Daniel Pelka Serious Case Review

Notes by Fiona Nicholson September 2013
http://edyourself.org/pelka.pdf

Recommendations

The SCR's recommendations for social care include: Review of domestic violence notification systems to ensure they are generate effective outcomes Strategy meetings to accurately record actions for individual agencies to undertake and be distributed in a timely fashion. Where medical opinion is inconclusive then assessments should still focus on child protection concerns until there is conclusive evidence to the contrary. A quality audit of newly commenced core assessments undertaken to determine if the inadequacy of assessments are systemic. A quality audit tool to be used by team managers supervising staff undertaking initial and core assessments. A review of the overall current workload of the referral and assessment service should take place headed by a senior manager.

http://www.communitycare.co.uk/articles/17/09/2013/119496/four-social-care-assessments-missed-risks-to-daniel-pelka-finds-serious-case-review.htm?cmpid=NLC|SC|SCDDB-20130917

Serious Case Review Coventry Safeguarding Children Board

http://www.coventrylscb.org.uk/dpelka.html

Summary

School staff talked to professionals about their concerns without ever making a formal child protection referral. The midwife didn't make a formal child protection referral. The school didn't know about the many domestic abuse incidents of the mother being assaulted which had been reported to the police before Daniel started school. The school didn't link up the separate facts of Daniel being underweight, trying to get food, and appearing at school with injuries. Incidents were viewed individually and there was no one person who was co-ordinating the concerns and identifying a clear pattern of risk. The children didn't speak about their home life and didn't present as neglected. The mother was not viewed as unco-operative, neglectful or harmful. Social services assessments did not lead to intervention. (3 out of 4 assessments were for domestic violence and substance abuse, not specifically to do with Daniel, and the 4th turned into alcohol misuse inquiry, even though impetus was Daniel's being taken to hospital with arm fracture.)

Quote from SCR:

"Daniel's mother and stepfather set out to deliberately harm him and to mislead and deceive professionals about what they were doing. They also involved Daniel's sister Anna in their web of lies and primed her to explain his injuries as accidental. A pattern of domestic abuse and violence, alongside excessive alcohol use by Ms Luczak and her male partners, continued for much of the period of time from November 2006 onwards, and despite interventions by the Police and Children's Social Care, this pattern of behaviour changed little, with the child protection risks to the children in this volatile household not fully perceived or identified. Missed opportunities to protect Daniel and potentially uncover the abuse he was suffering occurred:- at the time of his broken arm in January 2011, which was too readily accepted by professionals as accidentally caused, when the school began to see a pattern of injuries and marks on Daniel during the four months prior to his death, and these were not acted upon, and at the paediatric appointment in February 2012 when Daniel's weight loss was not recognised, and child abuse was not considered as a likely differential diagnosis for Daniel's presenting problems.

Social Services Assessments and Decision Making

Initial Assessment commenced April 2008 – The finding was that the parents had acknowledged the domestic violence and had implemented strategies to address this – case closed.
Initial Assessment commenced January 2009 – The finding was no further action as Ms Luczak said she

could protect the children.
Core Assessment commenced November 2009 - The finding was that the male partner (Mr Pelka) had left the home and the children were safe in Ms Luczak's care – case closed.
Core Assessment commenced January 2011 - The finding was as alcohol misuse was no longer thought to be an issue, that the domestic abuse would also cease and that there was a positive interaction between mother and children – case closed.

School

The school sought the help of a teacher from a neighbouring school who could speak Polish. Daniel was unable to use this opportunity - three days before he died - to explain what was happening to him. "The circumstances may not have been conducive, but in some way it seemed to reflect the complete helplessness that he was no doubt experiencing."

Concerns about Daniel's health and welfare emanated from the school in the autumn of 2011 although these were **not** linked to the backdrop of domestic abuse within the home because they were generally unaware of these. No school staff member chose to request the school to make a referral to CLYP about possible neglect.

There was no effective coordination between the school and the school nursing service who were both attempting to respond to Daniel's behaviours in separate ways when they could have been more effective if they collaborated and shared each other's concerns.

The school noted injuries on Daniel which had not been caused by any accidents in the school. There were two books in which to record concerns about a child. One of the injuries was recorded in the book for the reception class but none were recorded in the school book for this purpose. It was therefore apparent that the school did not have clear protocols to enable the compilation of information and concerns. This meant that there was lack of clarity about when exactly injuries were seen, how many there were, and of the response to them. Within the criminal trial, school staff gave conflicting accounts, particularly about the occasions when the head teacher was informed (who also had the role of designated safeguarding lead).

Despite considerable individual concerns by school staff, these were not developed into a coherent child protection. The reasons why they did not do so appeared to have reflected a disorganised response to injuries witnessed, meaning that no records were made, incidents were viewed individually, and there was no person who was coordinating the concerns and identifying that a clear pattern of risk was potentially emerging.

The system within the school to respond to safeguarding concerns was therefore dysfunctional at this time. The schools own safeguarding and child protection policy does not make it clear what the internal arrangements were for reporting and recording concerns. There was also the backdrop of the school's apparent view that Daniel had a medical problem, which coincided with a lack of enquiry or consideration that neglect or abuse at home were possible factors in his life.

An additional explanation may well be that the situation was influenced by the small size of the school, which may have relied on staff talking with each other fairly regularly about the concerns that they had, but this may have led staff members into a false sense of security that they were doing more than they actually were.

The school nurse made a false assumption that Daniel's weight and growth had been taken by a colleague.

Children Didn't Talk About Problems/Mother Didn't Seem Unco-operative/Children Didn't Seem Neglected

Neither child spoke of their home situation and did not convey concerns about home life. The children did not fit the image of neglected children – they had packed lunches at school and when visits were made to the home there were no concerns about the conditions and tidiness within the home. The mother was erroneously considered as presenting as concerned and committed to understanding Daniel's problems so she was not viewed as being difficult to engage or was avoiding the appointment.

Social Services

No follow-on interventions occurred after assessments when there often remained a need for further more specialist work to be undertaken. Generally the quality of the assessments reflect the findings from Serious Case Reviews nationally which identified that; “poor quality assessments which overlooked some information, did not take account of everything that was available or did not balance the information appropriately when assessing risks and making decisions”. Additionally there was a clear tendency in these assessments to respond to each situation individually, rather than “assessing the whole context or looking at the cumulative effect of a series of incidents or pieces of information”

Education Welfare Service/CAF

There was just one occasion (January 2012) when there was consideration by the education welfare officer and learning mentor for the need for a Common Assessment Framework (CAF), but the decision not to proceed with this was primarily because the school were at the time in liaison with the GP about their concerns for Daniel and had later written a “to whom it may concern” letter in respect of their concerns which the paediatrician had seen. In fact a CAF could have been considered at earlier stages of concerns, potentially by the school, but there was no evidence that this was considered. Planning opportunities were therefore missed by the school at the lower level because of the failure to complete a CAF at an earlier stage.

Health

The GP remained a passive recipient of information and concern. Hospital made a referral to social services when Daniel was brought to A&E with a broken arm in January 2011. It was decided it could be accidental, so social services focused on domestic abuse which they believed had now ceased, so the case was closed in May 2011.

On another occasion hospital midwife wished to make a referral to CLYP following the birth of a younger sibling. There were considerable concerns at this time and the midwife had appropriately accessed information about the pattern of domestic abuse and was now concerned for the welfare of the mother and the safety of the children, including the new baby. Despite a detailed discussion with the social worker, the midwife was advised not to make a formal referral but was told that the information would be logged for future reference. This was inappropriate advice in the circumstances – the midwife had the professional responsibility to make a formal referral if she considered this necessary. The lack of a formal referral meant that the concerns were able to be downgraded by CLYP which would not procedurally require a response from them. In fact they held no record of this contact.

There were also occasions when assumptions were made by some professionals about the actions or views of others without checking them out. For example when the health professional was told on an occasion when she was expressing concern, that CLYP had closed the case, the assumption was made that there were no child protection concerns, and no purposeful action followed from her.

The community health service experienced considerable difficulties during a period of organisational change and with health visitor caseloads considerably higher than the national recommended level, it could be seen why health visitors found it difficult to meet the needs of this family. The apparent good care of the other children appeared to give a false reassurance that Daniel’s problems were not related to abuse.

It appeared as though the health visitor was in effect deferring her responsibilities to that of the social worker in not making independent contact with the family because the social worker was.

Family In Different Area

In other respects in relation to the period of time that the family spent in Warwickshire, there did appear to be some ineffective communication once the family had returned. For example a MARAC was held whilst the family were in Warwickshire although the health visitor seemed to be the only professional in Coventry who was aware that it had taken place. At times the deputy head was leading on the management of the concerns, especially regarding those about Daniel’s cravings for food and his loss of weight, whereas it was the

designated person (in this case the head teacher) who would have had the more detailed child protection training.

Immigration Status

Due to both adult's immigrant status and the fact that Ms Luczak had not worked for a year in England, the family were not entitled to key state benefits, such as housing benefit or free school meals for the children. It was therefore clear that the family were going to struggle to maintain a basic level of existence although professionals seemed not to appreciate the pressures that this could bring upon a family.

When the family were about to be evicted, which was not the first occasion, the only advice given by the social worker was to contact Citizens Advice Bureau rather than to provide more proactive assistance at the time. Generally a more supportive stance could have been taken by professionals to identify the extent of the welfare concerns and more importantly to understand and be more sensitive to the cultural background of the family, as a way of identifying the most appropriate way to provide assistance and support as well as identify possible risks to the children.

Professionals failed to understand to what extent pressures that Ms Luczak's immigrant status may have had upon her ability to parent effectively or upon her attachment to her children. Nevertheless it may well have been a factor.

Cause of Death

Daniel did not die of malnutrition; he was significantly but not dangerously underweight at the time of his paediatric appointment three weeks before his death. He died of an inflicted head injury. Had he survived or not suffered the head injury, he would not have been at immediate risk of death by starvation although there would have been time to address these concerns.

Systems Analysis

No one professional, with what they knew of Daniel's circumstances, suspected or could have predicted that he would be killed. There seemed to be reliance upon the belief that having an agreed formal process or system in place in itself protected children, whereas it was the successful and consistent application of these processes by involved practitioners which was sometimes found wanting in these circumstances. There were also some occasions when professionals made assumptions about the actions of others without checking these out, and in doing so may have misjudged levels of risk to the children at that time and downplayed their own part in working with the family.