Briefing on Serious Case Reviews

Hamzah Khan (Published by Bradford LSCB, November 2013)

Background

Hamzah Khan died in December 2009 and his body was discovered in the family home in September 2011. Information provided through statements and from the post mortem examination indicate Hamzah was 4 years old when he died. He was “invisible” and unknown to services during his short life, having never had his birth registered, been registered with a GP or received any immunisations. Hamzah died as a result of criminal neglect by his mother, who was convicted of manslaughter and child cruelty in October 2013.

Mother is white British and father is Asian British Pakistani. There were reported incidents in the community; some of these appear to relate to the parents being from different racial and cultural communities.

There was a history of domestic violence; nine reports had been made to police between 1996 and 2008. On at least one of those occasions it was one of the children who reported the violence and further information about domestic violence was provided by one of the children when he asked for help.

Mother first became pregnant as a teenager. From the first pregnancy there was a pattern of avoiding contact with health services. It is documented that Mother experienced low mood and depression with all pregnancies. With all the children there were problems for the health visiting service and GP in seeing the children (or parents) which demonstrates further reluctance to engage with services.

The SCR also refers to Mother’s history of depression, the traumatic isolation she felt following the death of her mother, the disintegration of her relationship with the children’s farther and her chronic alcohol dependency.

Father was made the subject of a non-molestation order from 2009 following an arrest for assault against Hamzah’s mother.

The issues identified include; invisibility of children to education & health services, failure to take into account the impact of on domestic abuse on children, absence of enquiry into the cultural and religious complexity of the family, insufficient significance given to disclosure by adolescents, lack of professional curiosity, insufficient interagency cooperation and lack of an overall picture of family life.

Key Learning Points:

Focus on the child

- The lack of focus on the needs, wishes and feelings of children is a consistent theme in SCR's. The importance of encouraging children to talk about their concerns, feeling or worries and for professionals to hear these can not be overstated.

- 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. As in this case when one of the children, then an adolescent, did speak out about his unhappiness it was heard and probably misunderstood as being symptomatic of adolescent/parent conflict.

'Think Family'

- Professionals should see adult behaviour in terms of implications for children. "See parent, think children". Children need to be the focus of professional contact with vulnerable adults who may be reluctant to accept help or support; what emerged in the court case was that coercion can be applied by adults determined to keep information secret

- The true extent of the need within this family was insufficiently known and the barriers for accepting professional help were not understood well enough at the time.

The effect of domestic violence on children

- Domestic violence is always a child protection issue, and 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.

- Men remain largely invisible to service that work with vulnerable children even when their behaviour as in this case is one of the sources of concern and risk for children

Professional Curiosity

- 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

- 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

- 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

Social isolation and 'invisible children'

- The importance of primary health professionals in maintaining contact and oversight of pre-school children that extends further than administration of routine health care. Hamzah together with some of his siblings who had not ever got to school disappeared from the view of their extended family and community as well as from the view of universal services.

- 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. The fact that Hamzah was entirely 'off the radar' of services for so much of his life was an indicator of concern although this was not recognised until 2010 partly because nobody had a complete overview about the situation.

- A red flag must be raised when key appointments are missed so that children cannot disappear. Hamzah's mother made no attempt to register his birth; he missed midwife appointments, health visitor checks, immunisations; and he was never registered for school.

- In this case there was parental resistance, professionals were seemingly unable to overcome the resistance exhibited by parents. The extent to which both parents were unwilling to accept help or advice presented barriers to various professionals.

Commitment to interagency child protection processes

- Where there is a clear risk of significant harm agencies should act decisively to protect the child. In this case other complications arose because information was inaccurately recorded or poorly shared. Domestic violence, depression and substance misuse were persistent features that although there wasn't a shared, multi-agency understanding and acknowledgement of this.

- In this case the only multi agency discussion, which was limited, focused on risk to Mother and did not take into account her children. Not all relevant services were aware of the discussion or decisions reached at meeting.

Dealing with neglect

- 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. Neglect is so often not seen as serious child abuse despite being present in 60 per cent of cases resulting in death or serious injury. It can and does kill.