problems in Amanda Hutton's late notification of her later pregnancies. The health visiting service faced Amanda Hutton's reluctance to engage with them.
290. The fact that the children were not presented for routine immunisations or other health care at the GP or with the health visiting service was recognised and discussed between the two services. That the children were not brought for routine immunisation and developmental checks is not unusual in some parts of Bradford and this on its own would not have aroused any particular concern or further interest. The same author also points out that the general health system operates on an assumption that an adult is taking responsibility for a child's health (the education authors make a similar point in regard to enrolment for education).
291. The absence of contact meant that the child records were thin on detail and any information regarding Amanda Hutton's depression and alcohol use was not linked. The one and brief consultation with Sibling 8 in 2008 would have taken place without any knowledge of other siblings or of the wider family circumstances. The new SystemOne referred to in previous sections provides improved opportunity for busy general practices to have access to fuller information assuming that the system is being routinely updated and used for the purpose of patient consultation.
292. The police IMR comments on the recognition by uniformed officers that Amanda Hutton did not want to speak to male police officers about domestic violence and describes the steps taken to provide a female officer.

**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.**

293. The CAF was available from 2004. Some of the IMR authors refer to agency specific frameworks that with hindsight could have provided opportunity to explore Amanda Hutton's support needs for example as part of her maternity assessment. There were several other occasions when the use of CAF could have provided an opportunity to collate information that may have led to more focussed and informed referral and enquiry by the statutory services.

294. None of the services used a CAF or other framework to co-ordinate information and help for the family. Several of the IMR authors are doubtful that such an approach would have improved outcomes in this case because of Amanda Hutton's resistance to contact with services, although this should never be a reason to at least attempt to use the CAF. The CAF relies on parents giving their consent to participating in a CAF. The extent to which Amanda Hutton was able to keep various agencies away from her and the family is understood by the review panel and was clearly revealed as part of the criminal trial but was not so apparent to those working with Amanda Hutton at the time. If the CAF had been offered and refused this could have provided an opportunity for further reflection as to whether a more assertive approach was appropriate.
295. The CSC author believes that if a completed CAF had been used to support a referral it could have improved the response from CSC.

**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.**

296. The HOR describes professional judgement as generally being less than 'optimal' although also highlights some very good judgments such as the YAS handling of the emergency call out. The HOR author comments on factors such as the death of one of the health professionals being a possible contributing factor to the gaps in information being considered differently. The implications are that possibly a more questioning approach may have achieved a greater level of engagement with Amanda Hutton in particular.
297. The CSC author describes the involvement of CSC with the family as being 'reactive'. Little opportunity was taken to explore the individual incidents or events either within a more adequate historical timeframe that could have shown up patterns or to consider the extent to which the presence of alcohol dependency, depression and domestic violence are all common factors in cases of children being neglected or abused. This does not assume that all adults who have alcohol dependency or are depressed will abuse their children; it does suggest that inquiries and assessment have to be sufficiently rigorous with a clear focus on what the information means for the child's health and well being.
298. The fact that much of the agency response was conducted through duty arrangements and not creating the opportunity for more reflective enquiry and assessment meant that judgements were generally focussed on the immediate imperative of whether any other action was required. This approach of dealing in the 'here and now' could not identify the cumulative pattern and impact on the children never triggered the safeguarding thresholds of significant harm or other thresholds relating to need. The extent to which the children were in need was not explored. The Children Act 1989 not only defines duties in regard to helping children who can be seen to be at risk of abuse (s47) but also requires thought to be given as to whether 'preventative services' are appropriate to promote their well being and development and reduce the risk of significant harm (s17).

299. The CSC author concludes that the known presence of risk factors, the allegations made by Sibling 8 combined with the anonymous referral of the neighbour in March 2011 should have provided sufficient reasons to undertake an assessment of the children's needs and circumstances.
300. The probation author refers to the development of mindsets that overlook the dynamic interplay of risk and the cumulative impact of repeated low level concerns. Another facet of such a mindset was making assumptions that because other services such as education welfare were involved with the children that any safeguarding issues were already being identified. This overlooked the information that the OM had that could help other professionals make more balanced and informed judgments.
301. The YAS author provides details of how appropriate referrals were made in April 2007 via the police about the children when Amanda Hutton was in a distressed condition. The author reflects on how ambulance crews' thresholds of concerns can be different to other services levels and can result in challenge. The same author comments on a crew member describing conditions in the home as cluttered and the extent to which this was indicative of neglect or not.
302. The author for the GP IMR describes the decision by the practice to remove Amanda Hutton and her children from the practice register when they failed to be presented for appointments. GP2 who is the safeguarding lead within the practice deferred this decision but in October 2009 the family were removed when GP2 was away on holiday. The decision reflected a concern that they could be accused of maintaining 'ghost records' and be liable to allegations of fraud. If patients refuse to attend for appointments the practice is unable to provide the level of medical care expected and they also will not meet targets.
303. The GP IMR author points out that the decision to remove the family from the register did not breach any standards and concludes that clarification to local and national guidance would be helpful.
304. The fact that the family did not register with any other GP practice was not apparently flagged by any organisation. The GP author acknowledges that this represents additional vulnerability to a child in not having access to a full range of health advice and support and disappears entirely from an important part of the local primary health care system.

### **Using and Sharing Information**

**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.**

305. There was a considerable amount of information sharing although the frameworks being used were at times unclear or informal and the outcomes that arose from the activity were limited. There were also inconsistencies in the quality of recording in and between services. For example, the children's centre did not make any contemporaneous recording and did not seek any information from other services when they became involved for a few weeks in early 2009. Meetings such as MARAC were not consistently attended by the same agencies or their representatives; the MARAC author is confident that current

practice is much more secure from the arrangements in 2008 when MARAC was still a new arrangement in Bradford.

306. Some of the information that was shared between services arose because of routine or procedurally driven requirements. For example, incidents of domestic violence from 2003 were generally reported to CSC by the police although their purpose and intended outcome was not apparent between the two services. Given the number of domestic violence incidents, simply sending information through to another service can simply be stored and filed. It can be regarded as routine and administrative rather than a compelling record of concern being shared for the purpose of further enquiry and analysis.
307. The procedures for identifying children missing from education were largely managed as routine requests which did not trigger further levels of sharing or consideration of information.
308. In January 2011 the Year 8 pastoral manager reported her concerns to the school's named person for child protection when Sibling 6's attendance had dropped to 51 per cent and despite letters and phone calls from school they had been unable to make contact with home. A home visit had been undertaken by school staff. They made contact with the children's contact point (social care). A common referral form to CSC was completed by the named person from the school who was informed by CSC that there was no role for the assessment team in this case because it was a school attendance issue. There are reports of Sibling 6 presenting at school in a physically neglected state.
309. School B reported that Sibling 5's behaviour changed noticeably during 2010/11 in responses to school when they enquired about the reasons for absences from school. This suggests that the home circumstances were unsettling and beginning to impact on the children. However there is no evidence to suggest that this triggered further investigation by School B.
310. School B had believed that they had a good working relationship with the school nurse that provided an effective two-way communication process in which information was shared for individual pupils and their families. However, the IMR author comments about how indicators of concern were not discussed or reported and therefore undermined the effectiveness. Particular reference is made to information known to the school nurse in relation to Sibling 4; whilst the school nurse had clearly recorded information strongly suggesting chronic neglect of Sibling 4 of the type that would have been obvious to the school staff over a period of time (September 2011 a description of severe tooth decay and weight loss) there is no evidence that this important information was discussed with the head teacher. This leads the IMR author to question the quality of the information exchange between the head teacher and the school nurse.
311. By 2009 both schools were aware to some extent of the domestic violence incidents at home and there was knowledge of substance misuse by Amanda Hutton and one of the older children. However, at the same time School B reported the children as being well presented in school with no major concerns other than their habits of arriving late and of poor attendance.
312. The schools IMR concludes that School B did not fully recognise the potential impact that the domestic violence incidents might have had on the children nor did the school appreciate that the poor attendance was likely to be symptomatic of the home circumstances.

313. The YAS made a referral to CSC in April 2007 that outlined their concerns about Amanda Hutton's mental health although they were unable to make direct contact with a mental health team. A copy of the patient report was provided to the hospital by the ambulance crew when they transported Amanda Hutton for medical treatment.
314. Further complications arose from the resistance particularly from Amanda Hutton but also on occasion from father to agency contact or involvement. There were also the apparently rehearsed recitals of family plans to move to other areas and the explanation of relatives looking after children to explain absences.
315. The CSC author reports on changes to the initial point of contact with services that is now seeing the piloting of integrated multi-agency teams designed to create better opportunities for seeing across boundaries and sharing intelligence with greater purpose; this reflects recommendations made by the Munro Review. Further changes have also been made to the management of 'call handling'
316. The discussions between the GP and health visiting service were not shared more widely with other services. This apparently reflected, at least for the GP practice, that they had no greater concerns than a family who were not attending for immunisations or appointments. It is an example of where the information in isolation had less significance until it is seen within the context of wider information about the family that is evident through the collated information presented to this review. It seems that no other agency ever sought information from the GP practice.
317. The BDHT highlights the contrast in how information was shared more effectively with other services when for example Sibling 8 attended at A&E compared to when Amanda Hutton had been to A&E on earlier occasions as a result of the assaults on her. The IMR author commends the persistence of staff in responding to Sibling 8's needs especially within the context of a busy emergency treatment service. They ensured he remained on the unit while consultations took place with the police and CSC. Such decision making reflected a child centred approach.
318. The HOR comments on the evidence of communication between the community health services (health visitors and school nurses), CSC, schools, education social workers and agencies involved in MARAC; however, there is no evidence in the records that there was any multi-agency plans and interventions as a family in need. There was no evidence in the health records that the threshold was met for interventions regarding child protection even though there were concerns raised since 2006. GP services did not share information with any other agency except health visitors neither were they asked for any. Single and multiagency communication was erratic and inconsistent and was not seen in context as a whole picture but as a series of individual contacts and snapshots.

**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.**

319. The focus in MARAC was on the risk of violence to Amanda Hutton as the victim and did not sufficiently focus on the children. The changes that have been referred to in other parts of the report in regard to law and guidance, combined with the evidence of reviews such as this are giving a far clear focus and impetus to putting children central to risk assessment and management. The quality of reports and information were limited and was a reflection that the MARAC was just being established. Attendance by CSC was 'inconsistent'.
320. The CSC author highlights significant issues in regard to how information historically was managed between key parts of the service and the extent to which this left practitioners with an incomplete picture.
321. The author describes how there were delays in placing information discussed at MARAC in 2008 onto the CSC electronic system until 2009. The paper record from MARAC contains more detailed information about incidents that were unknown to the area teams that responded to subsequent requests for information or referrals.
322. Changes to arrangements since 2009 have apparently addressed these deficits although the limitations of relying on pro-forma requests for information are still highlighted by this review. For example the education and early childhood author noticed that inquiries in regard to the children missing from education focussed on whether the children's names, address and dates of birth could be confirmed and the date of last updating of information. The focus was on administrative functions rather than encouraging a more 'intelligence led' response.
323. It provides a good example of where unless people undertaking a task understand its purpose, the intended outcomes will be less secure. If individuals see the task as fulfilling an organisational and administrative requirement rather than seeing it as a means to an end in helping trace a child, they will display a lack of curiosity and the persistence that can transform both the activity and the outcome.
324. The CSC author comments that the quality and usefulness of much of the information provided was of limited value and provided little assistance to the practitioners dealing with events.
325. The YAS author comments on the potentially important information that YAS has following emergency response calls to family homes that is rarely sought by agencies or MARAC. The same author reports on the information sharing exercise between May and November 2011 organised by the Bradford Domestic Abuse Partnership (BDAP) that revealed that almost a third of cases discussed at MARAC had been visited by YAS.
326. The GP IMR author is unsure whether the GP practice remained unaware of the discussion at MARAC; there was no reference on the children's records. The SystemOne should improve the sharing of information.
327. Most health services provided no written information although there were verbal exchanges of information. The health visiting service provided a written child protection referral to CSC in November 2006 that the HOR comments was clear and of good quality. The general lack of written information reflected the fact that none of the individual items of information known to various health practitioners had reached a formal threshold of concern.

## **Engagement and acceptance of help and advice**

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

328. The extent to which Amanda Hutton in particular displayed a distrust of professional services does not appear to have been evident to the various people in contact with the family. Although Amanda Hutton requested support on one occasion from CSC after Sibling 8 had made his allegations, this was principally in regard to managing his behaviour rather than addressing any of the issues that had an impact on her as a parent. However once the immediate crisis was over Amanda Hutton withdrew and refused further help or contact citing that she had sufficient support from the YOT.
329. The final meeting of MARAC in January 2009 was informed that Amanda Hutton had engaged well with services such as Staying Put and the Family Centre.
330. The HOR refers to the national and local evidence that fathers are frequently absent from contact with services. The author refers to current research and training into the engagement of fathers by the Fatherhood Institute<sup>30</sup> to highlight the issues and improve this. The HOR author also reflects on the delays in responding to Amanda Hutton on the rare occasions she disclosed domestic abuse may have been a contributory factor in her disengagement.

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

331. The police IMR provided comment and information about the considerable efforts made by police officers in 2005 and 2008 to help Amanda Hutton to seek support in leaving the abusive relationship with the children's father. It is apparent that Amanda Hutton developed a high degree of trust in one particular officer. In spite of the considerable efforts to support Amanda Hutton which included making contact with relevant services and arranging appointments Amanda Hutton felt unable to follow up on plans to leave. The same authors also comment on the difficulties in securing Amanda Hutton's cooperation with the MARAC process.
332. The CSC author concludes that there was limited choice in the action that could have encouraged better contact and engagement with the family. This comment is a reflection of the fact that any help that was provided was on the basis of the voluntary arrangements under s17 of the Children Act 1989.
333. Although Amanda Hutton had demonstrated a long standing unwillingness to accept help, if practitioners had been better informed and equipped to take a more assertive and enquiring approach especially in regard to Amanda Hutton's problems and again when Sibling 8 made his referral there remains a possibility

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<sup>30</sup> The Fatherhood Institute is a UK fatherhood think-tank. and registered charity that collate and publish international research on fathers, fatherhood and different approaches to engaging with fathers by public services and employers.

that an improved level of contact could have been achieved; it could certainly have been attempted.

334. Father displayed a similar unwillingness to accept professional involvement. Despite frequent efforts by the OM, father continued to minimise his offending and disrupted group activities that led to his suspension from the supervised programme. Amanda Hutton also showed a reluctance to receive any help through the Staying Put project and YOT or the police. She was willing to receive limited help for example in regard to benefit payments but was not willing to address other difficulties.
335. The GP practice did not discuss the case with CSC; as described in previous sections the issues in regard to the missed immunisations and developmental checks were not a cause for enhanced concern at the time but are an example of how the behaviour of the parents had an impact on the children.
336. The HOR acknowledges that all the health IMRs identify opportunities to have tried to secure improved engagement. A referral to the mental health crisis team from YAS may have improved engagement with mental health services (although they did contact the police when they had no contact details for other services). A decision not to remove this family from the GP list and improved multi-agency communication from the GP may have increased engagement. The hospital IMR author suggests that clarity as to why Amanda Hutton did not bring her children back to the hospital for various follow up appointments could have been investigated further with more direct contact, as arguably she was not acting in the best interest of her children at this time.

### **Planning and Help**

#### **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.**

337. The MARAC IMR describes action agreed at MARAC meetings as being appropriate referring to the arrangements made for support through Staying Put and the education welfare service. The author acknowledges that with the absence of CSC there was no opportunity to check and confirm if there was any follow up action being taken by that service. When MARAC were told that the health visitor was unable to gain access to the house the action agreed was to see the children through the school nursing service; this would not have provide opportunity to see Hamzah.
338. The police IMR authors report on the degree of concern there was on Amanda Hutton's part in early 2009 that father might try to force his way into the family home and there was a high level of concern.
339. The author of the BDCT highlights how the fact that the family were subject of discussion at MARAC led the health visitor to mistakenly believe that Amanda Hutton was accepting help and support from other services.
340. The CSC teams who dealt with information requests and duty referrals had limited access to information that was discussed at MARAC. Arrangements have been improved since 2009 when area teams provide and receive information in regard to MARAC.

341. The HOR comments on the general lack of information about any statutory assessments although lists the various occasions when it could have been expected; after the physical abuse disclosure by Sibling 8 in May 2007, after more domestic violence in July and August 2008, following the MARAC in January 2009, following concerns of substance use by Amanda Hutton and older son and non collection of children from school in April 2009, following an anonymous allegation of shouting and swearing at the children in March 2011 and the increasing concern for the whereabouts of Hamzah and Sibling 2 throughout 2010 and 2011.
342. The HOR comments that the health visiting records are not clear about what assessment was completed after the child protection referral in November 2006.

**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.**

343. It is a recurring theme in serious case reviews, inspections and practice research that too little attention is given to seeking and recording evidence about children's views, wishes and feelings. Children growing up in troubled families will face a range of difficulties in telling their story and it represents a significant challenge for people such as social workers and police officers as well as other people working in early years, education, health and criminal justice services. It requires appropriate skills, curious persistence and the time to do it adequately and it is often overlooked. It can be seen as being a lower value 'talking' activity compared to other tasks that demand time and attention. It is notable that the police IMR is the only report to include the reaction of the children 'to a police presence' in their home. It indicates sensitivity to how young children reacted to uniformed 'strangers' in their home.
344. The CSC author describes the limited opportunities taken by staff to seek the direct views wishes and feeling of children. The two occasions when Sibling 8 raised his concerns there appeared to be a high reliance on what he said to the police, which is indicative of a concentration on evidential disclosures rather than encouraging a fuller conversation about how he was feeling and what he wanted. The focus on allegations on the second occasion was halted when Sibling 8 withdrew his complaint.
345. The CSC author describes the visit to the house on five occasions between November 2006 and December 2008 and refers to the children being too young to speak but 'had raised no concerns for the visiting social worker'. It would have been better practice if there had been more direct reporting of how the children had presented including their physical condition and emotional demeanour and how they responded to a stranger in their house.
346. When Sibling 4 and 5 were spoken to on other later occasions the CSC author reflects on whether both had been subjected to coaching or threats by their Amanda Hutton. The CSC author concludes that there was probably a naïve expectation that children would tell somebody if they were being harmed or would seek help; Sibling 8 tried to do this on two occasions and was unable to achieve a response. This would erode confidence in the willingness or capacity of the service to take their concern seriously and to act.

## **Practice Support and Supervision**

**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.**

347. The CSC author refers to the increased workload in Bradford that arose in the wake of the Baby P case in Haringey in early 2010. This had implications for some working practices especially in regard to the use of duty or welfare visits to respond to the lower risk cases. This was designed to avoid bottle necks and to create capacity to focus on cases that were seen to be of higher concern. The practice of relying on case recording rather than using an assessment framework reflects this workload management approach at the time.
348. These working practices appeared to have extended into areas prior to Baby P where there were queries and concerns regarding children's welfare. For example, the decision by the police to invoke their powers of police protection in regard to Sibling 8 on the 9<sup>th</sup> December 2006 involved discussion with CSC although none of this was structured around the BSCB requirements in regard to strategy discussions or s47 enquires.
349. The significance of the BSCB procedures is to provide a consistent framework for sharing information and creating the circumstances under which judgements, decisions and action are likely to be properly balanced by looking at all relevant factors. There was disagreement between the police and CSC in regard to how the allegations by Sibling 8 were managed and they were never taken to a wider discussion that could have placed them in a better context of information about the family.
350. The reliance on information being presented at the point of initial contact or referral to allocate priority to a case represents systemic risk. This case has shown the importance of exploring underlying information and patterns that will be less likely to be identified by reliance single agency contact. The evidence of SCR's nationally is that children are most vulnerable when their needs have not yet triggered a threshold requirement.
351. The probation author highlights a number of noncompliance issues identified by the agency review. These reflect issues highlighted by previous reviews. For example the use of CRAMS<sup>31</sup> risk alert flags for the well being of children where drugs, alcohol, mental health or domestic violence are issues. The sentence plan included no objectives in regard to safeguarding children in spite of the offences and risk assessment<sup>32</sup>.
352. The GP Practice had a safeguarding policy in place that was compliant with the Royal College of General Practitioners guidance. The lead GP for safeguarding had participated in training and the action in relation to the family complied with standards. The author of the IMR identifies the value of further local guidance in regard to managing families who do not respond to appointments and managing the removal from practice registers.

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<sup>31</sup> CRAMS is an electronic case recording and management system used by the national probation service.

<sup>32</sup> The IMR author includes information about serious personal difficulties that the OM was facing at the time that had an impact on their usual capacity and performance.

353. The police IMR authors note that in December 2008 when father was arrested for his assault on Amanda Hutton, a specific child protection referral should have been made in regard to the welfare of the children when father raised concerns about Amanda Hutton's neglect of the children and her use of alcohol. The authors provide the context that when the officers had visited the house all the children appeared fit and well and by implication may have regarded father's statements when he had been arrested for his physical assault on his wife as trying to deflect and divert attention.
354. In September 2011 when the PCSO was trying to gain access to the house and becoming increasingly concerned about the children, instead of consulting the CPPU they consulted a detective in an adjoining division who happened to be a personal friend. Although the detective friend provided advice about how to gain access to the house using a uniformed officer if necessary, the use of this informal source of advice was outside organisational protocols and meant that the CPPU were not alerted to the PCSO's concerns.
355. Although this is not to criticise the officer who was trying to do the right thing it does invite reflection about why the PCSO did not seek advice from specialist officers within the division. It appears to be the consequence of being very new into post and uncertain about the inference being given to the growing sense of concern.
356. The HOR refers to the absence of robust procedures for any of the health services, except for YAS on action to take where there is disengagement and non-compliance and no access. It was after 2010 that more comprehensive and rigorous arrangements were introduced in regard to issues such as the disengagement of families.
357. The HOR refers to previous SCR's that have increased the safeguarding training offered to staff either single agency or multi-agency, in domestic abuse, assessment and interventions, the impact of parental mental ill-health and substance use on children. There has been much activity in all the health services increasing the training levels of staff to comply with the recommendations in the intercollegiate document on competencies for staff in safeguarding children 2006 and latterly 2010. This is still in progress and is expected to be completed in 2012.
358. The ESWS author highlights how the CME protocols were incorrectly signed off. This resulted in the mistaken closure of the cases on Hamzah and Sibling 2 as 'being found in another LA'. Specifically there were no checks made with Portsmouth Education to see if the children were in school; no known address for the children on closure and a lack of clarity of guidance on checking family fostering arrangements. No checks were made with Southampton and Peterborough. The IMR author reflects on the important function of managers satisfying themselves that the information they are being asked to base their own judgments is complete and clear for them to make a decision.

**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 was an impediment.**

359. The importance of organisational arrangements is increasingly understood in terms of how the quality of practice and outcomes is linked to the robustness of the organisation's arrangements. It is also a fact that people undertaking difficult and complex work will face additional pressures such as bereavements or other disruptions in their personal as well as professional lives. One of the IMR authors describes how one of the professionals was affected by bereavement outside the workplace. Such personal pressures are exacerbated if individuals are also coping with excessive workloads. Good services rely on dedicated and appropriately trained people having the physical, psychological and emotional support and capacity.
360. The YAS author identified that several of the crew members responding to emergency calls had not completed level 2 safeguarding training and confirms action taken to address this. The author also describes other work being taken to help crew members in making judgments on what physical conditions might constitute neglect rather than lower level issues.
361. The CSC author describes how the assessment service was staffed by two experienced and qualified managers throughout the period under review and had the support of an experienced service manager. They had access to appropriate procedures and consultation was available. The practitioners who were involved with the family were level 3.
362. However there were a number of factors within CSC that represented a degree of vulnerability and impediment some of which have been commented on in previous sections.
363. There had been periods when sickness absence and annual leave had coincided, which left one manager in sole charge for some periods of time. This reflects an operational reality for any service. There were occasions when the assessment team has required support from agency staff which created some degree of instability and lack of consistency.
364. The introduction of an important system (ICS) in 2008 had placed some additional pressure on managers and practitioners before the system became established and familiar. The vulnerability of not having sufficient capacity to undertake assessments to a sufficient level of enquiry and consultation is that the hidden risk and need of children remains undetected and identified.
365. It was within these circumstances that working practice such as duty or welfare visits were used.
366. The admissions IMR author describes how access to independent choice for their children's education has been removed as a requirement although acknowledge this was never available in regard to primary education.
367. The HOR provides commentary on the organisational arrangements for the various health services in Bradford. Of some particular relevance in this SCR are the arrangements for the delivery of GP services in the city that comply with national and regional requirements.

368. GPs are independent contractors. At the time of Hamzah's death, GP services were commissioned by Primary Care Trusts (PCTs). A GP Practice that the family were registered with held a contract with Bradford and Airedale Teaching Primary Care Trust to deliver GP services. The type of contract was known as a Personal Medical Services (PMS) Contract, and was a form of contract used widely both locally and nationally. Under this contract there was a requirement for the practice as a whole to "give regard to the local safeguarding policy". The commissioning body for GP services is no longer the Primary Care Trust since this was abolished at the end of March 2013. Since then GP services have been commissioned by NHS England. The West Yorkshire Area Team of NHS England oversees contracting and commissioning of GP services in the Bradford area. However it is noted that since 2013 all GP practices must be registered with the Care Quality Commission and this organisation mandates adherence to safeguarding policies and procedures through its registration and assessment process.

**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.**

369. The CSC author comments on the absence of written consultation between practitioners and managers and is a reflection of some of the workload practice referred to in the previous section.

370. The GP IMR acknowledges that clinical records do not allow any judgement regarding the degree of critical reflection when discussions took place regarding the children not being presented for immunisations and developmental checks.

#### **Learning from SCRs and other review processes**

**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.**

371. The MARAC author comments on the changes made to the conduct of meetings following a SCR in 2010. The changes had put an emphasis on sharing information rather than more discursive case conference style discussion. Greater responsibility had been given to the designated officers attending the MARAC to ensure they had direct discussion with the staff member in their organisation that was in contact with the victim. Regular refresher training is also provided to the designated officers.

372. Two previous SCRs are referenced in the GP IMR regarding the importance of communication between primary health services. The introduction of the SystemOne is a response to that learning that is reflected in the historical case.

373. The police IMR authors refer to learning that had been identified in previous SCRs regarding the importance of all police officers having a clear understanding the importance of ensuring enquiries about the safety and welfare of relevant children should be a routine aspect of police work when responding to incidents. Although there are several good examples of where

police officers showed considerable awareness and persistence in following up concerns about the children the authors acknowledge that for a large and diverse police service the needs to ensure training and development is continually provided is an essential requirement for the service.

374. The HOR refers to learning from previous SCR's both locally and nationally. The similar themes and actions as identified in two previous SCR's in Bradford.
375. The SCR AI in 2007 identified a lack of a co-ordinated response and support to mental health problems of a mother, which is echoed in this case.
376. The child J SCR in 2011 contained several themes also duplicated here. Firstly the lack of multi-agency assessment and planning which would have contributed to what the children's life was like. Secondly, the lack of rigorous professional judgement and decision making which allowed this case to drift. Thirdly the invisible father, there is no evidence that any attempts were made to engage father and very little is known about him. Fourthly parental resistance to professional intervention is the key issue in this family and it appeared this was viewed as intractable and therefore contact was not pursued. Lastly there was no focus on the children's wishes and feelings; Amanda Hutton was the focus of health professional activity.
377. Common themes in other SCR's, national research and other documents has also been highlighted by the IMR authors, and these include:
  - a) the failure to take into account the impact on children of living within an environment where there is domestic abuse and the emotional unavailability of the parents in this situation;
  - b) no consideration of the presence of domestic violence, mental health issues and substance misuse as highlighted in Brandon et al (2009);
  - c) Insufficient challenge to both family members and between professionals as highlighted in both the Victoria Climbié and Peter Connolly inquiries;
  - d) Failure to register with a GP as in the Victoria Climbié case;
  - e) Failure to record information from liaison and discussions in patient's records.
378. The HOR describes the policy and practice changes and improvements from previous IMR's and SCR's which have been implemented:
  - a) Written referrals to children's social care within 48 hours were demonstrated in the IMR's;
  - b) There is now MARAC involvement from midwifery and A&E specifically;
  - c) The development and launch of the district wide health services violence against women and girls strategy (2011);

- d) Midwives are required to ask every woman at some point in the pregnancy about any domestic abuse;
- e) Failing to attend appointments and lack of engagement with services is an area in which Bradford teaching Hospitals in recent years have reviewed and developed a process for management around children who fail to attend appointments.

**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.**

- 379. Previous SCRS had identified the importance of specialist safeguarding leads in GP practices and over 90 per cent have such a role established. All of those leads are trained to at least level 3. The GP practice had one of the more experienced leads. The implementation of the SystmOne referred to in several of the previous sections is also a product of previous agency learning.
- 380. The HOR refers to single agency reviews done as part of learning the lessons reviews and serious incident root cause analysis reports. Cross cutting themes are similar to those in this review and include, non co-operation with medical treatment, communication and recording practices, poor recognition of neglect and abuse and failure to challenge parents and professionals. These are being dealt with at present in terms of action planning and practice sharing events.
- 381. There are also issues highlighted in the YAS IMR which has come recently from another learning the lessons report with respect to ensuring all staff have level 2 training and also in recording those children in the household in any 999 visit where it is practical and possible.
- 382. The HOR identifies thematic learning from the health IMRs that can equally be applied to other services.
- 383. **Professional judgement, assessment and decision making and single focus working** (identified as silo working). Professional focus was on single issues within the family rather than looking at the whole picture. Any assessments were superficial and decisions made without a true picture of the family. Health professionals need to access and be knowledgeable about family history and historical information. Assessments need to be made on the basis of knowledge, observation and analysis and followed by action planning. Action plans should be reviewed regularly.
- 384. **Lack of “think family” approach.** There was never any sustained effort to get direct contact and assess the children. There is no evidence of what life was like for the children in this family and any information given was taken on face value and not explored or challenged. There was no consideration of what effect the toxic trio (domestic violence, mental health issues and substance use) had on the children. This also needs to be part of any information gathering and assessment.
- 385. **Lack of engagement with the family.** The family disengaged from all health (as well as other) services and as this became more entrenched it appears that the family’s non compliance was considered to be unchangeable. Professionals need to be aware through training and supervision of positive engagement skills to attempt to engage with non compliant families. The recognition of

opportunities to engage and intervene is crucial and professionals should be empowered through supervision and management oversight to engage with these opportunities.

386. **Drift.** The loss of focus, the difficulty in getting access to the family and their disappearance at times all contributed to the lack of action over many years. Supervision of staff is crucial and case audit of records and the production of chronologies would ensure there is focus on positive action.
387. **Multi-agency information sharing, assessment and planning.** The lack of joined up assessment, information sharing and thinking, meant there were missed opportunities for multi-agency action to help this family and protect the children. Health professionals should be clear in their written and verbal communication and in what action will be taken. They should also be supported and encouraged through supervision and training to appropriately challenge multi-agency colleagues to re-examine their decision making if necessary.
388. **Invisible father.** There is no evidence that any attempts to engage father was made and little is known about him other than the alleged assaults on his partner. Training and supervision should ensure that professionals are aware of the importance of fathers in children's lives and the contribution they can make whilst at the same time assessing the well being and safety of children in circumstances where there are parental relationship problems.
389. **Standards of recording and access to records.** The importance of correctly recorded information in children's records where it can be accessed when needed and form part of an assessment was an issue for several agencies. The use of the template for recording safeguarding information in the electronic records is vital and all efforts to implement it as quickly and thoroughly as possible should continue. The HOR comments that the improvements made at BTHFT have resolved the issue in the A&E department.

#### **Agency specific key lines of enquiry**

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

390. The narrative chronology in chapter two describes the action taken by CSC and the police from the 12<sup>th</sup> September 2011.
391. The PCSO who initially dealt with the report from a neighbour about dirty nappies being thrown into his garden and stones thrown at his house and vehicle was new into post and had just completed their initial induction. The PCSO made five attempts to follow up the complaints by visits to the home prior to the 21<sup>st</sup> September 2011. After one of those unsuccessful visits the PCSO telephoned CSC to establish what information they had about the family; this contact was not recorded by the PCSO.
392. Around the 10<sup>th</sup> September 2011 the PCSO was in contact with CSC being aware of the state of the home and an 'overpowering smell'. The PCSO left a card through the letterbox on the 12<sup>th</sup> September 2011 asking Amanda Hutton to contact her; Amanda Hutton subsequently made contact on the 15<sup>th</sup> September stating that she was no longer living at the property and that the

children were living with her eldest son. Although the PCSO attempted to make an appointment to speak with Amanda Hutton she ended the call. The PCSO made a visit on the 20<sup>th</sup> September 2011, again leaving a card. The PCSO was determined to make contact with Amanda Hutton.

393. On the 21<sup>st</sup> September 2011 the PCSO spoke with SW2 and they agreed to make a joint home visit. The PCSO visited with another PCSO and they shouted through the letterbox that they required Amanda Hutton to open the door or they would force an entry; the PCSO had previously sought advice from a detective. Amanda Hutton opened the door but refused entry. The PCSO consulted with SW2 to establish what concerns CSC had about the children. SW2 contacted the CPPU and was advised to request a uniformed officer to attend in order to force entry to the property.
394. The CSC author identifies that there was a delay in the team manager being made aware of the initial contact and the case was not allocated to a social worker until the 15<sup>th</sup> September 2011. There was an initial reluctance to treat the information as a safeguarding concern and there was a delay in making contact with the CPU and organising a strategy meeting. Significant factors appeared to be that this was initially treated as a report of a smelly house which had less priority in comparison to other cases that had clearer and more explicit safeguarding concerns being raised about children. It provides an example of how relying on presenting information can misinform and misdirect professional judgment. This is not intended to criticise an individual manager who doubtless had to balance competing priorities for allocating work to qualified social workers.
395. Although earlier discussion with the police and an earlier strategy meeting would probably have achieved a quicker entry to the house and the discovery of Hamzah's body it would not have changed the outcome for him. The CSC author acknowledges that visits should have been made to the property and the fact that they were not reflected that other cases were taking priority at the time.

**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.**

396. The schools IMR acknowledges that there were missed opportunities in September 2009 for School B, the Admissions Service and the CME Team to enquire about the whereabouts of Hamzah and Sibling 2 when they could have taken up their place in reception class at primary school. Similarly in September 2010 there was a missed opportunity to enquire about the whereabouts of Sibling 3 when he could have taken up his place in reception class at primary school.
397. With the benefit of hindsight more could have been done between the services to clarify the whereabouts of the missing children (Hamzah, Sibling 2, Sibling 3) and that this was a lesson for the local authority to learn from. There was a lack of connectivity between the authorities to clarify the whereabouts of 'missing children' and that schools can only be aware of missing children if they are informed of their existence.
398. There is no record on the Capita ONE system of any of the children in the family accessing early years provision. When dealing with school applications,

the Admissions Team is not aware of younger siblings who would be due to start school in future years. Therefore, because Hamzah and Sibling 2 were not in a pre-school setting, the team were unaware of their existence and therefore were unaware of them missing education.

399. The action taken by the admission officer regarding Sibling 5 was good practice, in this instance. From information provided by School B and the decision to allocate a school place without an application form being completed, the proactive action ensured that Sibling 5 was allocated the same secondary school as the older sibling.
400. Liaison between the admissions team and education social work service has improved since September 2010 when all local authorities became responsible for the co-ordination of in-year admissions. Prior to this, parents made direct contact with their preferred school when applying outside the normal admissions round. Since September 2010, processes for identifying children missing education has improved significantly, but again, this is mainly dependent on the parent making an initial application. Reference has been made that education social work service was informed that Siblings 1 and 2 were returning from Portsmouth but at no time was an in-year application for a school place submitted. Although the children were placed on the CME register by education social work service between October and November 2010 as 'missing children', there was no liaison between the two departments at that time.
401. The admission service IMR acknowledges that the primary school application process could be more widely publicised, for example regular articles in 'Community Pride' the Council's publication that is sent to all Bradford district households three times each year. The IMR considers other avenues for obtaining details of children who are not in early years settings, such as Bradford Health Authority or Child Benefit data could be considered.
402. The arrangements put in place since December 2011 for the early years service to be notified about new births as a matter of course unless a parent decides to opt out provides stronger opportunity for improved inter-agency communication regarding all known vulnerable children, particularly those not yet in school and where parents tend not to engage with professionals. When these children are approaching school age, steps can be taken to ensure the family has engaged with the admissions process. Their details could be shared with the Admissions Team so that extra attention can be given to these children to ensure that a school application is made.
403. The DfE promotes the take up of online applications rather than the completion of paper application forms. Whilst this can be an easier process and more reassuring for parents that their application has been received, it results in the child's current nursery or primary schools not knowing whether an application has been made by the deadline date. Although the Admissions Team can inform the current school of this after all online applications have been imported into the admissions database, those parents disengaged in the process are not known until after the deadline date has passed. It is known that such families are less likely to complete a school application, so there is a need to improve their access to online facilities, such as drop in sessions within schools.
404. School A and School B followed the agreed systems and procedures in school at the time in terms of recording and monitoring attendance in relation to the

Family H children. However, recording and monitoring suggested a passive exercise rather than taking assertive action. Despite the actions and interventions described in the IMR that were put in place the impact was minimal in that attendance did not improve.

#### 4 Analysis of key themes for learning from the case and recommendations

405. Any meaningful analysis of the complex human and professional interactions and processes for decision making that characterise multi-agency work with vulnerable children and troubled families has to understand why things happen and the extent to which local systems help or hinder effective work within 'the tunnel'<sup>33</sup>.
406. The key findings in this chapter are framed using an adaptation of the systems based typology developed by SCIE. Although this serious case review has not used systems learning to collate evidence there is value in using the following framework to identify some of the underlying patterns that appear to be significant for local practice and which place individual action and behaviour within the context of agency and multi-agency working.
- a) Cognitive influence and human biases
  - b) Family and professional contact and interactions
  - c) Responses to incidents and information
  - d) Longer term work with vulnerable children and troubled families
  - e) Tools to support professional judgment and practice
  - f) Management systems
407. The remainder of this report aims to use this particular case, to reflect on what it appears to reveal about areas for further development in the local safeguarding system and use it as far as possible as a window into those local systems.
408. In providing the reflections and challenges to the BSCB there is an expectation that the Board will provide a response to each of the key findings as well as to the recommendations and action plans that are described in the agency IMRs. As far as the key findings described in the remainder of this chapter it is anticipated that the Board will take the following action.
- a) An indication as to whether the BSCB accepts the findings;
  - b) Information as to how the BSCB will take the findings forward;
  - c) Information about who is best placed to do lead on any particular activity;
  - d) An indication of the timescales for responding to the findings;
  - e) Information about how and when it will be reported.
409. The BSCB will determine how this information is managed and communicated to relevant stakeholders. This report recommends that the BSCB discuss the key findings and makes a formal response that is also published. The reason for structuring this final and important part of the report in this way is that it gives responsibility and empowerment to the people who know their community and services to develop appropriate responses rather than to have action imposed.

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<sup>33</sup> View in the Tunnel is explained by Dekker (2002) as reconstructing how different professionals saw the case as it unfolded; understanding other people's assessments and actions, the review team try to attain the perspective of the people who were there at the time, their decisions were based on what they saw on the inside of the tunnel; not on what happens to be known today through the benefit of hindsight and a far more detailed compilation of information.

**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 their response; understanding the significance of deviant or risky parental behaviour.**

410. This family were not regarded as the most vulnerable family known to the various services. Given everything that has been revealed since the discovery of Hamzah's body this will be difficult to understand but it is important to consider what was known at the time and why, as well as understanding the implications.
411. The earliest and historical contact with the family, particularly by primary health care workers, described the parents as being supportive of each other and the maternal grandmother was also regarded as an important source of support for Amanda Hutton and her children. This picture clearly changed over time and the HOR in particular is able to reveal the pattern of increased disengagement from professionals although this was not recognised by most at the time; the initial impression of a supportive family continued to prevail.
412. Reports of domestic violence, the poor engagement with health professionals, Sibling 8 seeking help, inconsistent school attendance and the prosecution of father were all indicators of behaviour that represented risk to the children's physical and emotional welfare.
413. Although there were discussions and consultations at various points as well as referrals to specialist services such as CSC none of this resulted in triggering either formal safeguarding protocols or other mechanisms such as CAF/TAC. Several of the IMR authors queried whether the use of such frameworks would have been any more effective in the face of the determined lack of engagement and cooperation from Amanda Hutton in particular. The value of using such frameworks would have been in highlighting more starkly the range of issues that were known to different people but were not collated and therefore seen in a more complete picture of the family's deteriorating circumstances. The metaphor of people working with single pieces of a jigsaw has been used to describe how professionals often face a challenge in being able to see a child's circumstances within the complete picture of their family and history and events.
414. Information about Amanda Hutton's susceptibility to depression had been recognised during her first pregnancy and the use of tools to assess the extent of that depression during subsequent pregnancies identified concerns in the higher quartiles of the measurement.
415. Although both parents disguised significant issues such as their level of drinking which was only explicitly disclosed by Sibling 8 when he sought help there were occasions when staff especially from one of the emergency services observed Amanda Hutton under the influence of alcohol.
416. The domestic abuse was evident from as early as 1996 although it was from 2003 onwards that the incidents were reported to CSC and in 2008 father's assault on Amanda Hutton was sufficient to require a non-molestation order and also resulted in criminal prosecution.

417. Father was able to minimise and deny his responsibility for the violence shown to Amanda Hutton and effectively limited his participation (through his lack of co-operation) in the court directed programme; it became primarily a matter of reporting to his offender manager at the office rather than participating in a group based programme designed to challenge attitude and behaviour.
418. The children missed routine health appointments and their attendance at school was problematic; the three youngest children never arrived in education or early childhood services and for the older children there were inconsistencies in their attendance.
419. The physical conditions in the home were described as poor in 2005 although on most occasions when a professional had access to the house, conditions did not cause concern. It was late 2011 when the neighbour made the referral that would eventually lead to the discovery of Hamzah's body it was clear that the property had become almost uninhabitable.
420. Although there were occasions of individual professionals having concerns, this was more often focussed on Amanda Hutton as a victim of domestic violence rather than what the impact on the children's emotional health was. Some concerted efforts were made to help her leave the violent relationship although it is clear that this was not successful. That is not especially surprising in itself; there is compelling evidence about the difficulties women face in fleeing abusive and violent relationships.
421. Although when the children were noticed as missing and there was contact and discussion between the various services the inquiries were largely misdirected by Amanda Hutton and by other family members who provided an account that some of the family had moved to other parts of the country.
422. When Sibling 8 sought help in December 2006 there was a disagreement between the police who initially used their police powers of protection to keep him at the hospital although CSC were unconvinced that Sibling 8 required protection. It was primarily managed as being symptomatic of a family dealing with adolescent behaviour.
423. At no point was there any discussion specifically about the children in a multi agency framework and only limited information was sought directly from any of the children. The MARAC discussions in 2008 were focussed on Amanda Hutton as a victim of violence.
424. The system (by which is meant the people and the processes for their communication, enquiry and assessment) is less able to deal with other more resistant aspects such as the depression, relationship difficulties and alcohol that were manifested in a more episodic manner and were not placed within a shared typology that could analyse and consider information with a greater degree of sceptical and informed enquiry and assessment. Further comments are made later in regard to the tools that support professional judgments.
425. Gaps in the sharing of information left all professionals without a complete picture but when episodic incidents occurred they were not apparently seen as symptomatic of longer term historic patterns or the implications for the children's emotional as well as physical wellbeing.

426. Practitioners may come to tolerate neglectful behaviour in materially deprived communities and households; neglect is more common in poor and disadvantaged communities but poverty does not in itself cause the emotional and physical neglect of children<sup>34</sup>.
427. An NSPCC research briefing<sup>35</sup> highlights the lack of consensus about what constitutes neglect that is reflected in the earlier finding in this report in regard to good enough parenting. The same briefing paper also describes the problems of coordinating help for families with complex problems that will, as in this case, involve several different services with different skills and professional backgrounds.
428. This process of normalisation has an impact on how professionals frame or categorise information and understand its significance and relevance. It has implications for how the style and quality of parenting is assessed as being good enough and is discussed in the last key finding.
429. A further feature in this case is the extent to which key professionals displayed a difference in their interpretation of thresholds of concern. For example, when Sibling 8 sought help it was evident that the police and hospital staff regarded the presentation of information by Sibling 8 as a safeguarding concern. This was interpreted differently for example by CSC who regarded it as more symptomatic of a parent and adolescent disagreement. The dispute reflects a difference of view in regard to how older children are assessed especially by services such as CSC.
430. Some of this reflects cultural assumptions that older children have greater resilience and can suffer 'agency neglect', some of it can reflect organisational anxiety that older children who leave their families and arrive in public care often face poor outcomes including a successful reunification; it can also be a reflection of the difficulties that professional generally have in identifying and assessing emotional neglect and abuse although in this case Sibling 8 had reported physical assaults and had suffered an injury to his thigh.

### **Issue for consideration by the BSCB**

- 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?

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<sup>34</sup> Stevenson O. Neglected children Issues and dilemmas Ch 3 pp20-29 Blackwell Science: London; 1999.

<sup>35</sup> NSPCC. Child protection research briefing child neglect 2007.

**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.**

431. Throughout this case the parents remained the key influence in the interaction with professionals and services. The extent to which parents effectively control the attitudes and behaviour of key professionals is increasingly understood through research and the analysis of serious case reviews. The interaction and relationship between professionals and vulnerable families is the subject of complex ethical and legal issues. In cases where families are resistant to help or contact by services requires considerable empathy, professional knowledge and interpersonal skills as well as time and resilience.
432. The fact that this was a family that was resistant to involvement and contact is not unusual. There are several academic sources that provide support to what Egan described as being 'impossible to be in the business of helping people for long without encountering reluctance and resistance'<sup>36</sup>. The behaviour which become acute when help is involuntary (for example the involvement of criminal justice in respect of father's offence, referral to CSC) can be exhibited in a range of ways that have been categorised as being dependency, closure, flight, or 'disguised compliance'<sup>37</sup>.
433. The first three behaviours were all displayed in this case at various times and served to keep professional focus misdirected and away from the needs of the children. Amanda Hutton's antagonism to hospitals and health staff was generally known about from early on and was used to rationalise the absence of contact with the primary health services. It had implications for late ante natal care, post natal support and the on-going care and immunisations of the children.
434. The panel identified that more regard should have been given to the signs of vulnerability that have been described throughout the report. The panel have also identified the additional factors that need to be taken into account in regard to multiple births and the potential implications.
435. The information about domestic violence was primarily managed as a threat to Amanda Hutton and when there were occasions when she was seen to be unfit through drink to have responsibility for her children the responsibility was directed to one of the older children.
436. Evan Stark<sup>38</sup> describes how domestic violence has to be understood more clearly as coercion in order to understand the impact on the women and to understand why these relationships endure, why abused women develop a profile of problems seen among no other group of assault victims.

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<sup>36</sup> *The Skilled Helper*: Egan, G. 1994.

<sup>37</sup> The term is attributed to Peter Reder, Sylvia Duncan and Moira Gray who outlined this type of behaviour in their book: *Beyond blame: child abuse tragedies revisited*, 1993.

<sup>38</sup> *Coercive Control: How men entrap women in personal life* Evan Stark: Oxford University Press 2007.

437. In this case Amanda Hutton was isolated from her wider community because some people in both the Asian and white community were unwilling to accept a relationship between two people from different cultural heritages. It is clear that she became more isolated after the relationship with father ended.
438. When health, education and early childhood as well as CSC all sought information about the missing children they were all misdirected. In late 2011 when the police and CSC were following up the referrals about home conditions the strategy used by Amanda Hutton was to close down any contact until the police overcame her resistance by use of their power of entry to the house. The investment in 'Think Family' in Bradford provides a framework for continuing to improve the response to vulnerable families in the future.

### **Issue for consideration by the BSCB**

- 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?

### **Responses to incidents and information; viewing individual incidents or crises in isolation; identification and clarification of patterns or inconsistencies that represent significant harm to children.**

439. A consistent finding in this and other cases that have been the subject of serious case reviews is the extent to which new and emerging information is often not recognised and therefore not sufficiently understood within a context of previous information and events. Each incident was considered in isolation. This applied in regard to information and evidence about the use of alcohol and the recurrent episodes of domestic violence as well as for example how the request for help from Sibling 8 was managed.
440. The systems for judging the thresholds of concern appeared to offer limited encouragement and opportunity to identify or enquire into underlying patterns, attitudes and behaviours. This resulted in a reliance on whether a presenting issue represented a significant and *current* threat to the safety and well being of a child with a focus on physical or other tangible evidence of significant concern.

441. The 'lower' level of help was seen to be primarily as providing practical and emotional support, giving encouragement on an informal voluntary basis; to that extent it was effective although did hide underlying issues<sup>39</sup>. The help provided to Amanda Hutton with the intention of assisting her to flee domestic violence was done on a voluntary basis and sought to secure a place of safety for her. When the efforts were not successful, it did not lead to any further follow up action.
442. This case again reveals the pattern for services at all tiers to be preoccupied with responding to incidents on an event focused basis especially in regard to making judgments as to whether particular events represent significant harm for example. At no point did anybody think that any of the children were at risk of significant harm as a result of the pattern of violence and neglect.
443. There could have been a better appreciation of the emotional harm for the children (as well as for Amanda Hutton) and attention given for example to what Sibling 8 was saying. A number of factors are influential that range from individual events never meeting a sufficiently high threshold of concern especially for the higher tier and statutory services such as CSC through to the limitations of the systems tools described in the next finding. Reports and verbal information sharing can be routinely passed through to services but are not then analysed for relevance and significance in terms of the emotional health and well being of children.
444. Understanding the habitual and persistent behaviours associated for example with minimising and disguising the use of alcohol and domestic violence and the implications for parents' emotional availability and capacity is not sufficiently embedded into practice. The complexity and ambiguity of such work is acknowledged but at present practice is apparently too reliant on what parents are willing to reveal and talk about.
445. The opportunities that were occasionally offered were not apparently recognised or followed up partly because they were seen at the time as a means of deflecting attention. For example, when father was arrested he wanted to talk about his concerns about Amanda Hutton's care of the children although this was seen as deflecting from his violent behaviour. No follow up was made to the suggestion that father make a referral to CSC if he was concerned.

#### **Issue for consideration by the BSCB**

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

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<sup>39</sup> The panel noted for example that the children's centre were invited to focus on practical issues such as budgeting; the younger children were eating 'finger food' for example which was probably an indicator of impaired social development; matters were compounded by the fact that they understood the children to be younger than they were.

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; 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.**

446. The long history in this case of children being subjected to domestic violence, having their routine health needs neglected and their disrupted and impaired education and the extent to which the home conditions had deteriorated so badly in recent years invites reflection as to whether the various services have a good enough collective understanding about some fundamental frameworks such as what constitutes good enough parenting.
447. There were indicators of vulnerability when Amanda Hutton was pregnant on all the occasions. Providing effective help for children rests on professionals having the capacity to recognise early signs and having the ability to work with a parent. Being able to secure the confidence of a parent without becoming collusive requires well developed interpersonal skills, emotional intelligence and confidence.
448. In this case, there were isolated examples of individuals trying to help Amanda Hutton but none truly had a focus on the needs, wishes and feelings of any of the children until September 2011 when the police and CSC overcame Amanda Hutton's resistance to allow anybody into the house.
449. Important issues such as the children's absence from routine primary health care were noticed and were discussed by the primary health care team. The decision to remove the family from the GP register led to the removal of one important agency from the network of agencies that should be working together to share information. It is noted that the decision to de-register the family took place only about 6 weeks before the estimated date of Hamzah's death. The review found no evidence of financial motivation for removal of the families, even though removal of patients from lists can have an effect on practice income.
450. None of the children were offered pre-school child care<sup>40</sup>. This could have been an important source of support both for the children's development as well as providing practical support to a mother who was increasingly unable to cope.

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<sup>40</sup> The early years 'offer' has changed since the eldest children were born. The number of children's centres has increased across the district and this has allowed a much wider and more comprehensive service to be offered.

451. The home conditions were noticed to be neglected and the children showed evidence of neglect in school.
452. A significant theme to come through in panel discussions is the extent to which national and local systems rely on parents acting responsibly and doing the right thing as good enough parents for their children. Many of the systems for example in regard to registering for statutory education or being registered with a GP rely on a responsible parent making the appropriate arrangements. This case shows the vulnerability of such an arrangement especially in a city with a significant transitory population.
453. The children's centre IMR author describes that just over 70 per cent of children aged 0-4 are registered with a children's centre in Bradford. The 30 per cent not registered included children such as Hamzah and his siblings. In 2008 the health visiting service began asking parents of newly born children to allow their details to be forwarded to the early year's service. That has resulted in just fewer than 50 per cent of babies being notified to the service.
454. Since December 2011 the arrangement has been changed to an opting out arrangement and the proportion of babies notified to the service is now 90 per cent. This provides a more secure basis of knowing about children in local areas but as the children's centre IMR highlights the practitioners need to have a proactive approach to engaging with families and especially those who for a variety of reasons are reluctant to have a service.

#### **Issue for consideration by the BSCB**

- 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; availability and use of tools for collating, sharing and analysing information; promoting analytical discussion and revealing underlying and long term patterns such as neglect.**

455. The effective sharing and analysis of information within a framework of appropriate and child focused assessment is a perennial challenge for multi professional teams or groups of workers and has been described and discussed in national research, inspections of children's services as well as being a regular feature in serious case reviews.
456. The assessment of neglect is especially problematic in the information and professional systems that do not have the capacity to reflect upon the accumulated evidence of direct observation and professional reporting.

457. National efforts to achieve improved consistency have largely resulted in processes becoming ever more bureaucratised and process driven through computer based electronic recording frameworks. This has left professionals completing processes that have little apparent benefit for improving the clarity and insights regarding complex behaviours and family circumstances and their interplay. The tools focus on describing events or behaviour and offer limited opportunity to record reflection, hypothesis or analysis. In this case there were further factors that included using case recording rather than assessment frameworks for recording information.
458. Recent studies have emphasised that although professionals such as social workers can be very effective at gathering information from a range of sources they face a far greater challenge in being able to identify ways to analyse the information for its relevance and significance in regard to risk and need for children, leaving assessment often to be 'slightly better than guessing' (Dorsey). An evaluation of assessment tools by the Department for Education has identified and reviewed three systems of assessment tools. The study concludes that although there needs to be a move towards more structured analysis and decision making there is limited evidence about the effectiveness of available tools in child protection work<sup>41</sup>.
459. The current systems work with the greatest effectiveness when a tangible event or incident is being reported or recorded and this has encouraged a degree of reliance on the single record or event needing to provide a compelling and clear reason for a reaction especially from specialist higher tier services that are working with the most vulnerable of children.
460. The evidence from this case and from other reviews and studies show that formal assessments are largely a copy and paste of the same information recycled and reiterated; there is little sense of either a dynamic narrative or developing insight and analysis about needs, risks and motivations. There was very little information about the parents' personal and family histories<sup>42</sup>. The current systems almost invite such an approach and especially in situations where workloads are high. The national frameworks for assessment have changed as a result of the abolition of the national assessment framework and will place a greater emphasis on local areas developing their own arrangements<sup>43</sup>.
461. The cumulative impact was that lower order information that is seen as either isolated or episodic as described in other findings is not shared and the underlying patterns are insufficiently revealed in regard to responding to events and incidents. The national assessment framework for children in need and their families was based on an ecological model that understands the

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<sup>41</sup> Systematic review of models of analysing significant harm; Barlow J, Fisher JD and Jones D, Department for Education March 2012.

<sup>42</sup> Reder and Duncan found similar issues in their review of serious case reviews in 1999; *Lost Innocents: A Follow-up of Fatal Child Abuse*. It has become apparent in this review and is commented on by the HOR that the maternal grandmother was an important source of support and her death had a significant impact on mother.

<sup>43</sup> The revised guidance is included in Working Together to Safeguard Children published in 2013.

importance of recognising that effective safeguarding relies on a dynamic interplay of multiple risk and vulnerability factors. Regrettably this has not translated into effective practice models and was acknowledged in the Munro Review referenced in earlier chapters.

462. In these conditions it is less surprising that much of the practice reflected through this case is a one dimensional and static approach to viewing the needs and circumstances of children and a preoccupation on physical conditions rather than the emotional needs and circumstances of children for example. In the absence of having a system that can offer better quality recording to the professionals, the completion of an assessment can be regarded as an administrative chore rather than being an important exercise of professional skill and judgment.
463. Another dimension revealed in this review and which is reflected in national studies<sup>44</sup> concerns the extent to which questions about what a child means to a parent and what the parent means to that child in respect of their emotional care and security are not routinely explored. The same report offers reflection on the important relationship between having a good understanding about all aspects of maltreatment and its relationship with the development of children.

#### **Issue for consideration by the BSCB**

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; 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.**

464. This serious case review has revealed that information that could provide indication of vulnerability (and indeed risk from significant harm) does not consistently lead to an appropriate escalation of concerns and follow up. Some of this is because different people have different parts of a child's information or narrative which on its own is not regarded as being significant or concerning.
465. The review has also highlighted that a number of factors may be taken into account when a GP takes the decision to remove a person from their list. GP practices have to balance their duty to maintain accurate registration lists wherever possible, against the risk of making access to primary medical

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<sup>44</sup> Brandon, Sidebotham, Ellis, Bailey and Belderson. Child and family practitioners' understanding of child development: Lessons learnt from a small sample of serious case reviews Department for Education May 2011.

services harder for families who are de-registered. This review found no evidence that the decision to remove Hamzah's family from the practice list was financially motivated, although it is recognised that GP practices receive payments that are both capitation based and performance based and in theory at least, financial factors could influence removal decisions.

466. The application of the missing children protocols within education, health and CSC all failed to confirm where the children were and yet did not trigger any other levels of enquiry. It is an example of where in the absence of evidence of specific harm the systems did not encourage any further progression.
467. There was evident confusion reflected in the IMRs about the application of particular aspects of legislation. A significant example was whether private fostering regulations were relevant to the information being provided by the family or whether there were other legal responsibilities on the part of any of the agencies.
468. Although this analysis has focussed on the younger children, there were issues in regard to how the concerns expressed by Sibling 8 were dealt with especially by CSC.

#### **Issue for consideration by the BSCB**

- 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?

#### **4.1 Issues for national policy**

469. GP practices, as contract holders, are mandated to follow local safeguarding procedures as part of the CQC registration and also through the terms of their contract for service delivery. With regard to individual GPs, the General Medical Council updated its professional guidance to all doctors in 2012 to indicate the responsibilities they carry as healthcare practitioners in considering and giving appropriate priority to the needs of children.

470. In terms of contractual obligations, GP practices with “open lists” should accept any patient onto their list and GPs should not remove patients from their list unless there is good reason, such as the patient no longer being in the practice area or there being a complete breakdown in the doctor-patient relationship. It remains a matter of some discretion however, whether to remove a patient or family if the exact address cannot be identified. Local guidance has been issued and consideration should be given to the need for any further local or national guidance on this issue.
471. The arrangements for the management of school admissions in Bradford are compliant with national requirements and standards. This review has identified how children who are never notified for admission to school can become missing without the knowledge of the authority.
472. The review has identified the importance of all public services having sufficient understanding about their role and responsibility in promoting the safety and welfare of children. The registrar of births in Bradford has highlighted the absence of guidance for that service at a national level.

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**November 2013**



**5 APPENDICES**

## **Appendix 1 - Procedures and guidance relevant to this serious case review**

### **Legislation**

#### **The Children Act 1989**

Section 11 of the Children Act 2004 places a duty on the key people and bodies described in the Act<sup>45</sup> to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. The application of this duty varies according to the nature of each agency and its particular functions. The Section 11 duty means that these key people and bodies must make arrangements to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children and this includes any services that they contract out to others.

Section 17 imposes a duty upon local authorities to safeguard and promote the welfare of children in need.

Section 47 requires a local authority to make enquiries they consider necessary to decide whether they need to take action to safeguard a child or promote their welfare when they have reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm. These enquiries should start within 48 hours. The local authority is required to consider whether legal action is required and this includes exercising any powers including those in section 11 of the Crime and Disorder Act 1998 (Child Safety Orders) or when a Baby Has contravened a ban imposed by a Curfew Notice within the meaning of chapter I of Part I of the Crime and Disorder Act 1998.

Section 46 provides the Police with Powers of Protection to take children into police protection where a constable has reasonable cause to believe that a child would otherwise be likely to suffer significant harm.

#### **The Children Act 2004**

Section 10 requires each local authority to make arrangements to promote co-operation between it, each of its relevant partners and such other persons or bodies, working with children in the authority's area, as the authority consider appropriate. The arrangements are to be made with a

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<sup>45</sup> Local Authorities, including District Councils, the Police, National Offender Management Service, NHS bodies, Youth Offending Teams, Governors/Directors of Prisons and Young Offenders Institution, Directors of Secure Training.

view to improving the wellbeing of children in the authority's area – which includes protection from harm or neglect alongside other outcomes. This section is the legislative basis for children's trusts arrangements.

Section 11 of the Children Act 2004 places a duty on the key people and bodies described in the Act<sup>46</sup> to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. The application of this duty varies according to the nature of each agency and its particular functions. The Section 11 duty means that these key people and bodies must make arrangements to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children and this includes any services that they contract out to others.

### **Safeguarding Procedures**

#### **The Bradford Safeguarding Children Procedures**

The procedures provide advice and guidance on the recognition and referral arrangements for children suffering abuse. This includes emotional abuse that involves causing children to feel frightened or in danger. The procedures also cover physical abuse of children. The procedures also describe abuse involving the neglect of children that includes failing to protect children from physical harm or danger or the failure to ensure access to appropriate medical care or treatment. This includes describing distinct action to be taken when professionals have concerns about a child, arrangements for making a referral, and the action to be taken. The procedures cover arrangements for the ACPC (now superseded by LSCB) to ensure there are effective arrangements that promote good interagency working and sharing of information and training. The procedures describe specific responsibilities for all agencies contributing to this serious case review.

#### **National guidance<sup>47</sup>**

#### **Working Together to Safeguard Children (2010)**

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<sup>46</sup> Local Authorities, including District Councils, the Police, National Offender Management Service, NHS bodies, Youth Offending Teams, Governors/Directors of Prisons and Young Offenders Institution, Directors of Secure Training Centres.

<sup>47</sup> The election of a coalition government in May 2010 has resulted in changes to guidance and policy that applied at the time.

The national guidance to interagency working to protect children is set out in *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*. The guidance includes safeguarding and promoting the welfare of children who may be particularly vulnerable. The guidance was replaced in 2013.

### **Framework for the Assessment of Children in Need and their Families 2001**

The guidance in respect of *the Framework for the Assessment of Children in Need and their Families* was issued under section 7 of the Local Authority Social Services Act 1970 and was therefore mandatory. The guidance was replaced in March 2013.

The framework set out the framework for ensuring a timely response and effective provision of services to children in need that applied at the time of the event described in this review. The framework is no longer national policy following the publication of *Working Together to Safeguard Children* in March 2013. It makes clear the importance of achieving improved outcomes for children through effective collaboration between practitioners and agencies. The framework sets out clear timescales for key activities. This includes making decisions on referrals within one working day, completing initial assessments within seven working days and core assessments within 35 working days. As part of an initial assessment children should be seen and spoken with to ensure their feelings and wishes contribute to understanding how they are affected. If concerns regarding significant harm are identified they must be subject of a strategy discussion to co-ordinate information and plan enquiries. Child protection procedures must be followed.

Assessments should be centred on the child, be rooted in child development that requires children being assessed within the context of their environment and surroundings. It should be a continuing process and not a single or administrative event or task. They should involve other relevant professionals. The outcome of the assessment should be a clear analysis of the needs of the child and their parents or carers capacity to meet their needs and keep them safe. The assessment should identify whether intervention is required to secure the well – being of the child. Such intervention should be described in clear plans that include the services being provided, the people responsible for specific action and describe a process for review.

### **Common Assessment Framework (CAF)**

The CAF is a key part of delivering direct services to children that are integrated and focused around the needs of children and young people. The CAF is a standardised approach to conducting assessments of children's additional needs and deciding how these should be met. It can be used by practitioners across children's services in England.

The CAF promotes more effective, earlier identification of additional needs, particularly in universal services. It aims to provide a simple process for a holistic assessment of children's needs and strengths; taking account of the roles of parents, carers and environmental factors on their development. Practitioners are then better placed to agree with children and families about appropriate modes of support. The CAF also aims to improve integrated working by promoting coordinated service provisions.

All areas were expected to implement the CAF, along with the lead professional role and information sharing, between April 2006 and March 2008.