BIRMINGHAM Safeguarding Children PARTNERSHIP

Serious Case Review

(BSCB 2017-18/03)

Hakeem

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Contents

Glossary of abbreviations and terms used in the report 3
1. Introduction 4
2. Scope of the Review 5
3. Methodology 5
4. Brief family background and synopsis of the case 6
5. Summary and analysis of professional involvement with Hakeem 7
6. Ability of professionals to understand what the daily lived experience was for Hakeem. 12
7. Effectiveness of multi-agency working, compliance and communication including compliance with procedures, information sharing, supervision and support. 13
8. Working with resistant parents and non-engagement. 17
9. Identification of risk of significant harm leading up to ICPC in November 2017. 19
10. Social Work Practice 20
11. How non-compliance issues by parent and drug treatment were managed 23
12. Adequate assessment and management of child's asthma, including prescribing practice. 25
13. Role of school nursing in management of Hakeem's asthma. 29
14. Findings and Conclusion 31
15. Key findings and recommendations 32
16. Post-script 35
17. References 36
Appendix 1 37

Glossary of abbreviations and terms used in the report

Hakeem	Subject of the SCR
Mother	Laura Heath
SW	Social Worker
DSL	Designated Safeguarding Lead
MGM	Maternal Grandmother
HV	Health Visitor
MW	Midwife
NSA	Non School Attendance
CGL	Change Grow Live
CASS	Child Advice and Support Service
BSCB	Birmingham Safeguarding Children Board (from April 2019 BSCB became Birmingham Safeguarding Children Partnership
BSCP	Birmingham Safeguarding Children Partnership
MASH	Multi Agency Safeguarding Hub
ICPC	Initial Child Protection Conference
BCSC/BCT	Birmingham Children's Social Care (from April 2018 BCSC became Birmingham Children's Trust).
SCR	Serious Case Review
ED	Emergency Department
NICE	National Institute for Clinical Excellence
BWCHFT	Birmingham Women's and Children's Hospital NHS Foundation Trust
CIN	Children in Need
CPP	Child Protection Plan
ToR	Terms of Reference
BTS	British Thoracic Society
CDOP	Child Death Overview Panel
WMAS	West Midlands Ambulance Service
CCG	Clinical Commissioning Group

1. Introduction

1.1. This overview report summarises the findings of an independently led Serious Case Review (SCR) commissioned by the Chair of Birmingham Safeguarding Children Board (BSCB) in 2018. It concerns Hakeem, a seven-year-old boy, described by his father as well behaved, bright and independent and by his mother, as a very bright loving boy who loved to dance. Hakeem was of mixed heritage with a White British mother and Asian father of Muslim faith. The report was completed in 2019, however, due to ongoing criminal proceedings it was prevented from being published until the outcome of the court case was resolved. Hence the significant delay in publication until 2022. The learning from the review has however been implemented by Birmingham Safeguarding Children Partnership (BSCP) and actions tracked to ensure there was no delay.

1.2. This (SCR) was conducted in accordance with Government statutory guidance entitled '*Working Together*'[1] following Hakeem's death on November 26th, 2017. It was commissioned prior to changes to statutory guidance that evolved since 2018.

1.3. On November 26th, 2017 West Midlands Ambulance Service attended an address (not the child's home address) and on arrival found Hakeem unconscious in the garden. The initial account provided by the child's mother was that he had been unwell the previous day and she believed that during the night he went into the garden due to his asthma. The ambulance service confirmed that Hakeem was deceased and had been so for some considerable time. The post-mortem confirmed that Hakeem had died of asthma. However, photos of the family home, and the house where Hakeem was found dead, which belonged to a registered sex offender, show evidence of chronic neglect, prostitution, and drug use. There was also a stockpile of inhalers used to smoke crack cocaine.

1.4. Throughout Hakeem's life there was sporadic multi-agency professional involvement with his family. He was placed on a Child Protection Plan (CPP) for neglect because of pre-birth concerns about his mother's substance abuse and her previous history where three of her children were removed from her care. This was discontinued in January 2011. A second CPP commenced at the end of 2011 again for neglect and ceased in August 2012, when it was felt the situation had improved. In July 2017, Hakeem became subject to a Child in Need Plan (CIN) as concerns about Hakeem's welfare were once more increasing. These concerns continued to escalate and, on the 24th November 2017, (sadly two days prior to death), he was made subject to a Child Protection Plan under the category of neglect.

1.5. This case has received local and national media attention following the high-profile coverage of the criminal proceedings and subsequent conviction of Laura Heath, Hakeem's mother, for gross negligence and manslaughter for which she received a 20-year sentence on April 28th 2022.

1.6. Hakeem's death follows a number of deaths of children which have been asthma related. There is a need to understand more about the quality and effectiveness of multi-agency practice involved with Hakeem and his family, leading up to his death.

1.7. This SCR identifies some key themes for learning and improvement through an appraisal and analysis of practice, in light of what was known at the time and the subsequent information received through the information reports, interviews and a practitioner event. The recently published recommendations in the national practice

[1] Working together to safeguard children, HM Government 2015.

review into the murders of Arthur Labinjo-Hughes and Star Hobson (Crown Copyright 2022) and the Independent Review of Children's Social Care (MacAlister, J. 2022) make many recommendations for action that resonate with this review.

2. Scope of the Review

2.1 The review covers the period from **July 2015** until the death of Hakeem on **November 26th, 2017.** Other significant information that relates to the review outside of this timeframe is summarised.

2.2 Full terms of reference for the Review can be found in Appendix 1. As part of the initial phase of the review ten agencies identified internal learning to help improve safeguarding practice. This early learning has been acted upon and the BSCP have verified that all actions have been fully implemented. The key lines of enquiry focused on the following issues:

a) The professional understanding of neglect and ability to recognise and respond to it and other risk factors (wider risk, substance abuse).

b) The level of effective multi-agency working and communication including compliance with procedure, information sharing, supervision and support etc.

c) The ability by professionals to really understand what the lived experience of the child was (including other factors: racial, cultural, linguistic etc).

d) Where there was non-compliance with a drug treatment programme, was supervised consumption and/or drug testing considered?

e) Was there adequate assessment and appropriate management of the child's asthma, including prescribing practice?

3. Methodology

Jenny Myers MA CQSW, a highly experienced independent reviewer, was commissioned to undertake the serious case review. Jenny is a qualified social worker, safeguarding sector specialist and independent safeguarding children's partnership chair, experienced in leading complex reviews and one of the pool of national reviewers for the Child Practice Review Panel. She is entirely independent of any of the Birmingham agencies.

3.1 A multi-agency SCR review team established by BSCB supported the review. There were representatives from:

- Birmingham Children's Social Care (now provided by Birmingham Children's Trust)
- Birmingham City Council Education
- Birmingham South Central NHS Clinical Commissioning Group (CCG) (now called NHS Birmingham & Solihull CCG)
- Change Grow Live (CGL)
- West Midlands Police

3.2 Sources of data. All agencies reviewed their records and provided timelines of significant events and a brief analysis of their involvement; these timelines were then merged to create an inter-agency chronology. This was carefully analysed by the lead reviewer alongside the 10 commissioned information reports in order to identify key

lines of inquiry/practice and organisational issues to be further explored with the practitioners who had worked with the family, at the practitioner event.

3.3 In addition, the author of this report held two separate meetings with the information report authors, accessed other key documents, and conducted interviews with the social worker and team manager. The author also met with the BSCB chair and CEO of BCT.

3.4 A number of key texts have informed the lead reviewers analysis and references to these documents can be found at the end of the report.

3.5 Practitioner involvement. The practitioner event took place on 13th September 2018, facilitated by the lead reviewer and was well attended by 19 multi-agency practitioners who had been involved with Hakeem and his family. Significant information was gained about how it had felt to work with the family and what the professional mind-set and understanding of the situation was at the time. This is reflected in the analysis section of the report.

3.6 Family involvement. The lead reviewer appreciates the involvement of those members of the family who chose to meet with her. It has been a difficult time for them and there is no doubt that the loss of Hakeem has been felt deeply by those who loved him. Where possible any feedback from these family members is incorporated into the text in order to gain their perspective on the effectiveness of the multi-agency support given to Hakeem and his family. The author met with Hakeem's father whilst he was in prison in 2018 and met with mother in May 2022. Their views have been incorporated into the report.

3.7 Limitations. The review was not given consent to access mother's medical records, there was delay in receiving full chronology and some other key texts from BCT, and delay in seeing family due to the parallel criminal investigation. Some key practitioners had left their roles or were on long term sick leave.

4. Brief family background and synopsis of the case

4.1 Family Composition

Immediate family

- Mother
- Father
- Maternal grandmother (MGM)
- Sibling 1 - Older Half-sister
- Sibling 2 - Older Half-brother
- Sibling 3 - Older Half-brother

Significant others

- The Baby (niece to Hakeem)

4.2 The family have been known to Birmingham Children's Social Care (BCSC) since 2008. Hakeem's mother as stated, had three older children, removed from her care in 2008 due to her misuse of drugs, poor home conditions and domestic violence. The two oldest children (sibling 1 and 2) were made subject of a Residence Order and placed with their Maternal Grandmother. Whilst sibling 3 went to live with their father when very young. Sibling 1 and sibling 2 have sporadically returned to live with their

mother over the years, but relationships have been turbulent, including allegations of sibling 2 being physically abusive towards their mother.

4.3 Due to the family history and concerns about mother's use of heroin, Hakeem was made subject of a pre-birth Child Protection Conference and Child Protection (CP) Plan in 2009 with both his parents completing a residential parenting assessment in 2010. Family support was offered, mother reportedly successfully detoxed, and the case was closed to Birmingham Children's Social Care (BCSC) in February 2011. Hakeem was subject to two other CP plans under the category of neglect, each being linked to issues of sustainability of care and impact of parental substance misuse. The CP plans were deemed necessary mainly due to mother's lack of engagement with services to ensure Hakeem was appropriately safeguarded. The second CP plan was discontinued in August 2012, on the grounds that mother was assessed as working well with professionals. The last one ceased following Hakeem's death.

4.4 In March 2014, when Hakeem was 4 and had started school, the school became concerned about a range of issues, including his poor attendance, the fact that he smelled of cannabis, lack of timely collection from school, and allegations by Hakeem that he had been hit by his grandmother. Further referrals from the school followed later in 2014 and in 2015. Referrals were followed up but there was not thought to be evidence that mother was not parenting Hakeem appropriately. At this point it was believed that mother was well supported by Hakeem's father. In 2015, father was arrested for a sexual assault against a 19-year-old woman, and after a period of remand, received a six-year custodial sentence. Although they did not continue to live together after his arrest, he was actively involved with the care of Hakeem until going to prison.

5. Summary and analysis of professional involvement with Hakeem

5.1 The next few sections provide a summary and analysis of the professional involvement with Hakeem, establishing not just what happened but where possible understanding why. It focuses on the significant periods or events over the two years where key aspects of the terms of reference are addressed including where agency practice was below expected standards. The discussion aims to inform learning and improvement across the whole system and reference is made to local practice, other reviews and literature. The analysis of practice is informed by the information reports by the key agencies involved. Learning points for the review and key findings are then highlighted in more detail in the final section.

5.2 <u>The professional understanding of neglect and ability to recognise and respond to it and other risk factors.</u>

5.3 Hakeem was seven years old when he died. The post-mortem shows that the cause of death was asthma-related. However, the circumstances in which he was found indicate that he was experiencing significant neglect.

5.4 Neglect, as described in the Inform Overview Practice Guide (Community Care online) is complicated and difficult to define. The threshold for neglect is somewhat vague, and a determination of whether or not a child is being neglected often requires judgement rather than meeting a set of specific objective criteria. This can cause confusion when trying to establish if a child is, *a child in need* or a child in *need of protection*. For Hakeem, the confusion appears to have arisen as there was a lack of understanding about the importance of appropriate management of his asthma, alongside the impact of a decline in his home circumstances, and deteriorating school attendance. Working Together (2015) states that neglect is, *"The persistent failure to*

meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development…… and may involve a parent or carer failing to: provide adequate food, clothing and shelter, protect a child from physical and emotional harm or danger; ensure adequate supervision…., ensure access to appropriate medical care or treatment. The definition has been criticised as it is too focused around the caregiver rather than being child-focused and should centre not on the acts or omissions on the part of adults but on what the experience of neglect means for the child. As Beckett (2007) argues, it is not that "neglect is impossible to define, but that it cannot be defined in absolute terms. Like other forms of child maltreatment, neglect needs to be interpreted in context".

5.5 BSCB have over the last few years disseminated information and delivered training on recognising and responding to neglect, including training on strengthening families and the graded care profile. There is a clear threshold strategy in place called the *Right Help, Right Time* and all professionals are expected to make use of it when considering how to respond to concerns. Practitioners at the event on 13th September 2018 were aware of the guidance and most had done some training and were also familiar with Strengthening Families Framework model of social work practice though may not have experienced it themselves in case conferences. However, it was clear from the professional practice described in the information reports that some of the basic premises of identifying and responding to neglect in the last years of Hakeem's life were not always recognised as such and this resulted in delay in providing an adequate response for Hakeem. The author of this report would suggest that confusion about definition and thresholds as described above might have contributed. Evidence of this is outlined in a number of ways.

5.6 Although we would expect that social workers and health professionals should be able to make professional judgements to determine which of a child's needs are basic, and assessments should be able to determine "seriousness", perhaps it is these aspects of the definition that are responsible for some of the confusion about thresholds, and the uncertainty as to the level of neglect required to trigger a referral, or to cross that threshold between "a child in need" and "a child in need of protection". This is the **first learning point** for the review and may be something which BSCB might want to explore further.

Learning Point 1: *There may still be confusion about significant harm thresholds and the level of neglect required to trigger a referral or cross between a child in need and a child in need of protection.*

5.7 The crucial issue is what did the experience of neglect mean for Hakeem? What were the consequences of not having the right medication, of not getting to school, of not being fed and being hungry at times, of living with a drug dependent mother? Hakeem made it clear to school staff what it felt like - these are just some of the quotes from his school of what he said to them when he was six years old.

"I am 5% happy, 100% angry and 1000% scared."

"I have not had any dinner, I sometimes have breakfast, sometimes lunch, but not during Saturdays and Sundays."

"I don't wash regularly as there is no money for gas and electric."

"My mum sleeps all day, and no one takes me to school", "I take care of myself whilst mum is asleep."

5.8 Medical neglect, missed appointments and the correlation between non-school attendance and his mother's drug use and the fact that Hakeem himself was telling school how unhappy and scared he was, should in the author's view have triggered an earlier and more robust response. Hakeem's mother's own reflection in her recent interview with the author of the review was to say that she felt "if a parent has an active addiction, the child should be removed".

5.9 In May 2017, the SW began a family assessment for Hakeem as the school had continued to report their growing concerns for his welfare to BCSC. However, as the information report author highlights, it was of poor quality and was in fact never properly written up or informed by wider professional views and information. The author of the BCT information report concluded that whilst the SW felt suitably competent and trained in neglect issues that this was not evidenced in either the family assessment or their interventions. Sadly, the last time that the SW saw Hakeem was in school in July 2017 some four months before he died. There was no evidence of any analysis in relation to multiple neglect factors that were present such as:

- Physical and emotional neglect, including observations of Hakeem being unkempt and shabby, his complaints about being hungry, not able to wash as there was no gas, and that he had been hit by his grandmother and mother, and general level of violence between mother and her other two children.

- Educational neglect, including adequate supervision by his mother, in relation to getting him to school on time, failing to pick him up, which impacted on his performance at school, his behaviour and frustration at going from being a 'gifted and talented' child to getting behind.

- Medical neglect – mother's failure to provide appropriate health care, missing hospital appointments or ignoring medical recommendations, such as the correct use of inhalers, and provision of inhalers to the school.

- Increasing parental substance misuse.

5.10 As the BCSC report points out, there is ample evidence in research and previous reviews about how neglect is a cumulative concern, rather than a one-off event, and how the combined effect of various factors, including substance misuse, chaotic lifestyle and domestic abuse can impact on parenting. The Joint Targeted Area Inspection (JTAI 2018) into the neglect of older children observes that there needs to be a coordinated strategic approach across all agencies and that both adult and child-focused services need to look holistically at the whole family, and this was not evident in Hakeem's case. Recent research in Adverse Childhood Experiences (ACES) would also have benefitted the SW assessment both of Hakeem and his mother.

5.11 There was not sufficient analysis of what was happening in this household from the point of allocation onwards (May 2017), but also in considering the history of this case. This included what accounted for the changes, given that mother's parenting up until that point was apparently 'good enough', the impact of the older siblings and a baby moving back to the household, of her partner being in prison and whether she had made a new relationship. In interview with the author mother described herself as, '*spiralling out of control'* once the relationship with her partner disintegrated following his conviction.

5.12 Part of the explanation provided by the SW is that he was the case worker for sibling 1 and her baby, and that was his primary focus. As concerns regarding Hakeem escalated, they were coming through to him rather than Hakeem being considered as an individual child in his own right. Reflections from both the SW and team manager have concluded that Hakeem should have had a separate social worker. The social worker for sibling 1 and the baby already had a busy case load and was struggling to keep on top of written work and recording due to dyslexia, which hugely impacted on his ability to carry out more structured written tasks that might have better informed the assessment. The wider observations about social work practice are discussed later in the report.

Finding 1 - This review has found there is a confusion amongst professionals around significant harm thresholds for neglect, which increases where a child has a chronic medical condition that is being poorly managed by a parent. There is a need for professionals to become more aware of the correlation between poor parental management of medication for children with chronic health conditions such as asthma, and wider childhood neglect. It is essential that where children have had hospital admissions for chronic conditions there is a robust discharge plan that includes identifying if any other agencies are involved. A reliance on parental self-disclosure may not always be best practice.

5.13 Non School Attendance (NSA) and Neglect. Hakeem was a bright child who had been identified early on by school as being potentially gifted and talented. He became increasingly affected by his non-school attendance (NSA) and upset at getting behind in his studies, which resulted in some more difficult and challenging behaviour when he was in school. By 2016-2017 Hakeem's overall attendance was only 58% with authorised absences of 7.5% and unauthorised 34.4%. He was brought to school late 18% of the time. Only 7.5% were attributed to illness and none to attending medical appointments. Non school attendance and the significance of this as an indicator of neglect was not considered enough.

5.14 Hakeem had been diagnosed with asthma when he was around three years old and did miss nursery and school as a consequence of sporadic episodes of breathing difficulties, some which had resulted in hospital admission and a number of GP appointments. However, the mindset at the time of some professionals appears to be that his NSA, if they were aware of it, was related to ill-health rather than anything else, though as the above statistics demonstrate this was not the case. Medical professionals have as part of this review confirmed that with routine asthma care and good parenting children should not be regularly missing school. There was not enough professional curiosity as to what else was happening to Hakeem. His mother frequently said that his asthma prevented him being in school and this went unchallenged by children's social care and health professionals.

5.15 The Designated Safeguarding Lead (DSL) at the Academy Trust was persistent in her attempts to raise her concerns about possible neglect of Hakeem with BCSC and in January 2017 submitted a Request for Support, a process which had replaced previous MARF (Multi Agency Referral Form). The form outlined very clearly details of neglect, stating that Hakeem had poor attendance but when in school was seen to be tired and unkempt, have sad sunken eyes, no breakfast or lunch, and was often late. This was the beginning of a series of ongoing contacts and debates with BCSC asking for better support for Hakeem and a 'ping pong' of communication that left Hakeem living with neglect without adequate multi-agency response. Whilst it is clear the school sought support from their National Safeguarding Advisor, closer links to the Education

Safeguarding provision within Birmingham would have brought about a more co-ordinated response to this case (see Learning Point 4).

5.16 The Academy Trust Hakeem attended at the time employed the services of an organisation called Big Community (which has since closed), which at the time offered pastoral and family support to schools in Birmingham and was also commissioned to oversee attendance issues. The attendance officer attempted to discuss issues with Hakeem's mother in December 2016, but she was dismissive of support. As his attendance continued to worsen, legal action was taken by the education authority and mother was fined twice, once in July 2017 and then again in November 2017. However there does not appear to have been any linkage made by the attendance officer within the school, the social worker, school nurse or other medical professionals such as the GP or even Hakeem himself to establish what the reality of life was like for him. Bearing in mind that Hakeem was on a CIN plan at the time, this is concerning. In fact, Hakeem told school on one day that his mother could not bring him as she was asleep in the dog basket. Additionally, at no time was Hakeem's birth father, who by July 2017 was in prison, informed of any concerns regarding the deteriorating situation at home or the legal action re NSA. The wider implications of excluding father are discussed next, but the principle of keeping absent fathers informed is one that should be recognised: see Finding 4.

5.17 In clarifying what expected practice would be in a case like this, the Head of Service confirmed that once a school has a concern about attendance every effort should be made to firstly contact parents to establish what the reason is for NSA, then follow up by letters and informal meetings to try and resolve any problems. Where it becomes evident that parents may require an early response, then school staff are trained to complete early help assessments which may result in request for social work or family support. The 'Spotlight on Attendance' programme is a time-limited intervention to warn parents of legal consequences of NSA rather than the safeguarding impact of such non-attendance on the child. If parents still fail to engage, or additional support does not result in attendance improvement, then legal action can be considered. In Birmingham this is after a child has accumulated 20 sessions of unauthorised absence within a calendar year, something Hakeem clearly had done.

5.18 If Hakeem had a medical condition that had been assessed as preventing him from being in school regularly, then there should have been an expectation that all the professionals involved with Hakeem should work together to explore why his asthma was preventing him from being in school and if necessary, looked at what additional education support was available. A systemic finding from this review is that the consequence of previous cuts to the Education Welfare service and the devolvement of attendance management to individual schools appears to have resulted in a lack of join-up and consistency in how attendance and welfare issues are managed and communicated.

Finding 2: In this case it was evident that there was a lack of join-up and communication between those responsible for Hakeem's non-school attendance and children's social care, which resulted in the two processes not taking account of the neglect that Hakeem was experiencing. In future there must be a better process to ensure communication between the school attendance officers and other professionals to establish more about the daily lived experience for children. They must clarify which absences are authorised or unauthorised, especially if they are on a CIN/CP plan and recognise that persistent NSA is seen as a potential indicator of neglect. Additionally, children with chronic conditions such as diabetes or asthma which may result in NSA should be adequately assessed and supported. It should be

noted that properly managed, asthma should not impact greatly on a child's school attendance.

It was also clear that Academy Trusts who employ their own safeguarding support need to ensure that more formalised strategic links are made between themselves and local authority support officers to ensure better guidance and support when they arise.

5.19 Medical neglect - discussed under the section on management of childhood asthma.

5.20 In conclusion there is strong evidence that the professional ability to recognise, assess and respond to evidence that Hakeem, who was only six years old and living with a multitude of factors that indicated neglect, was inadequate. Following the continued raising of concerns by the school in May 2017, BCT have reflected in their own assessment of the case, that if they had looked at the facts holistically, rather than piecemeal, then it should have triggered at least a complex case discussion, where all the different agencies, from health, hospital, GP, school were brought together to concur on whether thresholds for significant harm had been reached. Expected practice may also have considered a legal planning meeting to consider thresholds and perhaps a period of pre-proceedings, as opposed to being managed as a child in need.

5.21 Having spoken to all parties concerned, one of the striking features was the continued lack of authoritative practice and challenge to mother's refusal to engage with professionals which appears to have had a significant influence and is discussed more later, but most concerning is the lack of consultation with Hakeem about what a day in his life felt like to him.

6. Ability of professionals to understand what the daily lived experience was for Hakeem.

6.1 It is clear from undertaking this SCR that very few people had any idea what Hakeem's true daily lived experience was like and that is a sad reflection considering the number of people who had contact with Hakeem and his family over the two-year time period of this review. If anyone was trying to tell what the reality of life was like for him, that was Hakeem. From the school records alone, he described vividly what was happening to him and how scared he was and what loss he had suffered. In the last years of his life, his father had been sent to prison, his dog of which he was very fond, and paternal grandmother had died, his mother was repeatedly not taking him to school, and he was observed, as discussed, to be tired, hungry and unkempt. The school did their level best to try and obtain help for Hakeem, and as discussed there were many contacts with BCSC regarding their growing concerns.

6.2 The review has established that had the concerns from school been directed via the CASS route, rather than straight into the safeguarding team, then this may have triggered a more proactive response. As mentioned previously the contacts from school were directed to the SW who was already working with sibling 1 and her new baby, both of whom were on CIN plans. Too much emphasis was also given to mother not giving her consent for a further assessment of Hakeem in his own right. The SW reflected in interview with the lead reviewer that he was trying hard to keep the relationship with mother and sibling 1 open, to make sure the baby was not at risk and that when he showed any signs of concern about Hakeem, mother refused to discuss it, feeling strongly that had it not been for sibling 1 he would not be coming around. The SW described how he tried hard to build positive and strength-based relationships with mother but that in reflection he lost sight of Hakeem and was unduly influenced

by mother, who continually stated that his non-school attendance and appearance was due to his asthma and poor health, and this went unchallenged.

Learning Point 2*: Where one child is on a CIN plan and there are growing concerns about another in the family with very different needs, there is a need to ensure that the child is assessed in their own right and a separate plan and social worker allocated***.**

6.3 In conclusion, the allocation of the same SW to both Hakeem and sibling 1 and the baby was not helpful. There appears to be have been only one attempt at direct work with Hakeem and further attempts by the SW were stopped by mother being out, away, or Hakeem saying he did not want to speak to him. There was a lost opportunity to explore further some of the things Hakeem had said about being 1000% scared, unhappy, hurt, or hungry. There was also no link made between what it felt like to have asthma and other allergies, how these were affecting him, his school attendance or what support he felt he needed.

6.4 At the practitioner event it was surprising how few professionals had actually seen Hakeem. The midwife for sibling 1 was one of the only ones who was able to describe him, and her impression at the time was of a sweet natured, happy chatty little boy who was clearly besotted by sibling 1's baby. The GP practice described him as a gentle and caring child. The HV was also able to describe a positive interaction between him and his mother. She stated that he appeared at this time (Oct 2016) to be well looked after, with plenty of toys and a mother who doted on him. The home conditions were cramped and cluttered and though concerning for a new baby she felt were adequate for Hakeem, though he was sharing a bedroom with sibling 2 and witnessing volatile episodes between his mother, sibling 1 and sibling 2, as described by a number of police call-outs. Although home conditions at this time were not great, there does seem to have been a significant deterioration from Oct 2016 to Nov 2017.

Finding 3: In this case there was little professional understanding of the daily lived experience of the child. This resulted in a lack of assessment of what his reality was like through the day and night and the level of neglect experienced. Going forward it is essential that supervision processes and multi-agency assessments are required to clearly describe a day in the life of each child.

Most importantly there also needs to be clear and robust processes for ensuring that visits to CIN are done in line with BCT guidance and are monitored as closely as for those on a CP plan.

The work on ACES (Adverse Childhood Experiences) may be something that BCT and other partners want to explore further in order to strengthen practitioner understanding and impact when undertaking assessments.

7. Effectiveness of multi-agency working, compliance and communication including compliance with procedures, information sharing, supervision and support.

7.1 This SCR has not identified a pattern of multi-agency non-compliance around LSCB safeguarding procedures, or an endemic lack of support, but there are some concerns about management oversight of the case through formal rather than informal or group supervision. Reviews of this kind can always find improvements and things that could

or should be done better, and each agency has analysed its own practice and suggested actions that will increase compliance with their individual protocols.

7.2 The effectiveness of multi-agency working in this case has to be considered in the wider context of improvement work being undertaken by Birmingham Children's Trust. A number of initiatives have been introduced over the last three years to tighten up on compliance and improve social work practice, supervision and partnership working. Whilst in general these have been positive, there are still areas of practice that are inconsistent.

7.3 The Ofsted monitoring letter (October 2017) found that, "*considerable work needs to be done to ensure that services for children in Birmingham are of a standard at which outcomes for children are consistently good.*" It judged that the standard of management oversight, in affirming case direction and the quality of work done, remained too variable and clear guidance on case direction in many cases was not provided or clearly recorded. All of the above was evident in this case. Whilst there was adequate supervision and support for the social worker (who spoke positively about the team ethos), group supervision and line management support, at times this was too informal in nature and decisions and actions to be taken were not recorded as they should have been. The team manager reflected in interview with the lead reviewer that at the time there was a huge push for social work managers to undertake more reflective and systemic supervision. As a consequence, she felt she had lost her way a little and as a result some of her previous and more robust management oversight of social work practice was weakened in her attempts to try out new systemic supervision models.

7.4 In addition, it is the lead reviewer's opinion that the introduction of strength-based models and relationship social work, alongside more systemic and reflective supervision have at times had some unintended consequences which have resulted in a less authoritative approach to families where non-engagement and a lack of compliance is an issue. This is discussed further in the section under social work practice.

7.5 In CGL the change in commissioning and then sickness of the lead support worker resulted in significant drift in the case and it was not until the worker returned that support and supervision of the case improved. For the school, the designated safeguarding lead for the academy was very supportive, but the support was detached from the local authority systems and processes as discussed in the previous section.

7.6 West Midlands Police (WMP) identified six incidents of note in their information report. These included domestic abuse, allegations relating to physical assault between mother and her older children, and concerns regarding neglect, parental drug misuse and registered sex offenders. The first one that directly concerned Hakeem took place on May 15th, 2017, following a report that he had been missing from school for almost three weeks. The matter was risk assessed as priority status and although somewhat delayed due to a wider community emergency, Hakeem and his mother were located and seen, and information was then shared appropriately. The one area of concern regarding the police response followed ten days later when a further report was made regarding Hakeem's general welfare, living standards and possible parental assault. The concerns were shared via the MASH (Multi-Agency Safeguarding Hub) and the incident recorded by the WMP MASH representative as a non-crime number, therefore not resulting in a robust response. Given the circumstances reported in the MASH referral and disclosures made by Hakeem using hand puppets of physical assault and being '1000% scared', this should have resulted in Hakeem being seen by a child abuse police officer. Had this taken place it could have provided an opportunity to

explore more about the exact nature of his disclosure and provide him with an opportunity to talk about his experience of living at home. At the time the WMP representative had not attended any specialist child abuse investigation training or other core modules. The WMP report concluded that risk indicators at the time were not understood and the referral report was filed despite an outline of possible criminal offences and risk. WMP have now addressed this as part of their action plan in response to this review.

7.7 At the practitioner event, the multi-agency issues discussed tended to be systemic ones where there are no easy solutions, for example not having joined up IT systems, the changes in commissioning of services, difficulties in getting to multi-agency meetings and organisational change. It is important to stress that practitioners did describe the impact on them of the above issues; working under increased pressure, becoming desensitised so that working with families and neglect becomes the norm, having higher workloads, and the difficulty in keeping their records up to date. The impact of these issues on the level of effectiveness of multi-agency working is explored in more detail below.

7.8 **Communication and information sharing**. It became clear during the review that a significant amount of information on Hakeem and mother was not easily available to those involved. The continued split between adult-focused services and their IT systems, the hospital ED, respiratory clinic and GP, school and school nursing resulted in no one having the full picture of Hakeem and his family. These are not new messages and have continued to be written about in SCRs. At the practitioner event it was clear that for many attendees, this was the first time they had sat in the room with all the facts. Mother's history and dependence on drugs and involvement of CGL was just not known by many of the professionals involved. Despite there being such a wealth of previous information very few people had access to this. In fact, even at the multi-agency meeting held November 2016, for the unborn child of sibling 1, who was now living back with her mother and Hakeem, neither the health visitor nor midwife were aware of mother's increasing or previous drug dependency, and it was not considered when deciding to place the baby and sibling 1 on a CIN rather than a CP plan. The consequence was that mother's ability to parent and the potential impact of her drug use on her whole family, not just Hakeem, was not well understood.

7.9 Some of this can be explained by the original assessment on sibling 1 being undertaken by the ASTI (assessment short term intervention team). The significant information on mother was not considered as, at that time, sibling 1 was living permanently with her grandmother.

Learning Point 3: *When assessments are carried out in the ASTI team and then the responsibility for the child moves into the longer-term safeguarding team, there is a risk that unless a short review of the assessment and plan is undertaken by the new SW then any significant changes in family circumstances, may not be reflected in CIN/CP plans and shared with the other agencies involved.*

7.10 The CGL worker only had very scant information on mother's wider history and it was not until April 2017, some 18 months after he became involved, that he realised that there was a child living in the household with an allocated social worker, it was not until this point he made contact with the Social Worker. He had no knowledge of the baby and sibling 1. This was explained partly by mother's reluctance to share and her avoidance of face-to-face meetings, but also as described further on in this report, by the change in commissioning of drugs and alcohol services and a transfer from paper records to an electronic system, where previous details on mother had existed. In

interview with mother she said that she felt she had had poor support for her drug addiction and that when she had reached out for help after returning from, in her words, 'doing cold turkey' in Ireland in August of 2017, the worker from CGL failed to turn up to a planned visit and so she never met him.

7.11 As discussed, the SW for sibling 1 and later the baby became Hakeem's social worker by default. As concerns for him were escalated by his school the SW was asked by his team manager to take on responsibility for Hakeem as well, but his primary focus was on the new baby and young teenage mother. The SW was not aware of CGL's involvement and the deterioration in mother's drug management and her lack of engagement with their support service. The GP was also not aware of much of the family history, or mother's drug dependency and due to different names did not make all the connections about who was in Hakeem's family until after his death.

7.12 Birmingham Women's and Children's Hospital Foundation Trust (BWCHF) staff at the practitioner event described how they rely heavily on parental disclosure when routinely asking if the family has a social worker. When Hakeem was brought into ED at BWCHFT in September 2017, initially mother did not disclose and there was no system of flagging to identify that Hakeem had previously been on a CP plan or latterly was on a CIN (something that has been raised in previous SCRs (Polly, Derbyshire LSCB 2017). The CP-IS (child protection information service) only shows that a child is on a CP plan or is a looked after child. As the Consultant described, ED is busy, and they see many parents who have a range of multiple and complex issues, Hakeem and his mother did not stand out especially. The priority, not surprisingly, is always to treat the sick child rather than identify social history and neglect. Neither the GP practice nor any other agency had received any formal notification that Hakeem had been placed on a CIN plan.

7.13 There were other occasions described in the BWCHFT information report where information that was gained from mother about her history and situation should have triggered further seeking of advice from the hospital safeguarding team and been recorded within the hospital electronic handover system to ensure that the ED consultant shared information with the consultant paediatrician. The lack of compliance with the Trust safeguarding policy was explained by the use of peripatetic services[2], and the lack of written records. The staff nurse on the high dependency unit, where Hakeem was staying, was advised by the internal Early Help lead to contact the school nursing service, but it was eight days before a message was left, and there was further delay and a lack of ownership by nursing staff to follow up. This was partly explained by work pressures and partly by the difficulty in getting anyone to speak to in the school nursing team.

7.14 West Midlands Ambulance Service (WMAS) received five 999 calls in relation to Hakeem over the two-year time period, all relating to him having breathing difficulties. Each time he was taken to Birmingham Children Hospital (BWCHFT), the final time being on November 26th when he was found not breathing. WMAS were not aware of any involvement with children's social care as at the time they had no access to records as CP-IS was not fully implemented.

7.15 **Professional understanding of escalation process**. From January 2017 there was a significant increase in communication between the school and BCSC as their concerns for Hakeem's welfare increased. They believed they had sufficient evidence of what they felt to be neglect to warrant statutory involvement and the support of a

2 High Dependency Plus – paediatric consultants who outreach across the hospital to support and manage high dependency patients to reduce their need to be transferred to Paediatric Intensive Care Unit.

social worker. The difficulty the school staff had in getting any helpful response to their concerns regarding Hakeem's welfare was both frustrating and not in his interest, although eventually the family assessment commenced, and Hakeem was deemed to be a CIN in July 2017.

7.16 The school's concerns were significant, especially as the school holidays loomed and they knew that their oversight of Hakeem would not be there. Support for school was sought from the regional strategic safeguarding leads employed by the Academy chain and they appropriately considered the thresholds in the Right Service, Right Time document. BCSC continually advised that the threshold for significant harm had not been reached as they felt there was no immediate safeguarding risk (see previous discussion in section on neglect) and see Finding 2. The safeguarding leads advised the Academy that the BSCB escalation policy should be employed in contesting the assessments and view of their social work colleagues that the case should remain at CIN. This escalation never progressed beyond Stage One of the process. The information report for Education concluded that there was some confusion by the school about how to escalate appropriately and evidence their concerns, this was partly caused by the way the Academy Trust provided their safeguarding advice regionally.

Learning Point 4: *There was a lack of understanding and application of the escalation procedure by the Academy Trust when there were persistent safeguarding issues, which resulted in concerns raised not being appropriately escalated and resolved.*

7.17 When practitioners were asked about why they did not use the BSCB escalation process, they described that they felt it to be ineffective, requiring an enormous amount of persistence. The cumulative effect of getting a negative response from BCSC was both frustrating and had the unintended consequences of making them feel it was not worth it. This was not just within the school: the ED Consultant felt thresholds for child protection varied between Birmingham and other authorities (Solihull) and that she had received a more negative response from what is now BCT, which affected her confidence in them responding when concerns were raised. This is something that BSCB may want to explore further.

8. Working with resistant parents and non-engagement.

8.1 Research and evidenced based practice give us clear information about working with resistant families. In this case this should have been better understood and addressed by the SW, team manager, and the multi-agency team to both identify mother's pattern of behaviour and the causes of this, and then consider how to engage and work with her over the long term. At the practitioner event, those professionals who had worked with mother or who had come across her collectively and individually described her as *difficult, challenging, rude*, *ranting, abusive (verbally or via text), and demanding, she was also at times intelligent, articulate and when not high on drugs, lucid.* The impact of this behaviour as described by them, was to meet her demands and to get her out of the building as quickly as possible, to prevent further disruption or upset to others. Receptionists at school and the GP practice all felt the same. The school described letting Hakeem go home with his mother after she arrived intoxicated at school, their rationale being to avoid confrontation and that they had to consider the wider welfare needs of staff and school community. Her volatility caused, not surprisingly, huge apprehension. The real impact on Hakeem was not fully recognised or considered. In previous SCRs by the author of this report (Polly, Derbyshire LSCB 2017), working with this non-engagement and difficult parental behaviour has been discussed and a key learning point from that review was that non-engagement should be recognised

not as frustrating, but as carrying the potential to harm the child and central to a child's welfare. It is a parent's choice, not a child's choice, to not keep appointments, to be difficult to pin down, to not be seen alone, something recognised in the DfE Triennial analysis of SCRs (May 2016). It calls for authoritative professional practice, defined as an ability to demonstrate professional curiosity, respectful uncertainty and being able to challenge parents and other professionals (Tuck 2013).

8.2 As discussed, BSCB introduced an overarching practice framework for the city in 2013. Called "Right Service Right Time" (refreshed in 2018). This was a conceptual service guide for the city's practitioners and aimed to help them define particular levels of need, harm and risk for children and families using a strength-based approach based around Signs of Safety (Turnell, A, & Edwards, S (1999). Previously Birmingham had had a confusing number of different assessment tools for early help which were proving ineffective. Researchers from Kings College London found that Signs of Safety is "workable" where authorities make the necessary commitment of trust in their staff at all levels, backed up by time resources and reflective supervision (Ref Children and Young People Now, July 13th, 2017).

8.3 Signs of Safety is based on honest relationships between the worker and families and between all professionals involved to achieve a shared understanding of what needs to change, and critical thinking to minimise error and create a culture of reflective practice. However, where parents consistently fail to engage, are resistant and/or manipulate and demand things on their terms only, then this approach needs to have some clear safeguards in place. (see ref Fox, L 2016, Applying Signs of Safety in high risk cases, Community Care inform Children). After the CGL worker had reported to BCSC his concerns around safeguarding, mother then sent abusive texts. A plan was devised to ensure that a different drugs worker complete the drug test to keep her engaged but she never attended. The significance of mother's drug dependency and her historical reliance on drugs was never fully assessed or understood in the context of her ability to parent safely.

8.4 It is well documented that in such cases maintaining focus on the child can be particularly challenging, the problems of the adult often eclipsing those of children (RIP 2012). Typically, such cases can involve a downgrading of referrals from school, viewing incidents in isolation with no recognition of cumulative harm, possibly becoming desensitised to the child's difficulties, and with a potential for workers to over-identify with the parent. These issues were all evident in Hakeem's case.

8.5 In interviews for this review the SW believed that he was working well with mother, that she was at times engaging with him, and that he had a good relationship with Hakeem but the evidence to support this assumption is weak. He saw Hakeem alone on only a couple of occasions: the last time he recorded that he had seen Hakeem alone and had a reportedly reasonable conversation with mother was in June 2017. The team manager in interview with the lead reviewer said that she was not aware that Hakeem had not been seen, and if she had she would have acted upon it. There were opportunities during the group supervision in August (and later in November) or at the CIN meeting on 28 September 2017, that mother did not attend, for the practitioners involved to discuss this in a better-informed way and arrive at a set plan of intervention, timescales and contingencies, but this did not happen.

Learning Point 5: *Where parents are persistently not engaging in relationship-based practice, there is a role for social work supervision to intervene to consider a more authoritative approach ensuring that the child is adequately assessed, seen and safeguarded.*

9. Identification of risk of significant harm leading up to ICPC in November 2017.

9.1 At the end of May 2017 there was, as discussed previously, ample evidence that Hakeem may be suffering neglect once more. In the space of six weeks, the school had shared with BCSC multiple concerns about Hakeem's living environment and the detrimental effect it was having on him. This included him disclosing that life at home was miserable, his mother and sibling 1 were fighting, and he had witnessed his sibling 1 screaming and throwing the baby on the settee in frustration. (It is not clear how this was responded to or shared in the light of the vulnerability of a young mother and baby.) He was also presenting as hungry in school. His inhaler at school had run out, and his mother had not supplied a replacement and had failed to attend a school nursing appointment.

9.2 By July 2017, the school were rightly anxious that appropriate support be put in place before the school holidays. Whilst the concerns had been noted by BCSC, the decision to place Hakeem on a CIN plan, not a CP plan, did in the lead reviewer's opinion result in a lesser degree of action and protection. It is not clear to the lead reviewer what process was used to determine that a CIN plan was appropriate and how and if this decision was made in agreement with other key agencies as the plan was only written up posthumously. The SW acknowledged that he himself was anxious about the decision at the time but was re-assured by his team manager that a robust CIN plan with clear timescales for action would be the best option to keep mother engaged. BCSC should instead have undertaken a Strategy Discussion and then brought the case to an ICPC for a multi-agency decision to have been made.

9.3 The information that Hakeem had been missing from school for two weeks in September 2017, and then on November 10th allowed to go home with his mother from school who arrived late and intoxicated, rather than risk a confrontation, was not properly shared by the school, so the opportunity to trigger a home visit was lost.

9.4 In October 2017 a formal decision was taken for the case to be taken to a child protection strategy meeting and then onto an ICPC, though this had initially been suggested in August through group supervision. The expectation by BCSC at the time was that this should happen within 15 working days, however given it was now four months since the SW saw the child, and had had any contact with his mother, it should have been held earlier. The delay appears to have been caused by a number of unrelated factors. Firstly, it was presumed during the summer holidays that mother and son were in Ireland, though this was never properly validated, secondly Hakeem's NSA was coming to court and it was hoped this would improve the situation and lastly the SW was on annual leave and had not yet written up the family assessment or completed the conference attendance form which triggers an ICPC.

9.5 It would seem from the point of allocation of Hakeem as a case in his own right in May 2017 until the ICPC in November 2017 that there was little evidence of any effective social work intervention or management oversight of the case. The team manager reported that she was not aware that Hakeem had not been seen: she had assumed that the SW knew the case well and that appropriate visits were taking place. The SW reported that although he felt supported and spoke regularly to his team manager, he only received one formal supervision between May 2017 and Nov 2017.

9.6 It was clear from the minutes of the ICPC that the decision then to make Hakeem subject to a CP plan was the right one. However, the scaling from professionals who attended the conference rated him as between 0-2 on the scaling safety scale, which is very low. At the practitioner event one attendee at the ICPC said she left the meeting

feeling extremely anxious for his wellbeing. There is a learning lesson here for all agencies: firstly that if a practitioner feels unhappy or significantly concerned for a child's welfare after an ICPC, then they must speak to their manager, or designated safeguarding lead and consider escalation, and secondly that there must be some action taken by BCT and the ICPC chair to assess the perceived level of immediate risk.

Learning Point 6: *The review found that there was an absence of guidance for ICPC/Review Chairs when a review or strategy meeting register a child as having a safety scaling at 2 or lower (0 = no safety, 5 = moderate safety, 10 = high level of safety). In this case, the level of risk should have triggered consideration of the immediate removal of the child or the development of an appropriate safety plan to minimise and manage the risk.*

9.7 In this case whilst there may have not been enough evidence to seek legal action to remove Hakeem, at a minimum there should have been a safe and well check to see him. The lead reviewer has learnt that at the time the ICPC took place on a Friday afternoon, and that this influenced what actually happened as it was late and the end of the working week. In response to learning from this this case ICPCs are no longer held on Friday afternoons.

10. Social Work Practice

10.1 The analysis of social work practice has to be set in the context of wider improvement work that Birmingham Children Trust are undergoing. *In 2010* Children's social care services in Birmingham were graded 'Inadequate' by Ofsted. Government intervention, along with the appointment of a series of commissioners, has reflected the national concern for these services. In the Ofsted inspection in 2016, improvements were noted, but the overall judgement was still inadequate.

10.2 SCRs should attempt not to allocate blame but to understand the root cause of any problematic practice to determine more about why rather than what happened. However, it is important to not shy away from naming practice that falls below expected standards where these have had a significant impact on the management of the case. In this case there were a number of issues, many of which are being addressed internally by BCT, but some of which need some explanation. The issues listed below summarise the practice concerns which have been identified during the course of this review; they are not necessarily systemic or widespread but were a significant feature of this case.

- Not actively engaging with or seeing Hakeem alone from June 2017 until his death in November 2017, despite him being on a CIN plan.
- Not in any way engaging with Hakeem's father in prison or his extended paternal family.
- Allocation of one social worker to the two siblings and a new baby all on CIN plans with very differing needs.
- A poor-quality family assessment which took no account of the family dynamics.
- Drift in timescales and lack of urgency to hold an ICPC when the situation deteriorated over the summer of 2017.

- Failure to adequately write up social work records and complete the written CIN plan and share with others until after Hakeem's death.

10.3 Use of Children in Need. The decision to place a child on a CIN plan rather than CP Plan continues to cause concerns and this case once again shows how difficult it is to get it right. This issue is highlighted in multiple SCRs including the Birmingham LSCB SCR into Keanu Williams (Jan 2011). The BCSC practice guidance on CIN (2015) clearly identifies that there should be a holistic assessment, that the child should always be seen in the context of their community, ethnicity, culture and that the parents must accept the findings of the assessment. It also states that any CIN plan must be formulated with the child, family and any relevant partner agency within 10 days of the completion of the assessment. All plans must then be ratified by the team manager and children seen at a maximum of six weekly intervals and more frequently where intensive support is necessary. In reality almost no CIN meetings took place, or if they were recorded as CIN they were actually only professional meetings, as mother was never present and other professionals were not fully aware or included in the assessment, and mother was not engaged in the work in any way.

10.4 The team manager described her team at the time as holding quite high caseloads, where children on CP plans tended to be the priority as they were being closely monitored in terms of compliance as part of the DfE improvement work and that there was a backlog of recording needing to be done. The SW at the time had a case load of 22, had a backlog of recording, not helped by his dyslexia. The team manager stated that CIN plans were often not written up in such a timely way, and this sometimes resulted in them not being properly shared with other agencies often until just before the next CIN meeting. Recent audits of CIN cases in the team did verify that timescales were not always robustly met. As a result of issues raised in this review, BCT has re-issued practice guidance stating that CIN plans must be written up within 10 working days and shared with the family.

10.5 The lead reviewer has determined that the SW felt he was in a difficult position, he was trying hard to maintain the relationship with mother, sibling 1 and her baby, alongside beginning to build trust with Hakeem. Mother was determined that no one was going to take Hakeem from her, and therefore was very reluctant to let the SW see him, enter the house, or engage in any meaningful work. Hakeem himself was not that willing to see the SW and told him he did not want a social worker. However, part of the social work role is to have the skills and confidence to use authority and professional competence to overcome these issues, and where necessary seek support from managers to find solutions to being blocked by a child or family. Hakeem was a child in need and if there was an issue with gaining access to him, then that in itself should have warranted further urgent intervention. Mother was at the same time keeping the CGL worker at a distance as she was not wanting to acknowledge the state of the house, nor the number of drugs that she was back on, or indeed how she was funding her drug addiction. As we have heard from all other professionals, she was volatile and difficult and trying to keep her on board rather than confront her was the easier option. The impact on professionals of working with complex, resistant and difficult parents should not be underestimated and can, if not managed well, result in the unintended consequence of preventing the child being the primary focus. The SW as discussed should not have been holding the two cases with very differing needs in the family alone, see Learning Point 2.

10.6 The author of the report has sought to examine factors behind the problematic practice to ascertain if the social worker and team manager felt adequately supported, were regularly supervised and had received adequate training. All of the above were deemed to have taken place, including the use of group supervision and peer support.

The SW took Hakeem's case to group supervision for discussion in August 2017 and was advised by his peers to take the case to ICPC. However, the BCT information report does suggest there was some slippage in formal supervision which may, if it had taken place, have identified how long it had been since the SW saw Hakeem alone and alerted the team manager to the need to hold an urgent ICPC.

10.7 Some local authorities or Trusts appear to have a lesser degree of scrutiny of CIN plans than CP plans and as discussed, identifying neglect and seeing the risks associated with it from the child's point of view must influence decision making in a more authoritative way. BCT have sought as a consequence of this review to audit CIN practice to assure themselves that this is not now the case.

10.8 Lack of Engagement with Father and his extended family. There are two very striking concerns about the professional response to Hakeem and his paternal family. Firstly, at no time was there any evidence that their racial background was ever considered. His father was from a Muslim Asian background and until going to prison said that Hakeem had regular contact with his paternal British Asian family. There is no reference in any professional meetings or notes of the significance of this for Hakeem which resulted in his extended paternal family not being consulted or asked if they could offer support, or help with getting him to school, or any other aspect of his case, as things began to deteriorate.

10.9 The second point is that once he was convicted, there is no evidence that any agency including BCT, made any attempt to seek his views, describe the deteriorating conditions or inform him that his son was on a CIN plan, much to his regret. Hakeem's father described in an interview with the lead reviewer whilst he was in prison that although he did not live full time with Hakeem, he was a "hands on dad" who was very involved with his care. He regularly saw Hakeem, describing him as the best thing that ever happened, had been part of the residential parenting assessment when Hakeem was born and was very concerned for his health, often taking him to the GP and hospital appointments, as evidenced in all health records. Father had a good awareness of his partner's drug dependency and was clear that whilst he was there, he felt her use of methadone was kept under control.

10.10 At the practitioner event not one agency could really describe why this was, other than that they still focus significantly on mothers as the primary carer. Mother had been very vocal about her disgust at the allegation against her partner and that she wanted no agency to contact him, Hakeem was not consulted on this. The social worker acknowledged that his normal practice would be to involve a father, and consider cultural and racial backgrounds, whatever the circumstances and that he was unduly influenced by the offence he had committed which had been widely reported in the press, and mother's volatility towards any contact with him.

10.11 BCT have recently undertaken further work around this and established that there is a pattern of social workers concentrating most on whoever is the primary carer rather than involving both parents, so it not solely about just not engaging with fathers.

10.12 Basic good practice would expect that a birth father, especially one who had been so involved with his son, would be consulted even if they were in prison for a serious offence. He had not offended against a child. It was never recognised that Hakeem's overall care, happiness, medical and physical neglect began to seriously deteriorate once his father had gone to prison. BCT are now actively encouraging a better engagement of fathers and expecting to see it as part of assessments and plans for children.

Finding 4 - In this case the failure by all agencies to consult and inform the birth father of the growing concerns for his son's welfare resulted in professionals not adequately taking account of his ethnicity and background, alongside the potential for extended family support or wider engagement and support from the family's wider community. It is vital that the improvement work on engaging fathers progresses and includes those who may be on remand or serving prison sentences and makes appropriate reference to their own ethnicity and family support networks.
It is recommended that any assessment should include the impact on the child, in terms of possible loss of support, guidance and wider family contact when a parent goes to prison, not just the risk the parent may have posed.

11. How non-compliance issues by parent and drug treatment were managed

11.1 As discussed, parents who do not engage with services for themselves or their children present a significant challenge to professionals, particularly for those who are working with strength-based models. The lack of any meaningful engagement of mother by both adult-facing and children's services was a consistent theme in this case.

11.2 Analysis of CGL involvement. Mother only attended one key working appointment during her treatment episode with CGL from 1 March 2015 to 26 November 2017, missed 16 and cancelled four. She attended five medical appointments and missed four. The CGL key worker arranged three home visits, but she was always out, or cancelled so they never actually met her and only communicated with her by text or telephone. Historical information from Birmingham and Solihull Mental Health Foundation Trust stated that mother did not feel she needed to attend appointments, so this was not a new pattern of behaviour.

11.3 In October 2016, mother was initially prescribed methadone (50ml) on a supervised daily basis as she admitted that she had stockpiled some of her prescribed dose and had recently used heroin and a small amount of crack. She was later assessed by a CGL doctor to have more protective factors in place having described herself as a busy working mother, having a non-substance abusing partner, and using a safe storage box for her medication, though these facts were never verified, which would have been good professional practice. This led the doctor to agree to her collecting methadone three times a week rather than daily, which was not in line with CGL policy.

11.4 By March 2016, mother was not engaging in her treatment package, so her prescription was rightly changed back to daily collection. The focus of the work by CGL key worker was purely on engaging mother. They only became aware of Hakeem and his asthma-related problems and other siblings in August 2016. After case discussion with his CGL team leader he agreed to ascertain from mother what support she had in place for her children and to refer to children's social care as he felt there may be safeguarding issues. Unfortunately, the worker from CGL, before taking any action, went off sick, not returning to work until January 2017. The case drifted and was not reallocated in his absence so no information about CGL involvement with mother was shared with BCSC, something which is a learning point for CGL.

11.5 Mother was seen by CGL doctors twice in this period and there was some exploration around risk to children in the first appointment, however she refused to provide the CGL medic with the children's names when asked, which should have led to further action. At the second appointment she attended with the seven-week-old grandchild, who she said was now living with her. The baby was observed to be well cared for, but again it should have triggered a contact with the CASS to follow up on the information provided; this did not happen. It was not until April 2017 when mother was requesting

a late holiday prescription that she provided the names and dates of birth of her children and shared that BCSC were involved because the father of the baby was a convicted sex offender. The CGL worker contacted BCSC and spoke to the allocated social worker on the same day. This was, according to the SW, the first time he became aware of mother's medication, trips to Ireland, poor engagement, and previously reported drug use. This is extremely worrying practice as by this time sibling 1, her new baby and Hakeem aged six were all living with mother and sibling 1 and the baby were on CIN plans, which had taken no account of mother's current drug dependence or potential risk.

11.6 In May 2017 at her appointment mother was asking to come off supervised daily subscription. However, she tested positive for methadone and opiates, admitting she was now smoking heroin and cannabis, spending about £100 a week on drugs. The CGL doctor rightly recognised potential risk to children and suggested a transfer from methadone to buprenorphine, which is considered safer as the risk to children from accidental overdose is reduced. This was the only option to off-supervised prescription and was in line with the CGL family-focused prescribing policy. A plan was made to review daily supervision in a month if mother could refrain from heroin use, but again the significance of this information appears not to have been considered in the family assessment that the social worker was undertaking at the time. This pattern of non-attendance by mother continued and in August 2017 the CGL worker was informed by the pharmacist that she had not collected her methadone for two weeks. CGL escalated concerns to the duty team as the SW was on leave at the time and again later in the month when he heard that mother was moving to Ireland. He received no response from BCSC. He was appropriately concerned that there must be an increase in mother's illicit use of drugs and was aware there were children in the house.

11.7 It is important to understand practice by CGL in the context of wider changes. Birmingham City Council re-commissioned substance misuse services in 2014 with a planned 36% reduction in the budget. CGL were awarded the contract but as the CGL information author reported, over 5,000 service users, and 300 staff from 26 different contracts transferred across. Staff at the time had a mixture of skills, experience and backgrounds. The new model of funding impacted on staff as there was new IT, more flexible working, a reduction in locally based buildings and this impacted on staff morale and stress levels. The changes took time to bed in and although there was a plan to support the safe transition of service users around safeguarding, the outgoing provider for mother did not record any current safeguarding concerns and no electronic marker was placed on her electronic case file. This was significant as the case was not perceived to be safeguarding and the historical record that documented the previous risk assessment and history regarding Hakeem and his siblings was not included, so was never seen by the CGL workers who only had access to electronic records.

11.8 The information report into the practice of CGL concluded that there was evidence in the first 18 months that the focus was adult-orientated with the primary aim being to engage mother, and many attempts were made to get her back into treatment including offering psychosocial interventions. However, there was only minimal curiosity initially into the risk associated with drug use and children. The CGL safeguarding policy stated that where service users with children of school age are prescribed opiate substitute medication a home visit needs to be conducted and a parental needs assessment undertaken. Although four planned visits were arranged including an announced joint visit with the social worker, there should have been more efforts made to locate mother to undertake a home visit, seek management advice at her continual absence, and share information with school around concerns. Mother confirmed in her recent interview with the author that from her perspective she felt she never got any proper

support from her CGL worker and that when she requested help on her return from Ireland after, "doing cold turkey" the response was to forward her text to the social worker, rather than contact her directly to offer help, so she lost trust in them.

11.9 The role of pharmacists in supporting the prescribing of substitute opiates is important and this review suggests it is not well understood by professionals outside of drug treatment services. There is an expectation that pharmacists will contact CGL when a service user has missed three days of their dose. This did not always happen which meant that the CGL key worker was sometimes unaware that mother was without her prescribed medication. This is significant as it can be an indicator that she was getting her drugs elsewhere and was using class A drugs again; to obtain them needs substantial amounts of money. What we know now is that after Hakeem's death it was clear that mother had been using drugs for some time and was potentially funding this via prostitution from the same premises where Hakeem was sleeping. CGL drug testing policy states that service users should be tested every 12 weeks. In general, when mother attended, she was drug tested on most occasions, but as she missed many appointments the testing was irregular and positive tests alone should not be the only method of assessing how much someone is using. The crucial point is understanding the wider implications of such use. A second point was that mother was also requesting additional asthma inhalers for Hakeem, which she got from the pharmacist. It was discovered after Hakeem's death that she was stockpiling and using these inhalers for smoking crack. The review has established that pharmacists do not receive specific training around substance misuse and therefore it would be unlikely that they would make the link between alternative use of inhalers and dispensing prescribed opiate substitute medication. This may be something that the commissioners of pharmacy services may want to consider as part of their action plan (see Finding 5).

12. Adequate assessment and management of child's asthma, including prescribing practice.

12.1 Medical history. Hakeem seems to have had an early diagnosis of asthma and by the age of five had received steroid injections twice and was taking Beclomethasone (a steroid preventer inhaler) and using a salbutamol inhaler up to four times a day. He also had extreme reactions to nuts and eggs and had episodes of childhood eczema.

12.2 Hakeem was seen once within the timeframe by Heartlands Hospital Birmingham in July 2015 when he was brought into ED by his father. He was treated for asthma and discharged with prescription and advice to see his GP. It was noted that there was a family history of asthma and that he had not been using his preventative inhaler. The GP had recently referred Hakeem for a chest X-ray, but he had not been brought for it. There was no further explanation of why he had not been brought during the consultation at the hospital. The ED practitioner did not check electronic records as part of the routine triage, so was not aware of the family history. If they had, it would have identified a previous safeguarding alert on Hakeem's electronic records dating back to his previous CP plan for neglect in 2013. As Hakeem presented as well cared for, no further questions were asked. At this time compliance with record checking in the hospital was not good, and this was later subject to an improvement plan. The Trust reports that compliance in 2017-18 is now 97%.

12.3 In October 2015 Hakeem was taken by ambulance to BWCHFT and was admitted as he needed oxygen. The Paediatric registrar recorded that Hakeem had poorly controlled asthma with a concerning history and that an outpatient appointment was required. The respiratory nurse assessed wider medical and social needs and

recorded that mother said she smoked cannabis and had previously been a heroin user. The nurse sent a letter to the GP and parents summarising her assessment and advising that the school should be provided with more information to support Hakeem's education and health needs but did not consult with the hospital safeguarding team for advice or support following mother's disclosure, which would have been expected practice. She did however speak to the then Common Assessment Framework Coordinator (CAF) for advice and established there was no current involvement with the family from children's social care.

12.4 Hakeem was not brought to his follow up appointment in October 2015 but did attend with his father in November 2015 when his asthma was deemed to be more under control. The December appointment was also missed, and no explanation was sought so the Consultant Paediatrician sent a discharge letter to parents and the GP. No consideration was taken at this time into social history or curiosity as to why Hakeem was not brought, or the impact upon him.

12.5 Hakeem had one more hospital attendance in November 2016 but was not admitted. The real build up to concerns was in the September of 2017, a few weeks before Hakeem's untimely death.

12.6 It is expected practice by BWCHFT, that for each child with asthma, a holistic assessment is completed of health and social care needs. Whilst there was some evidence that this was undertaken by the respiratory nurse at BWCHFT, it was not undertaken at any of the ED attendances. The ED consultant at the practitioner event said that it would be unlikely that this would be actioned as in ED priority is on life saving activity and once the child is stabilised, they are quickly moved elsewhere.

12.7 From the records it is clear that his father played a key role in supporting the early treatment and oversight of Hakeem's asthma, a fact confirmed with the author of the report when she visited father in prison as part of this review. He described how hard it was to understand what was required and his frustration that more could not be done by the hospital and GP to prevent Hakeem from suffering. Both parents smoked, and the hospital doctor had talked to the father about stopping to prevent Hakeem's breathing difficulties becoming worse. The significance of father's imprisonment on the management of Hakeem's asthma as his health deteriorated was never considered by any of the professionals involved, in fact it is unclear if there was any knowledge of it by health professionals until mother disclosed the fact when Hakeem was in hospital in September 2017. Mother stated in recent interview with the author that she felt neither parent had really understood the life threatening seriousness of Hakeem's asthma and that medical professionals should be more transparent and direct when talking to parents.

12.8 The GP practice saw Hakeem 11 times during the period of review, eight times by the GP and twice by a practice nurse, and once by both on the same day. In general, the CCG information report concluded that the management of Hakeem's asthma did conform to national British Thoracic Society (BTS) guidelines, however it has identified some local practice points and wider learning. The GP practice works with many vulnerable and disadvantaged families and the ethos of the practice was described by the report author as trying to establish good partnerships with families, even those who are difficult and demanding. However, there is an important lesson for them to ensure that within this ethos and culture they do not fail to identify children who may be a significant risk of harm or parental medical neglect. There are a number of other specific learning points for the GP practice development that have come out of learning from this review and the information report.

12.9 Hakeem was prescribed the appropriate inhalers with spacer devices and given courses of steroids and antibiotics as required. There was a full asthma assessment with the practice nurse on 12 April 2017 and a written asthma management plan including written advice on how to use his inhalers. The GP also assessed his asthma on four other occasions the last being the 22 September 2017. Mother told the author that although on paper there was an asthma plan, she felt it was not helpful as it did not really spell out or explain the difference between the different drugs and how to use them, or the consequence of getting it wrong. Mother looked at the internet and felt there was different advice and treatment options available.

12.10 By July 2017, the GP had registered some concern about the number of inhalers being requested by mother, along with nebules, declining to prescribe any more nebules, stating that Hakeem must be seen when a prescription was collected. This did not happen, and no explanation could be given as part of this review as to why. They also then did not investigate when Hakeem was not brought to a follow up appointment six days later. The GP noted that Hakeem's asthma was poorly controlled due to poor adherence to preventer therapy.

12.11 The practice would say that mother insisted she knew best how to handle the asthma and because of previous discussions about her volatility this went unchallenged. Hakeem's inhaler technique was only checked once because mother did not allow staff to get any further in their assessment. The combination of poor control and mother's resistance to further medical input is, as the CCG information report author suggests, a cause for concern. The GP practice made no mention of mother's behaviour, or their concerns about it, when responding to information request from BCSC on Hakeem. This is a learning point for the GP practice and the CCG.

Learning Point 7: *The GP Practice, when sharing information with BCSC, only shared medical advice and did not include important information regarding obstructive parental behaviour and drug use, which would have enhanced professionals' understanding of the wider issues facing this family.*

12.12 The need for a better understanding by all professionals around the lack of parental cooperation in the context of poor health, and consideration of the impact on the child is a significant learning point from this SCR. It was also apparent at the practitioner event and within the review team that apart from a few medical professionals, very few professionals understood anything about asthma and what good management of it looks like.

12.13 The national review of asthma deaths (NRAD) makes some strong recommendations about the importance of children taking their preventer inhalers (brown ones) as well as the blue ones (reliever inhaler). In the last six months of his life Hakeem was dispensed more reliever inhalers and fewer preventer inhalers than is recommended. He was also prescribed nebules twice. The information report for the CCG identifies that nebules are used in a nebuliser (a machine that delivers the medication through a mask) and it is not generally recommended practice in UK for use by patients at home as they can be dangerous, and result in a reliance on them which stops the patient using preventer medicine. Nebulisers can be bought on the internet and in interview with the author Mother described how she had purchased one as she felt it might help Hakeem, though admitted she had no idea it could be so harmful if used wrongly. Thus, it is concerning practice that Hakeem was prescribed by the GP on two occasions (May 2017 and Sept 2017) salbutamol nebules (the liquid used in a nebuliser). There is no record of the GP exploring with mother where she had obtained it, or the dangers of using one. Normal practice would be that if a nebuliser was prescribed it would be part of a hospital treatment plan. The social worker observed on a visit to the house

Hakeem wearing the nebuliser and presumed it was part of his normal asthma medication.

Learning Point 8: *In this case the child, who was suffering from asthma, was prescribed nebules by the GP for use with a nebuliser. This course of treatment should only form part of an agreed asthma treatment plan with the child's local hospital.*

12.14 Hakeem was admitted to a high dependency unit at hospital with poorly controlled asthma in Sept 2017 and Oct 2017. On his discharge from BWCHFT, the level of concern about Hakeem's asthma was high and increased efforts were made by the GP and practice staff to contact mother and ask her to bring Hakeem in for review, but they never got hold of her. This concern was not shared with BCSC as the GP believed they needed the consent of mother to share information with other agencies. They were not, as mentioned, aware that Hakeem was on a CIN plan, nor of the growing concerns about Hakeem's wider welfare. There appears to have been no formal discharge plan for either time Hakeem left hospital.

12.15 Hakeem was prescribed four preventer inhalers in the last six months of his life (each one is supposed to last approximately one month, slightly fewer than ideal), and eight reliever inhalers, as children often lose them or need an extra one at school. While this alone does not give a clear picture, nevertheless the use of more than one reliever inhaler a month should raise clinical suspicions. The review has also identified that inhalers were issued by the pharmacist in October 2017, prior to prescriptions being given; this can happen legitimately at the discretion of the pharmacist but caused concern for the GP practice, who were rightly worried that mother was obtaining more reliever inhalers for Hakeem, without preventers or him being medically assessed. The CCG information report says that the approach of the pharmacist was not helpful and undermined the attempts by the GP practice to see Hakeem in person. There was some discussion between pharmacy and the GP over the issue and the GP practice took advice from the medicines management team of the CCG to clarify the issue. The pharmacists argued that they had a duty to provide inhalers on patient safety grounds, whether or not prescribed by the GP. This is accepted practice and in line with medical guidance. Whilst it may be accepted practice, it potentially leaves a situation where a child's poorly managed asthma is not recognised and therefore not acted upon in a timely way.

12.16 The management of asthma by parents is complicated and BSCB and CDOP (Child Death Overview Panel) have recently completed further research and issued publicity to raise the profile of it to parents and carers following four other asthma related deaths of young people and an unpublished learning lesson review which highlights many similar issues found in this case and summarised in the briefing note, (ref *Asthma can Kill*, Nov 2017, BSCB).

12.17 Asthma is a common condition affecting around 1 in 11 children. With effective control, hospital admissions and premature deaths should be avoided. A national review of asthma highlighted some avoidable factors which have a role to play in three quarters of asthma-associated deaths (Birmingham CDOP review Jan 2016). One of the most important factors that the CDOP report, BTS and NICE guidelines highlight is ensuring that there is an appropriate clinical review carried out by primary care, when a child's asthma becomes problematic, or within two working days of receiving treatment in hospital or via the out of hour's service for an acute exacerbation.

12.18 All children should also have an annual review and individual personal asthma plan. This personal plan should include structured education on how to recognise an asthma

attack, when to seek help and how to prevent a relapse. The importance of this being developed and shared with families, hospital, GPs, school nurses and any other relevant professionals is crucial. It also ensures that further encouragement is provided to children who are not brought to ensure any preventable harm to the child is avoided and problematic asthma is dealt with early.

12.19 In this case, whilst the hospital and GP had regular contact with Hakeem and there was an annual review of his asthma, there was little awareness among other professionals of the significance and risk associated with poor asthma care nor a well-developed personal asthma care plan for Hakeem which should, had it existed, have been incorporated into his CIN plan. It is also a concern that his mother did not feel the asthma plan helped her understand the different medications and the significant of Hakeem's asthma.

Finding 5 - This review has found that there is a lack of professional awareness around the appropriate use of medication for children with asthma that can result in a failure to identify patterns of over-prescribing of inhalers. In addition, there needs to be awareness that asthma medications can be misused where there is parental drug misuse. There must be a wider dissemination of the messages from the previous *Asthma Kills Learning Lessons Briefing* note in Birmingham with a suggested update of lessons from this SCR.

For GPs and other medical staff, there must also be an expectation that all children with asthma have a personalised asthma action plan which includes structured education on the medications prescribed and how they should be given, how to recognise an asthma attack, when to seek help and how to prevent a relapse. This plan must be shared with families, hospital, GPs, school nurses and any other relevant professionals.

There is also a need for pharmacists to have specific safeguarding training that addresses the wider safeguarding issues that by parents continuously requesting emergency medicine they may be unable to plan or meet the basic needs of their children. The training content also needs to make a link between parental drug misuse, prescription medical equipment and childhood asthma, especially where there is a tendency for parents to request emergency medication for their children. Communication between GPs and pharmacists in these types of cases is essential.

13. Role of school nursing in management of Hakeem's asthma.

13.1 The school health advisory service commenced in April 2016. Each primary school had a fortnightly visit and gave an opportunity for the school health advisors to talk with school staff regarding children where there were concerns. At the time of Hakeem's death, there were significant issues with sickness in the team in the area covering the school.

13.2 Like many of the other professionals in this case, the school nurse never met Hakeem or mother. In trying to understand why there was no more proactive involvement with Hakeem, the information report author concluded that one of the main explanations was that when Hakeem started school, his mother never returned the health questionnaire to the school health advisory service, which, had she done so, should have identified his medical condition. The consequence of this was that they were unaware of his asthma and other allergies or that he had any specific needs for support.

13.3 There appears to have been little communication between any of the health professionals and school regarding Hakeem's asthma, and they actually were not made aware of Hakeem until after his admission to BWCHFT in October 2017, when they were informed he had been admitted twice in the last two weeks with an exacerbation of asthma almost to the point of collapse, and which resulted in high dependency intervention. The doctors were concerned that mother did not seek medical attention until Hakeem was very ill. The Sister for medical complexities at the hospital rightly requested the school health advisers follow up in school and with mother, to look at the possibility of early help intervention. They were not aware that Hakeem was already on a CIN plan. This follow up, although recorded, did not take place, so no health assessment was undertaken, and no medical care plan developed. This delay in response by the school health advisory service is of serious concern. The interaction between health and education is crucial to ensure that children can succeed in school. It would have been expected that the school nurse advisor's role would have been to liaise with the GP, the mother, and the school to ensure good partnership working. Other than sickness there is no obvious other explanation for such a poor response.

13.4 It is not clear from the information report or practitioner if the role of school nurse is clearly understood by the wider medical professional or social workers. In interview with the lead reviewer the team manager said until the practitioner event she was not aware of the cuts to school nursing and presumed that every school still had regular access to a school nurse. Until July 2018, Birmingham Community Healthcare Trust (BCHC) commissioned the school nursing and health visiting service. In this case, as the information report highlights, there was no joined up working between health visiting and school nurse services and assumptions were made that each was aware of the other's involvement with Hakeem and his family.

13.5 One of the areas of concerns was the lack of timely response when information was received from BWCHFT in relation to Hakeem's acute admissions. It would appear that the school nurse at Hakeem's school had been off sick and only limited cover was provided. There was no obvious child health care plan, though it was suggested that one was developed but not signed off.

Finding 6: This case has highlighted that liaison across health providers is not as robust as it could be. It is speculated by agencies involved that the practice in this case of not routinely sharing information about chronic health conditions and wider welfare concerns is not a one off and that there is a pattern of poor communication between health (GP, hospitals, health visiting and midwifery) and a decreasing school nursing provision. There is a concern that with more cuts to school nursing services that there will be even more difficulty in ensuring information is appropriately shared and acted upon in a timely manner, which will continue to leave children without adequate support.

13.6 Was not brought (WNB)/missed appointments for Hakeem. Whilst there were 11 presentations at the GP practice and five at ED, there were only a few times when Hakeem was not brought to appointments at the asthma clinic in 2017, and therefore no real pattern can be found. If Hakeem was unwell then either his mother asked for emergency treatment at the GP, or if he was very unwell called 999. The real issue was the lack of persistence in following up after asthma reviews to see if there had been compliance and if health had improved. The CCG reported that they did recognise the importance of GP follow up after acute asthma attacks however, if the family are difficult to get hold of via phone, then follow ups may not happen due to pressure of work. The key point is how well supported are parents to manage childhood

asthma and what should happen if they are not complying with treatment plans and that this is seen in the context of possible medical neglect, and that the Think Family approach is embedded in all health practice, both primary and secondary.

14. Findings and Conclusion

14.1 This SCR has sought to address the key elements of the terms of reference as specified over the two-year period of the review. This review has, through the practitioner event and via other documentation and interviews, identified a number of practice and organisational issues which need to be considered by the BSCB, and individual agencies, in order to ensure that there is systemic learning and improvement. The SCR highlights six findings and some additional single and multi-agency learning points that the BSCB and agencies should take into consideration when considering their recommendations.

14.2 The findings from this SCR reflect to some extent the wider findings of the latest Ofsted inspection monitoring visit (August 2018) which followed the City Council's transition to a Children Trust in April 2018. The published Ofsted letter states that the Trust is continuing to make some progress in improving services for its children and young people. However, a number of areas continue to require improvements, which include the quality of the Trust's evaluation of social work practice, the consistent engagement of partners in contributing to multi-agency meetings and ensuring that in cases of neglect, over optimism does not lead to inaction. More work is required to ensure that plans for improvement in children's circumstances are easily understood by parents and that plans detail what the next steps will be when no progress is being made. All of these aspects are found to be the case in the analysis of practice with Hakeem.

14.3 Hakeem died of an acute asthma attack, but in the months leading up to his death there were a number of opportunities for professionals to have identified wider neglect factors that may have supported a more robust and protective professional response. The consideration of his welfare and care needs should have been assessed in light not only of his own health needs, but also of the reality of living with a substance misusing parent. The NSPCC Learning document on Parental Substance Misuse (Sept 2018) reflects how parents and carers who misuse substances can have chaotic, unpredictable lifestyles and may struggle to recognise and meet their children's needs which may result in their children being at risk of harm. A good assessment must involve both protective factors but also risk, be collaborative and seek the views of other agencies who are involved with the family, such as health professionals, teachers, substance misuse services and criminal justice agencies (Bogg, 2013; Cleaver, Unell and Aldgate, 2011; Cornwallis, 2013; Home Office, 2003). Following Hakeem's death as the West Midlands Police information report and photographic evidence identified, mother admitted her addiction was costing over £55.00 daily, she smoked heroin in the bedroom where Hakeem slept, and made makeshift crack pipes out of his prescription inhalers. If the drug key worker or social worker had gained access to the house or been more inquisitive about mother and her drug addiction they would have seen this for themselves.

14.4 We know that professionals have been deeply affected by this case and no one set out to fail to protect Hakeem, but collectively they did fail to see him or experience his lived and daily life, which had been deteriorating rapidly and was not hidden. Indeed, Hakeem himself told us on many occasions that life was not good for him.

14.5 As discussed, the review identified problematic professional practice which should be seen in context of changing organisational systems and performance at that time. It must also recognise the potential for professional de-sensitisation to conditions and level of poverty and neglect, to the extent that parental non-engagement becomes the norm, preventing the child being seen as central. This was a significant observation made by the lead reviewer following the practitioner event and other meetings.

15. Key findings and recommendations

15.1 The review identified 6 findings and 8 learning points that relate to issues that will, if addressed, impact on improvements in current professional practice.

Findings:

Finding 1	**This review has found there is confusion by professionals around significant harm thresholds for neglect where a child has a chronic medical condition that is being poorly managed by a parent. There is a need for professionals to become more aware of the correlation between poor parental management of medication for children with chronic health conditions such as asthma and wider childhood neglect.** It is recommended that where children have had hospital admissions for chronic conditions there is a robust discharge plan that includes identifying if any other agencies are involved. A reliance on parental self-disclosure may not always be best practice.
Finding 2	**In this case it was evident that there was a lack of join-up and communication between those responsible for Hakeem's non-school attendance and children's social care which resulted in the two processes not taking account of the neglect that Hakeem was experiencing.** In future there must be a better process to ensure communication between the school attendance officers and other professionals to establish more about the daily lived experience for children. They must clarify which absences are authorised or unauthorised, especially if they are on a CIN/CP plan and recognise that persistent NSA is seen as a potential indicator of neglect. Additionally, it is recommended that children with chronic conditions such as diabetes or asthma which may result in NSA should be adequately assessed and supported, it should be noted that properly managed, asthma should not impact greatly on a child's school attendance. It was also clear that Academy Trusts who employ their own safeguarding support need to ensure that more formalised strategic links are made between themselves and local authority support officers to ensure better guidance and support when they arise.
Finding 3	**In this case there was little professional understanding of the daily lived experience of the child. This resulted in a lack of assessment of what his reality was like through the day and night and the level of neglect experienced. Going forward it is essential that supervision processes and multi-agency assessments are required to clearly describe a day in the life of each child.** Most importantly there also needs to be clear and robust processes for ensuring that visits to CIN are done in line with BCT guidance and are monitored as closely as for those on a CP plan.

	The work on ACES (Adverse Childhood Experiences) may be something that BCT and other partners want to explore further in order to strengthen practitioner understanding and impact when undertaking assessments.
Finding 4	**In this case the failure by all agencies to consult and inform the birth father of the growing concerns for his son's welfare resulted in professionals not adequately taking account of his ethnicity and background, alongside the potential for extended family support or wider engagement and support from the family's wider community.** It is vital that the improvement work on engaging fathers progresses and includes those who may be on remand or serving prison sentences and makes appropriate reference to their own ethnicity and family support networks. It is recommended that any assessment should include the impact on the child, in terms of possible loss of support, guidance and wider family contact when a parent goes to prison, not just the risk the parent may have posed.
Finding 5	**This review has found that there is a lack of professional awareness around the appropriate use of medication for children with asthma that can result in a failure to identify patterns of over-prescribing of inhalers and use of asthma medications that may indicate parental drug misuse.** There must be a wider dissemination of the messages from the previous *Asthma Kills Learning Lessons Briefing* note in Birmingham with a suggested update of lessons from this SCR. For GPs and other medical staff, there must also be an expectation that all children with asthma have a personalised asthma action plan which includes structured education on how to recognise an asthma attack, when to seek help and how to prevent a relapse. This plan must be shared with families, hospital, GPs, school nurses and any other relevant professionals. There is also a need for pharmacists to have specific safeguarding training that makes links between parental drug misuse, prescription medical equipment and childhood asthma, especially where there is a tendency for parents to request emergency medication for their children, communication between GP's and pharmacists in these types of cases is essential.
Finding 6	**This case has highlighted that liaison across all health providers is not as robust as it could be. It is speculated by agencies involved that the practice in this case of not routinely sharing information about chronic child health conditions and wider welfare concerns is not a one off and that there is a pattern of poor communication between health (GP, hospitals, health visiting and midwifery) and a decreasing school nursing provision.** There is a concern that with more cuts to school nursing and other health services that there will be even more difficulty in ensuring information is appropriately shared and acted upon in a timely manner, which will continue to leave children without adequate support.

Learning Points:

Learning Point 1	There may still be confusion about significant harm thresholds and the level of neglect required to trigger a referral or cross between a child in need and a child in need of protection.
Learning Point 2	Where one child is on a CIN plan and there are growing concerns about another in the family with very different needs, there is a need to ensure that the child is assessed in their own right and a separate plan and social worker allocated.
Learning Point 3	When assessments are carried out in the ASTI team and then the responsibility for the child moves into the longer-term safeguarding team, there is a risk that unless a short review of the assessment and plan is undertaken by the new SW then any significant changes in family circumstances, may not be reflected in CIN/CP plans and shared with the other agencies involved.
Learning Point 4	There was a lack of understanding and application of the escalation procedure by the Academy Trust when there were persistent safeguarding issues, which resulted in concerns raised not being appropriately escalated and resolved.
Learning Point 5	Where parents are persistently not engaging in relationship-based practice, there is a role for social work supervision to intervene to consider a more authoritative approach ensuring that the child is adequately assessed, seen and safeguarded.
Learning Point 6	The review found that there was an absence of guidance for ICPC/Review Chairs when a review or strategy meeting register a child as having a safety scaling at 2 or lower (0 = no safety, 5 = moderate safety, 10 = high level of safety). In this case, the level of risk should have triggered consideration of the immediate removal of the child or the development of an appropriate safety plan to minimise and manage the risk.
Learning Point 7	The GP Practice, when sharing information with BCSC, only shared medical advice and did not include important information regarding obstructive parental behaviour and drug use, which would have enhanced professionals' understanding of the wider issues facing this family.
Learning Point 8	In this case the child, who was suffering from asthma, was prescribed nebules by the GP for use with a nebuliser. This course of treatment should only form part of an agreed asthma treatment plan with the child's local hospital.

16. Postscript

In the intervening period since the tragic death of Hakeem in November 2017 there has been significant development and improvement in the multi-agency safeguarding arrangements in Birmingham. This section focuses on some of the key changes that have taken place that directly relate to the emerging learning and findings from this case.

On the 1st April 2019 the former Local Safeguarding Children Board was replaced by new multi-agency partnership arrangements where statutory responsibility for leadership of the arrangements is shared equally between West Midlands Police, Birmingham City Council and Birmingham & Solihull Clinical Commissioning Group. The crucial leadership role that Birmingham Children's Trust plays in the new arrangements, since their creation in April 2018, cannot be underestimated.

Since 2017 there have three independent reviews of Children's Social Care undertaken by Ofsted. In January 2019 services for children in need of help and protection were no longer judged to be inadequate. Ofsted commented "the delegation of statutory functions to Birmingham Children's Trust has enabled the revitalisation of both practice and working culture, and, as a result, progress has been made improving the experiences and progress of children. Subsequent focus visits by Ofsted in January 2020 and November 2021 have provided further evidence of progress.

The BSCP will continue to focus on improving leadership and partnership practice in tackling childhood neglect. The BSCP has funded a Neglect Programme Manager to work alongside the Neglect Operational Group in piloting new models of working to support children and vulnerable families in the city. The BSCP will launch the Childhood Neglect Strategy for 2022-24 at a practitioner conference on the 26th September 2022 focusing on tackling childhood neglect.

In September 2021, NHS England and Improvement (NHSEI) published the national bundle of care for children and young people with asthma. Phase 1 of this national plan seeks to provide support for the new Integrated Care Systems in delivering high quality asthma care. In Birmingham there are two pilot projects that have these national standards at their core in engaging primary and secondary care together with key frontline practitioners from a range of agencies to achieve better outcomes for children with asthma.

The city's Child Death Review Arrangements will continue to review all cases involving deaths through asthma to maximise the opportunity to learn and promote good practice.

17. References

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Appendix 1

SERIOUS CASE REVIEW TERMS OF REFERENCE

1. Introduction

This Serious Case Review has been commissioned by Birmingham Safeguarding Children Board in accordance with guidance issued under Regulation 5(1)(e) and (2) of the Local Safeguarding Children Boards Regulations 2006. A serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child

2. Aim

The aim of a Serious Case Review is to undertake a rigorous, objective analysis of what happened and why, so that important lessons can be learnt, and services improved to reduce the risk of future harm to children. [3] The Serious Case Review should evaluate the quality of professional practice and the way in which professionals worked within their own agencies and with other agencies in order to identify the needs of the family.

The final report should:

- Provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence
- Be written in plain English and in a way that can be easily understood by both professionals and the public
- Be suitable for publication without needing to be amended or redacted.

3. Background

On 26th November 2017 an ambulance was called to an address where a 7-year-old child had been found unconscious in the garden.

The initial account provided by the child's mother was that he had been unwell the previous day and she believed that during the night he went into the garden due to his asthma. The ambulance service confirmed that Hakeem was deceased and had been for a considerable amount of time. West Midlands Police were conducting an investigation into the circumstances surrounding the death of this child. The child's three older siblings had all previously been removed from mother's care due to domestic violence and alcohol abuse.

Hakeem had been subject of a Child in Need (CiN) Plan, which had been put in place in May 2017 following the completion of a family assessment. During the period of May to October 2017 Hakeem remained open to Children's Services and was subject of a CiN Plan. There

[3] Working Together Chapter 4: Learning and improvement framework, HM Government March 2015

were on-going concerns during this period in relation to mother co-operating with agencies to meet the needs of Hakeem. Hakeem's school attendance and behaviour whilst at school were worrying as both had deteriorated further. Mother was not engaging with her drug support worker, nor was she taking Hakeem to health appointments in relation to the management of his asthma.

On the 24th November 2017 (two days prior to Hakeem's death) Hakeem was made subject of a Child Protection Plan under the category of neglect.

4. Process

At the Serious Case Review Sub Group on the 8th December 2017 it was established that the case met the criteria for a Serious Case Review as abuse and neglect is suspected to be a factor in the child's death. The Independent Chair of the BSCB was formally notified and ratified the decision to commission a Serious Case Review on the 21st December 2017. The commissioning of chronologies and agency reports, once requested, will have four weeks for completion. Presentation of the SCR report and learning is to be presented to the Executive Board at the conclusion of the criminal investigation.

The Executive Board has appointed an Independent Lead Reviewer to oversee the completion of the Serious Case Review, supported by a Review Team of safeguarding experts from:

- Birmingham Children's Social Care
- Birmingham City Council, Education
- Birmingham South Central CCG
- West Midlands Police
- Change, Grow, Live

This case, at that time, was subject to an ongoing investigation by West Midlands Police. The Serious Case Review would not be finalised until the outcome of the Police enquiries are known to enable any additional information to be incorporated within the review. The Serious Case Review Sub-Group will ensure that any emerging findings are acted upon as soon as possible by agencies to ensure that any early lessons are fully implemented.

The Review Team will consider the most appropriate way of involving family members in the review process. The Independent Lead Reviewer will be responsible for arranging liaison with the family with the support of West Midlands Police Family Liaison Officer.

The Review Team will consider all aspects of the racial, cultural, linguistic and religious background to this case. There do not appear to be any factors that impact on immigration status.

BSCB will obtain legal advice as necessary. The review will adhere to the Board's current legal advice relating to serious case reviews and other publications.

The Clinical Commissioning Group (Birmingham Cross City CCG) will notify the Local Area Team of NHS England of the serious case review through the "Sudden Untoward Incident" system.

The Review Team will take into account any relevant information that emerges from the Police investigation. The Police representative on the Review Team will be responsible for liaising with the Senior Investigating Officer and the Crown Prosecution Service.

The Social Care representative will be responsible for provision of information from family proceedings.

The Strategic Health Forum will oversee implementation of learning across the Health network in Birmingham.

The final overview report will take into account information from any other independent enquiry being held in relation to this case.

The final draft report will be presented to the Serious Case Review Sub-Group to quality assure and endorse the key learning, prior to presentation to the Executive Board for ratification and effective dissemination of learning. The Executive Board will be responsible for the publication and media strategy.

5. Scope of the Review

5.1 Time Period

The Review Team concluded that the Serious Case Review should focus on the period from the 1st July 2015 (to incorporate the decision made by Children's Social Care to close the case) until the date of the child's death on the 26th November 2017.

5.2 Individual Agency Reports And Chronologies

All agencies that had contact with the family should complete a key events chronology using the chronolator software provided. Each agency will review their records and files relating to the case to prepare an information report on the template provided identifying emerging learning and action that will be undertaken to take forward any improvements. All agencies are required to provide analysis of their agency's intervention with the subject child and family members, taking account of the below key issues. Guidance notes are provided for the use of the chronolator and content of information reports.

Consideration will be given to a briefing for Information Report Authors by the Independent Lead Reviewer. The session will cover the purpose and aim of serious case reviews. It will also provide guidance about analysing their agency's involvement in the case and any specific issues detailed in the terms of reference.

5.3 Practitioners Learning Event

Agencies will need to prepare a full list of those professionals and line managers who had direct operational involvement with the child and family to enable them to be invited to a practitioners learning event. The Independent Lead Reviewer will send out invitations providing plenty of notice, highlighting the importance of attending and explaining the purpose.

5.4 Key Issues To Be Addressed Within The Review

The review process will focus on the below key issues:

1. The professional understanding of neglect and ability to recognise and respond to it and other risk factors (wider risk, substance abuse).

2. The level of effective multi-agency working and communication including compliance with procedure, information sharing, supervision and support etc.

3. The ability by professionals to really understand what the lived experience of the child was (including other factors: racial, cultural, linguistic etc).

4. Where there was non-compliance with a drug treatment programme, was supervised consumption and/or drug testing considered?

5. Was there adequate assessment and appropriate management of the child's asthma, including prescribing practice?