Publication of the Serious Case Review into the tragic death of Khyra Ishaq

Date: Tuesday 27th July 2010

Time: 11.00

Location: Press Conference at Room 139, Aston Business Conference Centre in the Aston Business School Building at Aston University - access via Aston Street if walking, Woodcock Street if driving (as road works on Aston Street).

Details: The Birmingham Safeguarding Children Board (BSCB) today publishes the Serious Case Review (SCR) report into the death of Khyra Ishaq. The extent of the abuse inflicted by Khyra’s mother and her partner shocked the local community and the organisations involved with the family.

After discussion with the Education Minister’s office and careful consideration by all the partners of the Safeguarding Board for Birmingham we decided that there were compelling reasons to publish as full a version of the report as possible, and not solely the Executive Summary. Personal details and specific information relating to other children and family members of this case has been removed.

Hilary Thompson, who took over as the Independent Chair of the Birmingham Safeguarding Board in January 2010, said: “It is with great sadness that we today publish this report into the death of Khyra Ishaq, whose life was so tragically cut short. Those who were ultimately responsible for this crime have now been held to account, but the professionals who came into contact with Khyra and her family accept that they could have done more to unearth what was happening and protect her.”

Khyra Ishaq died on 17th May 2008. A Serious Case Review was commenced on 23rd May 2008. SCRs are not inquiries into how a child dies or who is to blame. These are matters for the Coroner’s and criminal courts. Khyra’s mother and her partner have been convicted for manslaughter.

The purpose of the SCR is to establish the lessons to be learnt by professional services and help ensure children are better protected in the future. The BSCB has a statutory responsibility to collectively hold agencies to account for the effectiveness of the child protection arrangements across the city. Where management or practice has fallen

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below expected standards, organisations are required to take appropriate remedial action.

The SCR concludes that although the scale of the abuse inflicted would have been hard to predict, Khyra's death was preventable. The report identifies missed opportunities, highlighting that better assessment and information sharing by key organisations could have resulted in a different outcome. The findings concurred with the judgements made in the care proceedings, that the death of Khyra was ultimately the responsibility of the mother and partner, but added “had there been an adequate assessment it could have been prevented”.

The confrontational attitude and resistance of Khyra’s mother to engage with the authorities impacted on decision-making and professionals appeared unclear about their safeguarding responsibilities, particularly in a context of home education. The report identifies a major safeguarding flaw in home education legislation which places greater emphasis on parental choice than the protection and welfare of children.

During 2008 an independent author from the National Society for the Prevention of Cruelty to Children was appointed to oversee a panel of experts drawn together to review the case. All agencies that had significant involvement with Khyra and her family were required to submit an analysis of the quality of service they provided. Evidence was gathered from 11 organisations including those providing education and health services to Khyra and her family.

The completion of the SCR was delayed as a result of needing to await the outcome of the criminal proceedings so that information which came to light through the trial could be taken into account in the final SCR. There was significant detail in this case and new information about the mother and her partner.

Although it has not been possible to publish the SCR before now, since May 2008 the BSCB has been responsible for ensuring that agencies take prompt action on the emerging recommendations from the draft reports and individual agency reports.

Today, the BSCB publishes the Serious Case Review Report and the complete Action Plan of recommendations for all agencies. The majority of the recommendations have now been fully implemented and where this has not been possible, significant progress has been made.

Some information has been removed to protect the identity of family members and in particular to protect the children of this family.

The Chair of the Safeguarding Board said: “Khyra died, but her siblings suffer every time there is extensive media coverage. We need to think about them and the Minister has been clear that I need to take their care into account.”

The report identifies key learning that will impact on all organisations delivering services for children in Birmingham and makes 18 recommendations with specific action required across the Primary Care Trusts, Birmingham City Council, West Midlands Police, the Safeguarding Board itself and the Birmingham Children’s Trust. A further 52 areas for improvement were identified following individual reviews by a wide range of safeguarding organisations delivering safeguarding services in Birmingham.
The 18 main recommendations focus on a number of key issues:

- Making sure that professionals delivering services to children communicate more effectively with each other to safeguard children
- Ensuring better systems are in place for the delivery of school health services and the monitoring of school weight and height checks
- Ensuring that the Police are not used as a substitute for comprehensive multi-agency safeguarding procedures
- Ensuring that effective assessment processes are in place where a child is referred to Children’s Social Care Services
- The provision of training and guidance for professionals working with challenging and aggressive parents and carers
- That the Secretary of State for the Department for Education reviews home education legislation to incorporate safeguarding responsibilities
- Ensuring that GP’s are aware of their responsibility to communicate safeguarding concerns arising from their interaction with children and their families
- Ensuring that the Education Otherwise Service (home education) demonstrates a prioritisation of the safeguarding of children educated at home
- Ensuring that social care staff receive appropriate support and supervision of their practice
- Calling upon the Children’s Trust partnership to initiate a public awareness campaign to enhance the understanding of how communities can contribute to the safeguarding of vulnerable children.

Hilary Thompson added: “This report identifies the key lessons that organisations need to act upon. Considerable work has been undertaken in the last two years since Khyra’s death and the Birmingham Safeguarding Board requires agencies to continue to demonstrate that improvements are now in place. A recent OFSTED and Care Quality Commission (NHS) inspection still found safeguarding services inadequate but with significant improvements and I am determined to hold agencies to account for sustaining improvement.

We, as a Board, can never be complacent and SCRs show that vigilance and a strong ethic of working together needs to be in place in which agencies feel better able to challenge each other. Serious Case Reviews are very work intensive. They are not the whole story. Out of this tragedy, which has so profoundly affected everyone in the city, comes a greater awareness that safeguarding children is everyone’s responsibility. In order for agencies to act, we need people to have confidence in reporting and what action will be taken.
Notes to Editors

- The BSCB reviews the death of all children that die in the city through its Child Death Overview Panel
- During the last year (April 2009 – end of March 2010) there were 194 child deaths from all causes.
- A Serious Case Review will only be commissioned where abuse or neglect is suspected when a child dies or is seriously injured and on average this happens six times a year
- Current national guidance requires all local safeguarding children boards to publish, as from those SCRs commissioned from 10th June 2010, a redacted version of the full SCR with consideration to the needs of the family, the key recommendations and an action plan in a such a way that the anonymity of the family and professionals involved is protected
- Recommendations that emerge from SCRs impact on a wide range of organisations that deliver services to children
- The SCR into Khyra Ishaq’s death was also informed by details that emerged from the Family Care Proceedings and criminal trial into Khyra’s death
- The Government publishes a bi-annual review of all SCRs completed nationally. The information helps to identify national trends and themes which shape safeguarding policy development and enables lessons learnt from such tragic cases to be disseminated more widely.

ENDS

For further information contact;
Birmingham City Council press office 0121 303 3287 who are assisting the Birmingham Safeguarding Children Board in co-ordinating and responding to media enquiries in relation to this case.

or

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