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PRESS RELEASE

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Publication of learning from a Serious Case Review (SCR)

Date: 1st September 2022

Details:

PUBLICATION OF SERIOUS CASE REVIEW INTO THE TRAGIC DEATH OF HAKEEM HUSSAIN

On behalf of the Birmingham Safeguarding Children Partnership I want to start by expressing the sincere sadness felt by all partners at the awful death of Hakeem, almost five years ago. The passage of time has not damped down our feelings, but it has given us time to genuinely reflect, inquire and learn from the events of Hakeem's often sad life and untimely and unnecessary death in 2017. We have used the time to act on that learning.

As we know, Hakeem's mother is now serving a very long prison sentence for the manslaughter through neglect of her seven-year-old son. However, through the Serious Case Review we have learnt that all those organisations and individuals who came into professional contact with Hakeem could and should have done better. Once again, we have a tragedy of a child dying from asthma. This is not inevitable or acceptable. Clearly Hakeem's mother should have provided much better care for his serious condition. Now, asthma sufferers should have an Individual Asthma Action Plan which is reviewed annually by an experienced clinician.

With the benefit of hindsight, the extent of Hakeem's neglect was there to be seen well before the decision to place him on a Child Protection Plan two days before his death. It is horrendous that Hakeem's unhappiness and fear of repeated asthma attacks, some of which required hospital admissions, and the marked reduction in his attendance and performance at school, did not trigger more effective intervention.

In particular, the school did not escalate their concerns effectively; there was a lack of join-up across Health Service organisations and ineffective discharge planning for his asthma; the Drugs Agency didn't sufficiently focus on the impact on Hakeem of his mother's drug addiction; the GP did not recognise a need to share important information without consent because of the risk of significant harm; the Social Worker was trying to work positively with Hakeem's mother and prioritised an older teenage daughter and her baby, to the detriment of Hakeem; and the Police did not identify opportunities to properly consider the safety of children when responding to incidents within the home.

All professionals found the mother challenging and difficult to engage and some were intimidated by her behaviour. Following the conclusion of the criminal proceedings, the mother contributed to the

review and reflected, “Hakeem should never have been left with me”. However, that was not her stance at the time, when agencies were supporting the family. The authoritative partnership practice required to enable Hakeem’s needs to be properly seen and his voice heard was sadly lacking. The assessment that should have identified the positive role his father had played before going to prison did not take place.

Many themes identified in this review reinforce national learning from case reviews:

- the need to hear the voice of the child and understand their lived experience 24/7;
- the need to give due attention to heritage, identity and extended family;
- the need to respond to changes and performance in school;
- the imperative to share information where protection is in doubt and not to rely on parental consent;
- the value of professionals coming together to gain a full picture of relevant factors.

In this case, the key factors were mother’s drug dependency linked with serious economic hardship, poor housing and personal consequences, competing concerns for other vulnerable family members. There was one other factor that finally proved fatal, and that was ASTHMA. This is a life-threatening, chronic condition, and when accompanied by the other factors listed above, it proved deadly.

In the intervening five years since Hakeem’s death in 2017, a lot has changed. All agencies acted quickly to improve their own practice and embed emerging learning from the review, whilst finalisation of the review and publication was delayed until the outcome of the criminal proceedings. There have also been significant developments and improvements in services for children and families in Birmingham, with the Police, NHS and Local Authority now having equal statutory leadership responsibility for the multi-agency safeguarding arrangement through the Birmingham Safeguarding Children Partnership. There has been a major restructuring of how health services are commissioned and provided through the new Birmingham Integrated Care Board, the merger of the probation services and the formation of Birmingham Children’s Trust in 2018. Health discharge planning has been overhauled. Experienced clinicians review and update children’s Individual Asthma Action Plans each year. Child Protection Conferences are scheduled to enable urgent immediate action, if necessary. Change Grow Live (CGL) drug treatment services are more mindful of the needs of children. This summer the city’s refreshed Childhood Neglect Strategy will be launched at the Safeguarding Practitioners’ Conference in September 2022.

We cannot guarantee that no child will suffer neglect, nor die from asthma; we can assure everyone that learning from Hakeem’s death has contributed to positive and lasting improvements in partnership working for the protection of children. It is our ambition that Birmingham should be a child-friendly city where all children flourish.

Penny Thompson CBE
Independent Chair
Birmingham Safeguarding Children Partnership

Note to editors

The purpose of an SCR is to establish whether any lessons can be learnt by professional services to help ensure children are better protected in future.

The SCR is published on the Partnership's website (lscpbirmingham.org.uk/serious-cases). A copy can be downloaded from the table on the webpage (Case Reference BSCB2017-18/03). A copy has been forwarded to the National Case Review Repository hosted by the NSPCC.

Birmingham Women's and Children's NHS Foundation Trust have produced a short YouTube film 'Managing Asthma in Children' which provides advice for parents on caring for children with Asthma. This will be released to coincide with publication of the SCR and can be accessed via the following link; Managing Asthma in Children - YouTube

If you are concerned about a child living in Birmingham, please ring Birmingham Children's Trust's Children's Advice and Support Service on 0121 303 1888.