



### **Extraordinary Meeting of the City Council**

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**Time and Date**

2.00 pm on Thursday, 10th October, 2013

**Place**

Council Chamber, Council House, Coventry

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**Public Business**

1. **Apologies**
2. **Declarations of Interest**

**Item for Consideration**

3. **Serious Case Review Report into the Death of Daniel Pelka** (Pages 3 - 104)  
Report of the Executive Director, People

**Private Business**

Nil

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Chris West, Executive Director, Resources, Council House Coventry

Wednesday, 2 October 2013

Note: The person to contact about the agenda and documents for this meeting is Carolyn Sinclair/Suzanne Bennett 024 7683 3166/3072

Membership: Councillors F Abbott, N Akhtar, M Ali, A Andrews, M Auluck, S Bains, L Bigham, J Blundell, K Caan, D Chater, J Clifford, G Crookes (Chair), G Duggins, C Fletcher, K Foster, D Galliers, D Gannon, A Gingell, M Hammon, L Harvard, P Hetheron, D Howells, J Innes, L Kelly, D Kershaw, T Khan, A Khan, R Lakha, R Lancaster, J Lepoidevin, A Lucas, K Maton, J McNicholas, C Miks, K Mulhall, J Mutton, M Mutton, H Noonan (Deputy Chair), J O'Boyle, E Ruane, R Sandy, T Sawdon, H S Sehmi, B Singh, D Skinner, T Skipper, H Sweet, K Taylor, R Thay, S Thomas, P Townshend, S Walsh, D Welsh and A Williams

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**Carolyn Sinclair/Suzanne Bennett**

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## Public report

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**Extraordinary Meeting of the City Council**

**10 October 2013**

**Name of Cabinet Member:**

Leader of the Council – Cllr Ann Lucas

**Director Approving Submission of the report:**

Executive Director, People

**Ward(s) affected:**

All

**Title:**

***Serious Case Review Report into the Death of Daniel Pelka***

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**Is this a key decision?**

No

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**Executive Summary:**

This report presents the findings of a Coventry Local Safeguarding Children Board Serious Case Review relating to the case of Daniel Pelka.

**Recommendations:**

Council is recommended:-

1. To note the contents of the report and to give consideration to any further recommendations it may wish to make
2. To receive a 6 monthly update report from Education and Children's Services Scrutiny Board (2) on delivery against the multi-agency action plan agreed through the independent Local Safeguarding Children Board

**List of Appendices included:**

1. Serious Case Review report
2. Minutes of Education and Children's Services Scrutiny Board meeting – 26 September 2013

**Other useful background papers:**

None

**Has it been or will it be considered by Scrutiny?**

Yes – Education & Children’s Scrutiny Board – 26 September 2013

**Has it been or will it be considered by any other Council Committee, Advisory Panel or other body?**

Yes the report was considered by the Coventry Safeguarding Children Board during September and released by them for publication on 17 September 2013

## **Report title: Serious Case Review report into the death of Daniel Pelka**

### **1. Context and background**

Daniel Pelka was murdered in March 2012 by his mother and stepfather.

In line with statutory guidance applicable at the time of Daniels death Coventry Safeguarding Children's Board conducted a serious case review (SCR) into the involvement of organisations and professionals in the lives of the child and family. A serious case review is always held when a child has died and abuse or neglect is known or suspected to have been a factor in the death. The purposes of this serious case review reflected the relevant government guidance at the time to: -

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- Improve intra and inter-agency working to better safeguard and promote the welfare of children.

Following the conviction of his mother and stepfather in July 2013, the Daniel Pelka SCR report was published on Tuesday 17<sup>th</sup> September 2013. To ensure impartiality and objectivity the report author, Chair of the SCR Panel and educational advisor to the SCR were all fully independent of Coventry organisations. In addition, the Chair of the Board and Chair of the standing SCR sub-committee are also independent of the Council and its partners.

The publication has raised significant public and media interest, both nationally and locally.

At its meeting on 26 September 2013 Education and Children's Services Scrutiny Board (2) considered the SCR report and enabled responses to a number of questions and representations being made from representatives of the Local Safeguarding Children Board (LSCB) and senior officers within the Council. The minutes of meeting of the Scrutiny Board are attached for consideration and will be formally ratified at its next meeting. The Scrutiny Board made a specific recommendation that Council give consideration to any further recommendations that it may wish to make.

### **2. Recommendations from the Serious Case Review**

The 76 page report made 15 recommendations to local partners, covering domestic abuse, referral and assessment processes, training of staff, practice in schools and health as well as the requirement to disseminate messages to the Children's Workforce. These recommendations are copied below (taken from pages 74 – 76 of the SCR report at Appendix 1)

#### ***Domestic Abuse***

*16.1 There must be a review of the systems which currently exist for the notification and sharing of information in respect of domestic abuse incidents within families to ensure that they generate effective outcomes in relation to the safeguarding of children. The review should particularly focus on:*

- the timeliness of notifications,*
- the agency to which they should be distributed, including schools,*
- the importance of a focus on the needs and safety of the children,*

- the efficiency and effectiveness of the joint screening processes and the responsibility for agreed outcomes, and
- how repeat domestic abuse incidents need to be responded to more holistically.

16.2 In order for the LSCB to understand and identify how to improve the multi-agency response to domestic abuse notifications, particularly in respect of the safeguarding of children, then an audit process must be developed to judge how individual agencies respond to notifications which they receive, and as a result, what changes are needed to improve the ways in which agencies individually and collectively ensure that the protection needs of the children involved are being addressed by such responses.

16.3 The LSCB needs to demonstrate a clear cohesive understanding of the scope of early help and prevention work to support children living with domestic abuse.

### **Referral and Assessment**

16.4 The LSCB will need to be assured by the provision of evidence that assessments undertaken by Children's Social Care appropriately involve and consult with other agencies and professionals in the completion of such assessments and do so in a timely manner.

16.5 The LSCB must be assured that Strategy Meetings/Discussions are being efficiently and accurately recorded with actions clearly identified for individual agencies or professionals to undertake, and that the record and listed actions are distributed to the relevant agencies in a timely fashion.

16.6 In instances within a Strategy Meeting/Discussion when medical opinion is inconclusive regarding whether an injury was accidentally or non-accidentally caused, then the follow up interventions with the family must continue to include the child protection concerns as factors and address them rigorously until any new information or assessment discounts them.

16.7 Children's Social Care need to assure the LSCB, via an audit of compliance, that effective processes are in place to ensure that there is appropriate and consistent feedback to professionals who make safeguarding referrals, of the work undertaken in response to those referrals.

### **Training**

16.8 The LSCB must consider the need to initiate multi agency training or generate professional development opportunities in respect of the detection and identification of severe emotional abuse and neglect in children and young people, and include the details from this case to enhance the learning. The training will need to provide clarity regarding the responses necessary to address such abuse.

16.9 The LSCB will need to review the adequacy of multi-agency and individual training in respect of domestic abuse and its impact upon children, and promote that such training in the future includes their role in any revised systems for joint screening of domestic abuse concerns.

16.10 The LSCB must review the adequacy of child protection training for school staff in terms of its sufficiency of provision, its take up and of its effectiveness in improving and developing child protection practice.

## **Schools**

- 16.11 *The LSCB must be assured by the Local Authority that education settings which are under their control, and assured by governing bodies for those schools which are not maintained by the Local Authority, have: -*
- *a robust system for recording any injuries or welfare concerns identified or noticed about a child by staff, and of necessary actions to address those concerns*
  - *and that the role and responsibilities of the designated professional for safeguarding are clearly understood and utilised effectively.*

*NB: An additional report prepared by the consultant utilised to consider the role of education in this case, will need to be provided to CLYP in order that they can more rigorously develop the learning in respect of safeguarding in schools.*

## **Health**

- 16.12 *The LSCB should monitor developments within the Coventry health visiting provision in ensuring its progressive delivery of the Healthy Child Programme in line with increased health visiting capacity. The Local Area Teams representatives of NHS England on the LSCB will need to ensure that the LSCB receive updates on the progress of such developments.*
- 16.13 *Paediatricians and other medical staff who are required to assess the welfare of children who present with unclear concerns, should always consider child abuse as a differential diagnosis as part of an holistic assessment of the child. The LSCB will need to be assured by the relevant health body that this practice has been consistently adopted.*

## **Issues of culture and language**

- 16.14 *The LSCB should develop a protocol which will help to ensure that individual agencies consistently utilise interpreter services with families who do not have English as a first language and especially in cases where there are concerns about the welfare of children. The protocol will need to stipulate that interpreters must be used to interview children alone or to enable them to understand their wishes and feelings, when they are the subject of safeguarding concerns.*

## **Overall learning**

- 16.15 *The lessons learned from this SCR and detailed in paragraphs 15.1 – 15.14 must be disseminated to relevant staff working with children throughout Coventry, and a process identified to ensure that these lessons have been learned and as far as possible be integrated into safeguarding practice. Particular opportunities should be afforded to those individual practitioners, managers and their teams who were directly involved with Daniel and his family, to consider the findings from this SCR in a learning environment, identifying how to use this as a supportive experience to develop and improve safeguarding practice of children in the future.*

*NB: Additionally the LSCB may wish to develop further actions or recommendations based on the analysis of practice in this case and which are deemed pertinent to Coventry.*

### **3. Timetable for implementing the recommendations**

The Local Safeguarding Children Board has been monitoring action plans stemming from the initial investigations following Daniel's death for some months. Now that the serious case review

is published with its recommendations the Board will continue to hold agencies to account for their progress with each recommendation.

The Education and Children's Services Scrutiny Board (2) will review progress reports at three and six months.

#### **4. Comments from Executive Director, Resources**

##### **4.1 Financial implications**

Specific financial implications will be established in response to any recommendations agreed.

##### **4.2 Legal implications**

Regulation 5 of the Local Safeguarding Boards Regulations 2006 sets out that one of the functions of a Local Safeguarding Board is to undertake reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

For the purposes of the regulations, and the statutory guidance at the time of Daniel's death, a serious case review includes where abuse or neglect of a child is known or suspected and the child had died.

The Council's Constitution provides that Scrutiny Boards are able to review any matter they consider relevant to their work area and to make recommendations to the Council as they see fit.

#### **5. Other implications**

##### **5.1 How will this contribute to achievement of the Council's key objectives / corporate priorities (corporate plan/scorecard) / organisational blueprint / Local Area Agreement (or Coventry Sustainable Community Strategy)?**

The implementation of the recommendations from this serious case review by all the agencies involved will contribute to the Council's objective of ensuring that children and young people are safe.

##### **5.2 How is risk being managed?**

The Local Safeguarding Board is responsible for ensuring agencies implement the recommendations which are pertinent to them. Risk will increase if recommendations are not implemented effectively.

##### **5.3 What is the impact on the organisation?**

The specific organisational impacts will be established as the recommendations of the review are progressed.

##### **5.4 Equalities / EIA**

The learning from this serious case review includes specific arrangements to ensure vulnerable children are protected.

##### **5.5 Implications for (or impact on) the environment**



None

## 5.6 Implications for partner organisations?

A number of partner agencies have recommendations for them included within the Serious Case review. Partner organisations will be working alongside the Council as part of the Coventry Safeguarding Board to implement appropriate recommendations and to hold each other to account for the implementation.

### Report author:

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<b>Contributors:</b>				
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Adrian West	Asst Director Scrutiny & Transformation	Resources	30 September 2013	1 October, 2013
Julie Newman	Children & Adults Legal Services Manager	Resources	1 October 2013	1 October 2013
<b>Names of approvers for submission: (officers and members)</b>				
Finance: Chris West	Executive Director	Resources	30 September 2013	1 October, 2013
Legal: Christine Forde	Asst Director Legal Services	Resources	30 September 2013	1 October, 2013
Director: Brian Walsh	Executive Director	People	30 September 2013	1 October, 2013
Chief Executive: Martin Reeves	Chief Executive		30 September 2013	1 October, 2013
Members: Councillor Ann Lucas	Leader of the Council		1 October 2013	1 October, 2013

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[www.coventry.gov.uk/councilmeetings](http://www.coventry.gov.uk/councilmeetings)

**Appendices**

Appendix 1 – Serious Case Review report

Appendix 2 – Minutes of Education & Children’s Scrutiny Board (2), 26 September 2013



# Coventry Safeguarding Children Board

## **Serious Case Review**

*Re Daniel Pelka*

*Born 15<sup>th</sup> July 2007*

*Died 3<sup>rd</sup> March 2012*

## **Overview Report**

Independent Serious Case Review Panel Chair – Dr Neil Fraser

Independent Overview Report Author – Ron Lock

**September 2013 – Final Publication Copy**

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## 1. Introduction

- 1.1** This Serious Case Review (SCR) was commissioned following the death of Daniel Pelka, the middle child of a family who had migrated to this country in 2005 from Poland and who lived in Coventry for most of the time that they resided in the UK. Daniel was 4 years 8 months old at the time of his death on the 3<sup>rd</sup> March 2012, and he had an older sibling, who will be referred to as Anna in this report, and a younger sibling, who will be referred to as Adam, who were aged approximately 7 years and 1 year respectively at the time of their brother's death. (Please note their names have been changed to protect their identity and the gender used in this report may not accurately reflect their actual gender). At that time the family comprised of the children's mother, Ms Magdalena Luczak, and the father of Adam, Mr Mariusz Krezolek.
- 1.2** The circumstances of Daniel's death suggested that he had been suffering abuse and neglect over a prolonged period of time. He was found to be malnourished at the time of his death and also had an acute subdural haematoma<sup>1</sup> to the right side of his head, as well as other bruises on his body. Subsequent pathological examination also identified older mild subdural haematoma of several months or years duration. Ms Luczak and Mr Krezolek were charged with murder, and evidence presented at their criminal trial gave details of the neglect and physical abuse that Daniel suffered and that he had for periods of time been locked in a sparsely furnished room in the home as a form of punishment. The adults were found guilty of these charges on 31<sup>st</sup> July 2013.
- 1.3** If "abuse or neglect is known or suspected to be a factor in the death" of a child, this requires that the Local Safeguarding Children Board (LSCB) should "always conduct a SCR into the involvement of organisations and professionals in the lives of the children and the family"<sup>2</sup>, and therefore in response to this guidance, Coventry LSCB commissioned a SCR following Daniel's tragic death.
- 1.4** The purposes of this Serious Case Review reflected the relevant government guidance at the time to: -
- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
  - Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and

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<sup>1</sup> "A subdural haematoma is a collection of blood on the brain and are usually the result of a serious head injury. When one occurs in this way it is referred to as "acute" and is among the most serious of all head injuries. The bleeding fills the brain area very rapidly, compressing brain tissue. This often results in brain injury and may lead to death" National Library of Medicine – July 2012.

<sup>2</sup> Paragraph 8.9 – Working Together to Safeguard Children – A guide to inter agency working to safeguard and promote the welfare of children – Dept. for Children, Schools and Families – March 2010 (NB: This guidance was reissued in March 2013 after completion of much of this SCR although very similar criteria for conducting a SCR is included)

- Improve intra and inter-agency working to better safeguard and promote the welfare of children.<sup>3</sup>

**1.5** In order to undertake the SCR effectively and to ensure that the agencies in Coventry were able to individually and collectively learn any relevant lessons in respect of safeguarding children, each agency that had some direct involvement with Daniel and his family was required to undertake an Individual Management Review (IMR) to look openly and critically at its practice in relation to their involvement with the family. In undertaking this, each agency was also required to produce a chronology of its contact with the family. The managers/officers conducting the IMRs did not at the time immediately line-manage the practitioners involved and were not directly concerned with the services provided for the children or the family.

**1.6** Senior representatives from relevant organisations in Coventry were brought together to form a SCR Panel in order to review and analyse the material from the IMRs and other information presented to the panel. This took place over a number of meetings for a period of approximately six months. Because the criminal proceedings had not been completed by this time, it was not possible to finalise the SCR process or consider publication of the Overview Report at that time. Dr Neil Fraser, an experienced paediatrician from outside Coventry, was commissioned to be the independent chair of the SCR, and Ron Lock, an independent safeguarding consultant with extensive professional experience in safeguarding children and young people, was commissioned to detail the analysis and findings from this SCR and complete the Overview Report. (Short biographies are attached at Appendix 1)

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<sup>3</sup> Paragraph 8.5, Working Together to Safeguard Children – Dept. for Children, Schools and Families, March 2010

## **2. Brief Summary of the Case and Findings from the SCR**

- 2.1** Daniel was murdered by his mother and stepfather in March 2012. For a period of at least six months prior to this, he had been starved, assaulted, neglected and abused. His older sister Anna was expected to explain away his injuries as accidental. His mother and stepfather acted together to inflict pain and suffering on him and were convicted of murder in August 2013, both sentenced to 30 years' imprisonment.
- 2.2** Daniel's mother had relationships with 3 different partners whilst living in the UK. All of these relationships involved high consumption of alcohol and domestic abuse. The Police were called to the address on many occasions and in total there were 27 reported incidents of domestic abuse.
- 2.3** Daniel's arm was broken at the beginning of 2011 and abuse was suspected but the medical evidence was inconclusive. A social worker carried out an assessment but no continuing need for intervention was identified.
- 2.4** In September 2011, Daniel commenced school. He spoke very little English and was generally seen as isolated though he was well behaved and joined in activities. As his time in school progressed, he began to present as always being hungry and took food at every opportunity, sometimes scavenging in bins. His mother was spoken to but told staff that he had health problems. As Daniel grew thinner his teachers became increasingly worried and along with the school nurse, help was sought from the GP and the community paediatrician.
- 2.5** Daniel also came to school with bruises and unexplained marks on him. Whilst these injuries were seen by different school staff members, these were not recorded nor were they linked to Daniel's concerning behaviours regarding food. No onward referrals were made in respect of these injuries. At times, Daniel's school attendance was poor and an education welfare officer was involved.
- 2.6** Daniel was seen in February 2012 by a community paediatrician, but his behaviours regarding food and low weight were linked to a likely medical condition. The potential for emotional abuse or neglect as possible causes was not considered when the circumstances required it. The paediatrician was unaware of the physical injuries that the school had witnessed.
- 2.7** Three weeks after the paediatric assessment Daniel died following a head injury. He was thin and gaunt. Overall, there had been a rapid deterioration in his circumstances and physical state during the last 6 months of his life.

## Findings

- 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.
- At times, Daniel appeared to have been "invisible" as a needy child against the backdrop of his mother's controlling behaviour. His poor language skills and isolated situation meant that there was often a lack of a child focus to interventions by professionals.
- In this case, professionals needed to "think the unthinkable" and to believe and act upon what they saw in front of them, rather than accept parental versions of what was happening at home without robust challenge. Much of the detail which emerged from later witness statements and the criminal trial about the level of abuse which Daniel suffered was completely unknown to the professionals who were in contact with the family at the time.
- A number of critical, significant lessons have been identified by this SCR, which are detailed later, and it is now of utmost importance that they are translated into action by front line professionals and adopted for inclusion within relevant child protection processes and systems and as part of the support and supervision that these professionals require in their day to day work with vulnerable children.



### **3. The Serious Case Review (SCR) Process**

#### **3.1 Time Period**

The time period covered for this SCR was from the earliest contacts with the family in 2005, which was the year in which members of the family arrived in the UK from Poland, until the death of Daniel in early March 2012.

#### **3.2 Agencies required to provide Individual Management Reviews (IMRs)**

- Coventry and Warwickshire NHS Partnership Trust
- University Hospitals Coventry and Warwickshire NHS Trust
- Coventry City Council - Children, Learning and Young People Directorate (CLYP)
- NHS Coventry/NHS Warwickshire
- West Midlands Police

Additional information was provided to the SCR Panel by the Community Services Directorate of Coventry City Council, Bedworth Children's Social Care, Warwickshire, and the Staffordshire and West Midlands Probation Trust.

#### **3.3 The Serious Case Review Panel**

Dr Neil Fraser – Paediatrician and Independent Chair

- Interim Business Manager – Coventry Safeguarding Children Board
- Senior Manager SEN, Education and Learning – CLYP - Coventry
- Head of Safeguarding – Children's Safeguarding Service - Coventry
- Named Dr, Child Protection, UHCW (University Hospital Coventry & Warwickshire NHS Trust)
- NSPCC Manager & Chair of Coventry LSCB Serious Case Review Sub Committee
- Detective Chief Inspector – Public Protection Unit, West Midlands Police
- Head of Service, Social Work and Family Intervention - CLYP, Coventry City Council

#### Also in Attendance

- Ron Lock – Independent Overview Report Author
- Legal Officer, Coventry City Council - Legal Advisor to the LSCB and to the SCR Panel.

#### **3.4 Independence**

**3.4.1** All authors of the IMRs were independent of the services delivered to the family and the details of their independence were clarified in each of the IMRs.

**3.4.2** Dr Neil Fraser provided the role of independent chair of the SCR Panel and had no previous knowledge or direct involvement with the family who were subject to the review. He was also able to provide specialist contributions to the analysis of paediatric assessment in this case.

**3.4.3** The overview report writer was independent of all professional agencies in Coventry and had no previous involvement in a professional capacity with safeguarding practice in the West Midlands. His background as an independent safeguarding consultant has included involvement in numerous SCRs either as author or chair.

**3.4.4** There was some additional independence via a consultant who specialised in primary education and safeguarding, who provided additional analysis of this aspect of professional intervention for consideration by the overview author.

### **3.5 Specific Issues for the SCR to consider.**

The following were provided as guidance to IMR authors for their analysis of professional practice:

a) Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?

b) When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services?  
Was this information recorded?

c) Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?

d) What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?

Specifically:

- To what extent did the concerns about domestic abuse, neglect and health inform the assessments, planning and decision making and how were the concerns dealt with
- What was known about the adults and was there any evidence to suggest that they might pose a risk to the children

e) Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?

Specifically:

- The quality of assessment and decision making and how that was recorded
- The quality and relevance of any service provided

f) Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?

Specifically:

- The quality of cross border communication and liaison between agencies

g) Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?

h) Were senior managers or other organisations and professionals involved at points in the case where they should have been?

i) Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?

- j) Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resource issues such as vacant posts or staff on sick leave have an impact on the case?
- k) Was there sufficient management accountability for decision making?
- l) The Impact of housing mobility on the welfare of the children
- m) Did the family's migrant status have an impact on the child/children or on the parents' capacities to meet their needs?
- n) Specific considerations around ethnicity, religion, diversity or equalities issues.

### **3.6 Methodology/Process**

**3.6.1** Due to the timing of the SCR, it primarily utilised the process for undertaking SCRs which existed at that time (i.e. prior to March 2013). This meant that a multi-agency chronology of professional involvement with the family and the IMRs formed the main foundation for the understanding of what transpired with the work with this family and to develop the analysis of professional practice. Additionally because of pending criminal proceedings it was not appropriate to fully engage staff who had direct involvement with Daniel, as part of the analysis of the case, other than via their individual contributions to their respective IMRs. Throughout this process, whilst individual practice was analysed, this was undertaken with a focus on the systems and processes which underpinned and directed such interventions, in order to gain a better understanding of how lessons can be effectively learned in the future.

**3.6.2** All of the IMRs were fully scrutinised by the SCR panel, with each agency presenting their reports to the panel. Revisions were required as new information and analysis emerged. All of the IMRs ultimately completed a set of recommendations for the development of future practice for their own organisation, based upon what was learned by the critical analysis of their own organisational and individual practice in this case.

**3.6.3** An independent health specialist from outside Coventry produced a Health Overview report which reflected an analysis of the collective practice of the different health agencies and health professionals involved in the family. This proved extremely useful to the Overview Author's understanding of the medical issues in this case.

### **3.7 Parallel processes**

**3.7.1** Care proceedings were instigated in respect of the two siblings following Daniel's death, and updates were provided to the SCR panel of the progress in respect of these. The care proceedings did not adversely impact on the work of the SCR panel in terms of the collection and collation of information. These two siblings remained in local authority care for the duration of the SCR process and continue to do so.

**3.7.2** Criminal investigations were on-going during the period of the SCR in respect of Ms Luczak and Mr Krezolek, who were both responsible for the children at the time of Daniel's death. The criminal investigations did not in any way compromise the work of the SCR panel, and updates were received by the panel of any progress in relation to the investigations and of the likely trial date.

**3.7.3** The SCR process was finalised prior to the completion of the criminal trial, although it was recognised that evidence presented to these criminal court proceedings revealed additional information about the care of the children which had been unknown to professionals involved with the family at the time they were working with them. Both the independent chair of the SCR Panel and the independent author were given sight of the written evidence and statements taken after Daniel's death which were to be used in the care proceedings in respect of Daniel's siblings, and in the criminal proceedings. Much of this was completely new information to the SCR panel, and where relevant, this evidence has been included in this Overview Report, with the intention of giving a clearer picture of what the life of these children was like within their home. Furthermore, verbal evidence from involved professionals at the criminal proceedings gave additional information about incidents of concern and actions taken, and these have also been included, where relevant, in order to give as full a picture as possible of professional views and actions in respect of Daniel.

### **3.8 Involvement of the family in the process**

**3.8.1** Given that the mother and step father (Ms Luczak and Mr Krezolek) were subject to criminal proceedings, and whilst approaches were made to the Crown Prosecution Service via the Police representative on the SCR panel about the potential for them to contribute to the SCR process, this was not ultimately considered appropriate as it was thought that to do so could potentially compromise the criminal proceedings. Both were however informed by letter that the SCR was being undertaken.

**3.8.2** The SCR Panel have considered that Ms Luczak and Mr Krezolek could be contacted following the completion of the criminal proceedings, so they could add their own insight and experiences about professional interventions which they received. However, to do so would fall outside of the timeframe for the SCR. Nevertheless if it was felt to be appropriate for Coventry LSCB to arrange contact with them in order to obtain their contributions, and in turn potentially gain some useful insight into the way in which they related to the range of professionals that they came into contact with, then this could potentially be arranged. If this is undertaken, an addendum would need to be added to this Overview Report.

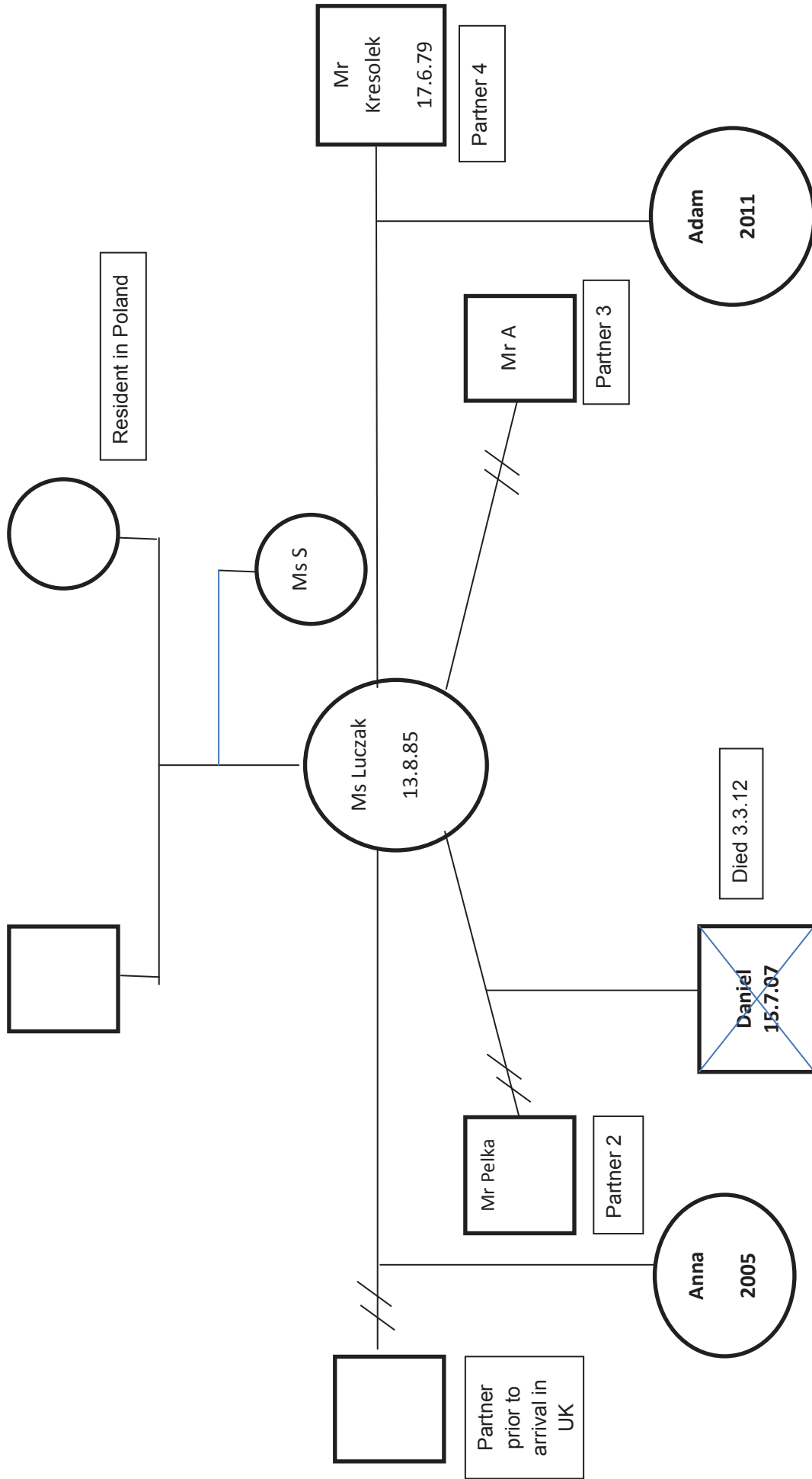
**3.8.3** In respect of contact being made with the eldest child in the family, (Anna), as she was to be a likely witness in the criminal trial, it was considered not appropriate to do so at the time that the SCR was being conducted, in the knowledge that it would likely compromise the criminal proceedings. Similar arrangements could be applied in respect of her potential contribution after the criminal trial, although clearly in terms of Anna, it would need to be judged to be in her best interests to do so. Anna did in fact give evidence in the

criminal trial and the details of her evidence have been viewed and where appropriate, reference has been made to some of this evidence within the body of the report.

**3.8.4** Mr Pelka, the father of Daniel was interviewed following his evidence in the criminal trial, and he was able to provide some insight into family life at the time he lived with them for approximately three years between 2005 and 2008. Where relevant, his contributions have been included within the body of the Report. Although Ms Luczak's sister, who lived locally and had a reasonably regular involvement with the family gave evidence in the criminal trial, she had very limited contact with professional agencies about any incidents or concerns, and it was therefore considered that she would not be able to add any understanding about the effectiveness of professional interventions with Daniel and his family. Detail of this sister's evidence in the criminal trial has however been viewed and where appropriate reference has been made to some of this evidence within the Report, as it has given some context about the relationship between Ms Luczak and Mr Krezolek.

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Genogram



#### 4. Factual Information

- 4.1** It was Daniel's father, Mr Pelka who brought the family to the UK from Poland, their native country, **at the end of 2005** and he remained with the family until the end of 2008, by which time Anna was approximately 3 ½ years old and Daniel was just over a year old. A second male then lived in the home **from late 2008 until mid-2010**, (referred to as Mr A) and then Ms Luczak's third male partner (Mr Krezolek) moved into the family home shortly after. He became the father of Adam who was born just over a year later. Mr Krezolek was resident in the home at the time of Daniel's death, and was therefore subject to the criminal charges along with Ms Luczak.
- 4.2** All adult family members, including the different male partners, are of Polish nationality, moving to the UK as adults. The family are thought to be Catholic. None of the family had English as their first language.
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- 4.3** Ms Luczak first registered with a GP in Coventry in **March 2006**. The first reported incident of domestic abuse incident took place in **November 2006** between Ms Luczak and Mr Pelka. Ms Luczak was said to have threatened Mr Pelka with a knife after an altercation with him. Mr Pelka accepted a caution for the offence from the Police. Both adults were intoxicated and Ms Luczak was said to be pregnant with Mr Pelka's child. Anna was said to be upstairs asleep at the time of the domestic abuse incident. On this occasion Ms Luczak said that she intended to return to Poland. The respective domestic abuse notification was received by the health visitor on the **8<sup>th</sup> December 2006** – It was not noted to have been received by Children's Social Care until **13<sup>th</sup> March 2007**. *(NB: In Coventry, Children's Social Care is known as the Children, Learning and Young People Directorate (CLYP) and will be referred to as this within the remainder of this report)* When Ms Luczak attended her booking-in appointment on the **7<sup>th</sup> March 2007**, Ms Luczak denied any alcohol use during pregnancy. Mr Pelka translated for her on this occasion.
- 4.4** Daniel was born on **15<sup>th</sup> July 2007** and a new birth visit was made by the health visitor on the **1<sup>st</sup> August 2007** when Daniel was seen along with his older sister. As a result, the family were offered services at the Care Pathway 2 level<sup>4</sup>. It was Anna who attended a local walk in centre with Ms Luczak on the **15<sup>th</sup> August 2007** with a viral infection –it was noted that she had a lump behind her ear, said to have been caused by a fall on the previous day. Anna was 2 years 3 months old at the time. Daniel was seen for his eight week assessment on the **31<sup>st</sup> August 2007** with no concerns reported. The family moved home on the **6<sup>th</sup> September 2007** but remained in the Coventry area.
- 4.5** There was a domestic abuse incident on the **16<sup>th</sup> December 2007** when Ms Luczak and Mr Pelka were found to be drunk and fighting. They were said to have drunk two bottles of vodka. There was reference to Ms Luczak threatening her partner with a knife, although both were released without charge. Anna and Daniel were reported to be present but they

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<sup>4</sup> A service above the Universal Care Health Programme – it would provide follow up contact, with referrals to the nursery nurse or other health professionals as appropriate

were not witnesses. They were left in the care of the maternal aunt. The Police informed CLYP of the incident and the health visitor recorded that notification of the incident was received by her on the **17<sup>th</sup> January 2008**.

- 4.6** A further incident occurred which the Police attended on the **26<sup>th</sup> December 2007** which consisted of arguments and threats made between Ms Luczak and Mr Pelka – both parents were reported as intoxicated at the time.
- 4.7** **On the 9<sup>th</sup> January 2008**, Ms Luczak attended the A&E Dept. accompanied by the Police – she was intoxicated and said that she had taken an overdose because her relationship with Mr Pelka had broken up. She had also jumped in front of the ambulance. She said she had no money, job or support, though when she had sobered up she said that she had good social support and that the children were well looked after. The children were with Mr Pelka at the time of the incident. The hospital did not consider that there was a need to alert CLYP but decided to inform the health visitor.
- 4.8** Ms Luczak and Mr Pelka were reported as being drunk and arguing in the street on the **13<sup>th</sup> January 2008**. The Police attended and Ms Luczak refused to go home, leaving the two children in the care of Mr Pelka. A “safe and well check”<sup>5</sup> by the police reported no concerns in respect of their care at this time. On the **29<sup>th</sup> January 2008** a multi-agency domestic abuse Joint Screening meeting<sup>6</sup> was convened which considered the previous incidents and Ms Luczak’s recent suicide attempt, resulting in the decision that an Initial Assessment be conducted by CLYP. There was no record of this decision in CLYP records or of an Initial Assessment being undertaken at this time.
- 4.9** A further incident took place on **the 1<sup>st</sup> March 2008** when both Ms Luczak and Mr Pelka called the Police to say that the other had assaulted them. Mr Pelka was arrested but Ms Luczak refused to support a prosecution. The Police undertook a “safe and well check” of the children who were said to be asleep upstairs – they were left in the care of Ms Luczak.
- 4.10** Daniel was taken to A&E on the **31<sup>st</sup> March 2008** with a minor laceration over his right eye. The history given was that Ms Luczak was changing Daniel’s nappy on her lap when he rolled off and hit his head on the corner of a table. Daniel was 8 months old at this time. No concerns were raised about the incident although the health visitor was notified. The family again moved home at about this time within the Coventry area.
- 4.11** **On the 6<sup>th</sup> April 2008**, Ms Luczak contacted the Police and claimed that Mr Pelka had Daniel and was refusing to give him back to her. The Police reported Ms Luczak to be drunk and uncooperative whilst Mr Pelka was sober and calm. The children were described as safe and well at this time. The Police reported the matter to CLYP on **24<sup>th</sup> April 2008**, who then undertook an Initial Assessment. The assessment concluded that “the parents have acknowledged that a continued pattern of domestic abuse would present a significant risk of

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<sup>5</sup> This is to simply check whether the children are present and that they have been seen and are in reasonable health and are safe – it does not consist of any additional form of detailed assessment of the children’s condition.

<sup>6</sup> The purposes of these meetings, established in Coventry in 2006, was to jointly screen domestic abuse referrals between the key agencies of police, CLYP and health services in order to share information, discuss the children involved, and review the family history. Instances are graded 1-4 as to their seriousness.



harm to the children”, and that the parents had “implemented strategies to minimise this risk”. The case was then closed by CLYP on **21<sup>st</sup> May 2008**

- 4.12** The family once again moved house on the **28<sup>th</sup> May 2008**. In **June 2008** Anna failed to attend her arranged three year developmental assessment.
- 4.13** The Police were called to the family home on the **17<sup>th</sup> August 2008** following a phone call from Ms Luczak screaming that she needed the Police. On arrival, Ms Luczak was found to be extremely intoxicated whereas Mr Pelka was sober, calm and compliant. As no offences were identified, no further action was taken. Information about this incident was received by the health visitor approximately **three weeks later**.
- 4.14** Ms Luczak was taken to A&E Dept. on **1<sup>st</sup> September 2008** by two people who did not know her, but she said she had taken an overdose of tablets along with alcohol – she was assessed by A&E as suicidal and that she needed to be admitted. According to the hospital records, the doctor contacted CLYP by phone regarding concerns about the children at home, and they agreed to undertake a visit. A multi-agency referral form was completed and sent off to CLYP. Ms Luczak later took her discharge in the company of a male. There is no corresponding record by CLYP of their involvement and response to this incident.
- 4.15** There was a Joint Screening meeting on the **15<sup>th</sup> September 2008** in respect of domestic abuse – there was no discussion of the outcome of the previous initial assessment undertaken by CLYP. Although the outcome of the meeting was recorded as “to contact and monitor” the case, in practice this did not require any specific action, other than for the different agencies to be alert to the circumstances of the family and to make links with any subsequent incidents.
- 4.16** Following Ms Luczak’s attendance at the midwife booking clinic on the **9<sup>th</sup> November 2008** as being twelve weeks pregnant and it was recorded on the GP record that the health visitor was notified and had referred the matter to CLYP. The main reason for the referral was the lack of money in the household and a pending eviction with the history of domestic abuse noted. There was no corresponding record in CLYP files of this referral being made.
- 4.17** **On the 19<sup>th</sup> November 2008**, Mr Pelka (who had now separated from Ms Luczak) reported to the Police that Ms Luczak had arrived at his home with the children because she had been arguing with her new partner (Mr A) who had been drinking heavily and had smashed up the home. Ms Luczak said that she was going to stay with Mr Pelka and find her own accommodation. The Police took no further action as the property was owned by Mr A.
- 4.18** There was a domestic abuse incident on the **24<sup>th</sup> November 2008** when Ms Luczak and Mr A were reported as engaged in significant violence towards each other and that they were drunk. Ms Luczak was reported as holding Daniel when the Police arrived. The Police record did not make any reference to the circumstances of Daniel or of his older sister, Anna. Mr A was arrested on suspicion of assault although he claimed that Ms Luczak had assaulted him. CLYP were informed of the incident and the health visitor received notification of the incident on the **9<sup>th</sup> December 2008**. Between the **13<sup>th</sup> and 17<sup>th</sup> December 2008** there were some instances of drunkenness and arguing at the family home reported to the Police, although no further action was taken in respect of these.

- 4.19** On the **7<sup>th</sup> January 2009** neighbours of Ms Luczak reported to the Police that there was a disorder at the home with Ms Luczak crying and the children crying. On attendance by the Police, Ms Luczak claimed that she was receiving nuisance calls from Mr A and that he had tried to force his way into her home with a knife. He was found in the garden carrying a knife. Mr A was arrested and charged with offences relevant to the incident, for which he was later found guilty.
- 4.20** There were two incidents on **11<sup>th</sup> and 17<sup>th</sup> January 2009** reported to the Police in respect of adults being drunk at the family home, with Ms Luczak drunk on both occasions. No onward referrals were made in respect of these instances. There was a Joint Screening discussion on the **16<sup>th</sup> January 2009** primarily because of the incident on the 7<sup>th</sup> January - there was no recorded outcome.
- 4.21** Following discussions at a team meeting, the health visitor made a referral to CLYP on **the 22<sup>nd</sup> January 2009** following the most recent domestic abuse incident (In November '08). As a consequence, a social worker undertook a home visit on the **29<sup>th</sup> January 2009** in order to undertake an assessment. It appears that it was an Initial Assessment which was undertaken, the outcome of which was that no further action would be taken as it was considered that Ms Luczak could protect the children. Although it was intended that the family would receive support from the Family Support Service as a follow up, there was no record that this was provided or sought by the family.
- 4.22** The family had another house move on the **12<sup>th</sup> February 2009** although it was recorded that Ms Luczak told the Police at this time that she had rent arrears of £1,300.
- 4.23** Mr A was convicted on the **16<sup>th</sup> February 2009** with being in the possession of a bladed article (in relation to the incident of the 7<sup>th</sup> January 2009) when he pleaded guilty, although over the ensuing months, he constantly breached his community order sentence of 120 hours unpaid work. The Probation assessment of Mr A described him as posing a medium risk to his ex-partner and highlighted the potential risk to children due to the environment of domestic abuse.
- 4.24** There was another incident of Ms Luczak being reported to the Police as being intoxicated on the **8<sup>th</sup> March 2009** and that she had been assaulted by her “ex-partner”. Ms Luczak however refused to cooperate with the Police and no action was taken. The children were noted as “safe and showed no signs of distress whatsoever”. The matter was referred by the Police to CLYP. On the **25<sup>th</sup> March 2009**, a Joint Screening process of domestic abuse referrals took place between the Police and CLYP when four incidents were noted to have taken place in the last year, with the last noted as being the 7<sup>th</sup> January 2009. The agreement from the meeting was that a Strategy Meeting<sup>7</sup> would be held and that this was the responsibility of CLYP. In fact no Strategy Meeting took place for a further six months.
- 4.25** Ms Luczak had a miscarriage on the **23<sup>rd</sup> April 2009**

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<sup>7</sup> This is a formal meeting set up to consider whether a recent incident or set of concerns about a child will warrant a child protection investigation being undertaken under Section 47 of the Children Act 1989. As a minimum the meeting (or sometimes a telephone discussion) will be held between the Police and Children's Social Care (in this case CLYP). Health professionals are also sometimes involved, depending on the circumstances being discussed.

- 4.26** On the **9<sup>th</sup> May 2009**, Ms Luczak reported a verbal altercation with Mr A and that he was beating her – Ms Luczak was uncooperative and made no allegations when the Police arrived. This occurred during the early hours of the morning - both children were said to be present at the time.
- 4.27** Over the **1<sup>st</sup> and 2<sup>nd</sup> June 2009**, fighting was reported between the adults in the house – Ms Luczak’s sister called the Police saying that there had been too much drinking in the house and the children were crying. Police officers did see Ms Luczak but no offences were reported.
- 4.28** Following continuing breaches of his community order, Mr A was re-sentenced for his original offence on **23<sup>rd</sup> July 2009** and alongside a suspended prison sentence and further unpaid work, a curfew of 8 p.m. – 8 a.m. was imposed for 13 weeks. This curfew was made to the address of Ms Luczak.
- 4.29** Further domestic abuse incidents took place on the **27<sup>th</sup> July 2009** when two calls were made by a woman screaming. On arrival by the Police, Mr A, who was still her current partner, had left, and Ms Luczak said that he had been drinking all day and had been abusive towards her but that she had not been assaulted. The confrontation had been witnessed by the children but she said that they had not been harmed. Although the police officers could smell alcohol on Ms Luczak’s breath, she said that she had not been drinking. It was noted that Mr A had been “tagged” as part of his sentence for the 7<sup>th</sup> January incident when he was charged with possession of a knife. A breach of conditions was reported to the tagging company.
- 4.30** **On the following day** Ms Luczak called the Police to detail a further incident of Mr A returning to the home and smashing a window. When seen, Ms Luczak was noted by the Police to have a minor facial bruise said to be caused by being punched the previous day, (although this had not been noticed by attending police officers on the previous day). A complaint of assault was recorded. The police officers saw the children who they said presented as “quite lively” and that they “seemed to be well”. Because Ms Luczak said that she was fearful of Mr A, the police officers took Ms Luczak and the children to stay with her sister. The Police referred the incident to CLYP and the health visitor. Ms Luczak would not later cooperate with a prosecution of Mr A and when he later denied the allegations, he was released without being charged. From a Police perspective, the situation was raised from a medium to a high risk.
- 4.31** Whilst there was a Joint Screening meeting on **the 14<sup>th</sup> August 2009**, the last incident discussed was that relating to the 8<sup>th</sup> March 2009. The Police records noted that agreement had previously been reached about the need for a Strategy Meeting which had still not taken place. The police officer stated that she would insist on a Strategy Meeting. At about this time the offender manager from Probation working with Mr A, contacted CLYP in the knowledge of recent domestic abuse incidents, but was told that although the family were known, the case had been closed and there were no concerns.
- 4.32** There was a further domestic abuse incident on the **18<sup>th</sup> September 2009** when Ms Luczak and Mr A each alleged that they had been assaulted by the other, and they were both arrested for assault. Ms Luczak was intoxicated at the time. She said that she was 11 weeks

pregnant and that she was losing the baby although the Police did not consider that she was telling the truth. She was seen at the hospital and had a negative pregnancy test. Ultimately neither adult wished to take the matter further. Whilst under arrest it was reported that Mr A's brother went to the home address to care for the children, who the police officers otherwise recorded as appearing "fine with no issues". An action by the Police was to refer Ms Luczak to the Police Watch scheme which would mean that uniformed officers from the neighbourhood teams were made aware of these incidents and asked to visit from time to time. A breach of Mr A's curfew was reported to Probation and Mr A explained that it had occurred because he was taken into Police custody overnight.

- 4.33** A social worker from CLYP undertook a visit to the family home on the **5<sup>th</sup> October 2009**, but a male answered the door saying that Ms Luczak and the children were not at home. A further Joint Screening meeting was held on the **12<sup>th</sup> October 2009** when it was noted that a Strategy Meeting was still outstanding. As a result, a Strategy Meeting was called on the **23rd October 2009** in response to the most recent incident, when the majority of the previous domestic abuse incidents were also discussed. The outcome was that CLYP would undertake a Core Assessment. On the **30<sup>th</sup> October 2009**, the offender manager (working with Mr A) made a second contact with CLYP and was told that the social worker was visiting the following week and would liaise back if there were any concerns.
- 4.34** A further domestic abuse incident took place on the **5<sup>th</sup> November 2009** (though Ms Luczak was not located until the following day) when she said that her "ex-partner" Mr A had called at her home whilst intoxicated but she would not let him in. The Core Assessment commenced on the **6<sup>th</sup> November 2009** and was concluded on the **8<sup>th</sup> December 2009**. Probation undertook an assessment review of Mr A on the **17<sup>th</sup> November 2009** and the offender manager was asked by his/her manager to follow up the outcome of the recent home visit by the CLYP social worker, although there was no record that this was done. Due to the belief that Mr A had now left the home, the CLYP Core Assessment concluded that the children were safe in Ms Luczak's care, and the case was then closed on the **7<sup>th</sup> January 2010**. It was on the **13<sup>th</sup> January 2010** that Mr A was further convicted of an offence which activated his suspended sentence, and he was sentenced to one month's imprisonment.
- 4.35** Ms Luczak and the children moved address within Coventry **between November 2009 and January 2010**, although the landlord of the new address reported that Ms Luczak had left and had taken some property and defaulted on the rent. **Between January and March 2010**, there were numerous occasions of Anna's low school attendance. There was a further house move to a new address outside the Coventry area in **March 2010** and Anna then changed school. The family also changed GP practice at about this time.
- 4.36** Warwickshire Police attended Ms Luczak's new home on **2<sup>nd</sup> March 2010** when she reported a domestic incident stating that Mr A had attended her home and made threats to her and she was afraid of what he might do. Mr A was later arrested but denied the allegations. The Police made a referral to the local Children's Social Care team, although they stated they would not be taking any action. A Multi Agency Risk Assessment Conference (MARAC)<sup>8</sup> was held in Warwickshire on the **25<sup>th</sup> March 2010** when it was recorded that Mr A had followed

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<sup>8</sup> A multi-agency forum to consider risk issues to vulnerable adults.

Ms Luczak to Nuneaton (from Coventry) and caused criminal damage to her car, and was known to carry weapons. The meeting reported that Ms Luczak was to pursue a non-molestation order and the health visitor was to offer support.

- 4.37** Ms Luczak reported further harassment and threats from Mr A on the **6<sup>th</sup> April 2010** and he was again arrested but ultimately released with insufficient evidence to proceed with any charges. The local Children's Social Care (Bedworth) acknowledged to the Police that an assessment would be undertaken.
- 4.38** Ms Luczak rang the Police for assistance on **2<sup>nd</sup> May 2010** in respect of a domestic incident with her new partner Mr Krezolek – children were heard crying in the background. Mr Krezolek was arrested for assault (for an injury to Ms Luczak's finger) although Ms Luczak refused to make a statement and he was released without charge. At the time of the incident Mr Krezolek was taken to a friend's house to avoid any further confrontation. As the children were present at the time, a referral was made to Children's Social Care in Bedworth. Ms Luczak attended the A&E Dept. **the next day** with a fracture of her finger due to it being trapped in a door frame when the door had been slammed during the incident on the previous day. These instances took place in Warwickshire.
- 4.39** The involvement of Children's Social Care in Bedworth, Warwickshire primarily consisted of unsuccessful attempts to locate the family at home although by the **1<sup>st</sup> June 2010**, the case was closed by them with no concerns having been identified. In **July 2010** Ms Luczak and the children returned to live in the Coventry area – Ms Luczak's partner was now Mr Krezolek.
- 4.40** The health visitor undertook a home visit on the **5<sup>th</sup> July 2010** when both children were seen. Daniel had a bruise to the side of his head, with the explanation given that he "fell over". Although he was reported by Ms Luczak to have been seen by a GP at this time, with no concerns noted, there was no corresponding record of this GP consultation. It was noted by the health visitor that Ms Luczak spoke little English. Input from the nursery nurse was to be arranged. Daniel's 3 year assessment was completed on the **20<sup>th</sup> July 2010** – it was noted that he could speak very little English. During both of the recent health visitor contacts, the issues of domestic abuse had been discussed with Ms Luczak.
- 4.41** Ms Luczak went to her GP on the **21<sup>st</sup> July 2010** when she confided that she was experiencing a "domestic problem" living with her boyfriend, and the GP diagnosed her as depressed and prescribed anti-depressants and to review in four weeks. It was noted in the records that she had two children. There was no record of a follow up appointment being made.
- 4.42** A domestic abuse incident occurred on the **8<sup>th</sup> August 2010** when knives were evident in an altercation between Ms Luczak and Mr Krezolek, resulting in Ms Luczak receiving a small cut from a knife and she described losing consciousness from a strangulation attempt. She said that Mr Krezolek was drunk at the time and that the children had witnessed the whole incident. There was no reference in the records to the Police checking the welfare of the two children, who were aged 5 years and 3 years old at this time. Following his arrest, Mr Krezolek was eventually returned to the home address with no charges being made against him. Ms Luczak was apparently happy for him to return as long as he slept separately. **On**

**the following morning** a police officer called to check that all was well – Mr Krezolek had gone to work and Ms Luczak said that it was arranged for him to stay at a friend’s house.

- 4.43** In addition to the domestic abuse allegations, Ms Luczak also claimed that Mr Krezolek had been using his computer to view indecent images of young teenage girls. Although the computer was seized, Ms Luczak later withdrew the allegations saying that the images only related to fully clothed children who were not engaged in any sexual acts, and so the investigation was not taken further and the computer was not examined. Ms Luczak had also alleged that Mr Krezolek had raped her “many times”, but he was not arrested or questioned in respect of these allegations. Ms Luczak in fact later refused to again discuss the rape allegations.
- 4.44** As part of the enquiries at this time, Mr Krezolek alleged that Ms Luczak could not “live without cannabis and amphetamine” although this concern was not formally recorded by Police and the information was not further shared.
- 4.45** Follow up telephone calls were made to Ms Luczak by the Police on the **10<sup>th</sup>, 14<sup>th</sup> and 18<sup>th</sup> August 2010** to check that all was well, and on the latter occasion she said that she had agreed for Mr Krezolek to return to the home. Ms Luczak attended A&E Dept. on the **21<sup>st</sup> August 2010** after being involved in a road traffic accident as a pedestrian – she was not badly hurt but the recording in the hospital notes read: “drinking +++”. A police officer visited on the **23<sup>rd</sup> August 2010** when both Ms Luczak and Mr Krezolek were present and Ms Luczak said that she did not want any further help from the Police – apparently a female friend was to stay in the home which it was thought (by Ms Luczak) “might help with the relationship”.
- 4.46** Anna commenced at a new school in **September 2010** and it was recorded that she settled in well and had made friends without any problem. Some attendance problems **during November and December 2010** gave the school some concerns.
- 4.47** Ms Luczak attended A&E Dept. on the **14<sup>th</sup> November 2010** with a lacerated arm which she claimed was caused by broken glass falling on her. There was a domestic abuse incident on the **27<sup>th</sup> December 2010** with both adults intoxicated and fighting, which had occurred in the presence of the children. A neighbour had reported the incident. The Police record however reported that the children were “none the wiser” and did not witness the incident. No referral was made to CLYP.
- 4.48** Daniel was taken to the A&E Dept. by Ms Luczak and Mr Krezolek on the **6<sup>th</sup> January 2011** where an examination revealed a spiral fracture of Daniel’s left arm. There was also multiple bruising to the arm as well as a small bruise on his left shoulder and a bruise on his lower stomach which Ms Luczak said was probably caused by a fall from his bicycle, which he was said to frequently do. During his examination, Daniel was noted to be interacting well with his mother and with Mr Krezolek. The explanation for the fracture to the arm was that he had been playing with his sister and had been jumping from the settee and had fallen onto the floor. This had happened the previous day and Ms Luczak said that it was not until the following morning that Daniel complained of a pain in his left arm. The medical examination noted that the fracture would have involved a significant twisting mechanism

and that the ‘swelling and pain would have been evident yesterday’. During his admission, Daniel’s weight was identified as 14.8.kg.

- 4.49** The hospital made a referral to CLYP and the reasons given to Ms Luczak was because the cause of the fracture was not clear and because of the delay in presentation. She was said to be upset but understood and was cooperative. CLYP informed the Police of the referral who then sent two officers to the hospital where they spoke to Daniel’s family and to medical staff. The officers then visited Anna who was at that time staying with a friend, and she confirmed the account of the cause of Daniel’s injury as given by her mother. Although Anna could speak quite good English, the friend of Ms Luczak was asked to help with translation. Anna said that she was happy in the care of her mother and Mr Krezolek, and did not want to disclose anything.
- 4.50** A strategy meeting took place on the **7<sup>th</sup> January 2011** and on this occasion the consultant paediatrician said that after further discussion with colleagues, the explanation for the fracture given by Ms Luczak and Mr Krezolek could be plausible. Whilst there was an acknowledgement that the injury to Daniel was therefore possibly of an accidental nature, there were concerns about the history of domestic abuse incidents, with the meeting referring to the most recent as in August and December 2010. The decision from the meeting was for an “in depth assessment” to be undertaken. CLYP were agreeable to completing a Core Assessment and for the outcomes to be fed back to all professionals. It was agreed that should any further concerns arise via the assessment then a further Strategy Meeting would be convened.
- 4.51** When Daniel returned to the hospital on the **17<sup>th</sup> January 2011** for manipulation of his arm under anaesthetic, his weight was recorded as 15.2 kg.
- 4.52** The Core Assessment was completed on the **23<sup>rd</sup> February 2011** and the case eventually closed by CLYP in **May 2011**. The assessment concluded that the domestic abuse between the couple was no longer an issue, as both adults had ceased drinking due to Ms Luczak’s current pregnancy with his child. It was considered that all of the domestic abuse in the past had been closely related to alcohol misuse. The assessment also noted that the family were about to be evicted due to rent arrears and that the couple were not entitled to housing benefit because of their status as EU nationals who had worked for less than a year. The couple were advised to seek advice from the Citizens Advice Bureau. The assessment noted a positive interaction between the children and their mother and with Mr Krezolek.
- 4.53** **On the 9<sup>th</sup> February 2011** Ms Luczak attended the ante natal clinic. At this initial appointment Ms Luczak said there was no alcohol or drug use and that her current partner (Mr Krezolek) was the father. This was assessed as a high risk pregnancy from a medical perspective, requiring consultant led care.
- 4.54** A Joint Screening meeting took place on the **16<sup>th</sup> February 2011** although there was no recorded outcome. On the **7<sup>th</sup> March 2011** the health visitor received three domestic notifications relating to incidents on the **6<sup>th</sup> November 2009**, **8<sup>th</sup> August 2010** and **29<sup>th</sup> December 2010**.

- 4.55** The family moved home again **during March 2011**. **On the 4<sup>th</sup> April 2011** Ms Luczak was seen at the antenatal clinic – she was now 19 weeks pregnant. She told the midwife and consultant obstetrician that her partner was putting her under emotional pressure to have a termination. Within the discussion Ms Luczak denied that there was any domestic abuse although it was made clear to her what to do if she did feel threatened. She was told that it was too late to have a termination. A letter was sent to the GP to explain that there were significant social issues at this time - the child protection midwife was copied into the letter.
- 4.56** On the **8<sup>th</sup> April 2011**, the school wrote to Ms Luczak because of concerns about Anna's attendance problems.
- 4.57** Ms Luczak attended the A&E Dept. on the **26<sup>th</sup> April 2011** and was assessed to have a severe urinary tract infection. She was urged to be admitted into hospital and informed of the danger to her health and the unborn baby if she did not receive in-patient treatment. Ms Luczak's social circumstances were noted to be "no money and no childcare" and that she had to be home due to her partner's job. Although offers were made to call her partner's workplace and to contact CLYP to get assistance, Ms Luczak still wanted to go home. She therefore took her own discharge, and further attempts were made **two days later** to get her to be admitted, but she still refused. The named midwife for safeguarding contacted the Police and gained the background history of domestic abuse, that the current partner has alcohol issues and a criminal record, and of the recent fracture sustained by Daniel. The Police explained that CLYP were undertaking a Core Assessment but when checked by the midwife, it was confirmed that the case was now closed to CLYP and she concluded that "therefore there were no on-going child protection concerns".
- 4.58** Ms Luczak was admitted to hospital on the **5<sup>th</sup> May 2011** with possible kidney stones and remained in hospital until the **10<sup>th</sup> May 2011**, during which time she developed a further infection which was a complication of the hospital antibiotic treatment. On the **10<sup>th</sup> May 2011**, Mr Krezolek was very angry on the ward and demanded that Ms Luczak be discharged, and pulled out the drip in her arm – eventually Ms Luczak took her own discharge on that day. Ms Luczak's care was then briefly transferred to another hospital and all the information about the recent admission was sent to the GP. The same community midwife however continued to remain involved during this time
- 4.59** Ms Luczak failed to attend four ante natal appointments **from June 2011** under the new hospital arrangements, and Ms Luczak's care was returned to the original local hospital on the **13<sup>th</sup> July 2011** following an admission into this hospital for a week from the **6<sup>th</sup> July 2011** because of threatened preterm labour. Ms Luczak again took her own discharge – while in hospital Ms Luczak was specifically asked about domestic abuse but she denied being a victim. It was not recorded who was caring for the two children during the hospital admissions.
- 4.60** **During late June and early July 2011**, there were four incidents of Anna receiving injuries whilst at school, three of them to the head, from falling over.
- 4.61** The community midwife made a home visit on the **13<sup>th</sup> July 2011** at Ms Luczak's request when she disclosed several incidents of domestic abuse towards her but saying that Mr Krezolek was never violent to the children. In particular she claimed that **two days earlier**



Mr Krezolek had tried to strangle her and had pulled her hair. However, she explained that the relationship was over and that she wanted help to get safe accommodation. The midwife gave her some contact details of organisations that could help and advised her to dial 999 in an emergency.

- 4.62** During a planned brief hospital admission on the **18<sup>th</sup> July 2011** Ms Luczak reported that she was still living with Mr Krezolek and that he was controlling but that she hoped he would be better when the baby arrives. Because of concerns for Ms Luczak's safety and that of the children, the named midwife (for safeguarding children) was contacted by the midwife, and safeguarding issues were discussed, with the outcome that if concerns remained then to seek permission from Ms Luczak to involve CLYP. The midwife was also to contact the Police to find out if there had been any recent domestic abuse incidents. It was noted that Ms Luczak's mother was staying at the family home and would be there until September – she had visited from Poland.
- 4.63** Baby Adam was born in **August 2011** and prior to the hospital discharge the midwife made contact with CLYP and spoke with the duty officer on the phone which entailed a long discussion about the family history and past concerns. The social worker advised the midwife not to complete a multi-agency referral as a lot of information had already been shared and that this would be recorded as a contact rather than a referral for action. The midwife had checked that Ms Luczak was happy to go home and this was agreed to be appropriate in the circumstances. It was considered that there were no child protection concerns at present and the social worker reported that the conversation had been recorded "in case anything escalated in the future". Ms Luczak was told of the conversation with the social worker before she was discharged home with Adam.. It is understood that this conversation was recorded on Adam's CLYP file only.
- 4.64** Daniel commenced the same school as Anna on the **14<sup>th</sup> September 2011** although for the following two months there were several occasions of both children arriving late for school as well as being absent for periods of being unwell. Anna also had two further minor accidents at school which were dealt with by school staff.
- 4.65** Evidence later presented for the care and criminal proceedings indicated that on **7<sup>th</sup> October 2011**, Mr Krezolek had told Ms Luczak via a text message to take Daniel to "the room" and to lock him in, saying that she would then get some peace and to wait for him to return home. This was the first reference to there being a specific room in the house (later referred to by Ms Luczak as the "junk room" or "box room")) which was used to put Daniel in, apparently as a punishment. The use of this room was not known to any professional working with the family and the full detail of its use and condition emerged from later evidence after Daniel's death. There was also a reference in this communication between Ms Luczak and Mr Krezolek that Daniel would not be given any food after school on that day.
- 4.66** The school nurse made a referral to the community paediatrician on the **12<sup>th</sup> October 2011** following a review of Daniel's health records in school and after a joint home visit between the school nurse and the school nursing support worker. It was explained by Ms Luczak that Daniel had aggressive behaviour towards her and had an excessive appetite and was a secretive eater, with speech and language delay and possible learning difficulty. Ms Luczak

also reported that Daniel had recently been soiling his bed and smearing faeces but that this had stopped since going to school, where she said he was happy. Daniel was not seen during this visit. The referral to the paediatrician included reference to the domestic abuse history as well as the concerns which were beginning to emerge within school about Daniel's apparent obsession with food. In the meantime, arrangements were agreed with Ms Luczak for the school nursing support worker to commence a package of interventions regarding behaviour management, although after two appointments on the **18<sup>th</sup> and 31<sup>st</sup> October 2011**, Ms Luczak disengaged from this service after several failed attempts to make contact.

- 4.67** It was on the **21<sup>st</sup> October 2011**, that there is the first reference to use of salt in the home when later evidence suggested that Ms Luczak had asked Mr Krezolek via a text, to buy salt "as a must" and that Daniel was very unwell on that day. It was not clear from this evidence what the intention was for the use of the salt and no link within this information that it was to be given to Daniel. **Two days later**, Mr Krezolek apparently communicated with Ms Luczak (via text) to ask her to remove Daniel's door handle so as Anna would not be able to open the door for him. (It was later found that the door handle to the box room had been removed so as the door could not be opened from in or outside, although the locking mechanism was later found in the adult's bedroom). This information was all gleaned from later evidence and so the continued use of a separate room for Daniel, and the fact that he may be being locked in, remained unknown to the professionals who were involved with the family at this time.
- 4.68** Whilst appointments were made for Daniel to be seen by the paediatrician on the **15<sup>th</sup> and 29<sup>th</sup> November 2011**, the first appointment was cancelled by Ms Luczak and she failed to attend the second. Later evidence to be presented for court proceedings indicated that Ms Luczak had told Mr Krezolek on the **15<sup>th</sup> November 2011** of her intention to cancel the appointment because Daniel was "even more ill than he was". At the time of cancelling the first appointment, Ms Luczak was reported to be able to speak English clearly and although an interpreter had been booked for the original appointment, Ms Luczak declined it for the next appointment which was made for the **20<sup>th</sup> December 2011**. However, Ms Luczak cancelled this on the day before it was due to take place; with the reason recorded as "mum cannot make it as child ill". Ms Luczak was offered further available dates and she chose an appointment in February.
- 4.69** During **November 2011**, the school made their concerns known to Ms Luczak about Daniel's continued obsession with food and that he was taking food from other children's lunch boxes. Whilst he was not stating he was hungry he was said to be always focussed on eating whatever he could obtain – regularly taking 4-5 pieces of fruit from the "fruit corner" in the classroom. Ms Luczak presented as concerned but said that he must not eat more than what was in his lunchbox.
- 4.70** The education welfare officer (EWO), accompanied by a translator, made a home visit in **mid-December 2011** when Ms Luczak said that the children were not well enough to go to school although the EWO considered that they were. Ms Luczak however refused to send them to school. At this time, a letter was sent to Ms Luczak by the school head teacher and the learning mentor regarding Daniel's attendance which was below 64%.

**4.71** **After Christmas 2011**, the deputy head teacher became concerned that Daniel was not growing and of his obsession with food, and as a result spoke with Ms Luczak on two occasions **from January 2012**, when Ms Luczak reported that Daniel was taking food at home and getting up in the night to raid the fridge. She reported that Daniel got diarrhoea as a result. Later evidence given in the criminal trial by school staff about Daniel **during January and February 2012** spoke of how Daniel “looked for food everywhere” and that he “would eat whatever he could get his hands on”. On one occasion he found and ate half of a large cake meant to be given to all the children as it was the teacher’s birthday. Despite his poor engagement with peers, he was nevertheless said to take or persuade other children to give him food and eat it in the toilets. On some occasions he had taken food from bins and had tried to eat discarded food. He also tried to eat beans being planted in soil and raw jelly taken from a sandpit. Daniel had a lunch box everyday which school staff said contained the bare minimum, and that he would always eat this.

**4.72** **Between December 2011 and February 2012** there were occasions when Daniel was seen at school with facial injuries. Because of a lack of appropriate recording of such injuries within the school, it is unclear what injuries were seen and when. From information given to the respective IMR author and from evidence given at the criminal trial, the injuries on Daniel were stated as follows:

- “approximately four spot bruises down the neck from the ear to the shoulder” - seen by the class teacher and recorded in the concerns book (for the reception class) **dated 16<sup>th</sup> January 2012**

- “fresh blue/black bruises on the eyes and a scratch across the nose” – seen by the class teacher sometime **before the 10<sup>th</sup> February 2012** and she stated that she told the head teacher. There was a description of a similar injury, although referred to as:

- “severe mark on his nose,(almost like a dent), a black eye and blood spots on his face” seen by one of the teaching assistants **“in January or February”** and that the head teacher had been told.

- “a bruise to the centre of the forehead” – seen by a teaching assistant though unsure if this was before or **after Christmas 2011**.

- Another teaching assistant referred to “a large bump on the left hand side of his forehead about the size of a 2p piece” and that she told the class teacher of this.

- “a graze to the top/front of his forehead” – seen by the head teacher who ascertained what had happened from Anna who said that her brother had been pushed over by another child outside of school. The head master thought that this had occurred two or three weeks prior to Daniel’s death (**i.e. mid-February 2012**). The head teacher had not recalled seeing any other injury.

**4.73** Daniel had been asked by one of the teaching assistants about how two of the injuries were caused, but he was reported not to give any explanation and just look down and would not say anything.

- 4.74** Because of lack of supporting evidence and some conflicting accounts given in the criminal trial about what injuries were seen and reported to the head teacher, it is difficult to provide a factual account of what injuries Daniel actually sustained – some of the explanations from different staff members may well refer to the same injury. Whilst there were references to “black eyes” being seen on Daniel, other members of the teaching staff reported having no recollection of seeing such injuries. None of these injuries were referred to CLYP or the Police.
- 4.75** **During January 2012** the learning mentor discussed the possibility, with the new EWO, of completing a Common Assessment Framework<sup>9</sup> although it was noted that the deputy school head teacher/Special Education Needs Coordinator (SENCO) was working closely with Ms Luczak in respect of Daniel and that this would be sufficient. Also because of improved school attendance for both Daniel and Anna, a letter of congratulations was sent to Ms Luczak on the **9<sup>th</sup> February 2012**.
- 4.76** Because of the concerns about Daniel’s eating habits and excessive appetite, the deputy head contacted the GP by telephone on the **25<sup>th</sup> January 2012** and the GP advised that she should ask Ms Luczak to bring Daniel into the surgery. The deputy head told Ms Luczak the next day that she needed to make an appointment and believed that Ms Luczak understood the need to do this.
- 4.77** Further evidence from personal texts emerged as part of the development of the later criminal and care proceedings, which indicated that in **late January 2012** Ms Luczak had told Anna to tell people who may ask, that Daniel ate more than her and that he was retarded. **A week later** there was further text communication from Ms Luczak to Mr Krezolek, firstly in relation to Mr Krezolek apparently earlier hitting Daniel on the hands and that this was still hurting him, but later that day in mid-morning, that Daniel was temporarily unconscious because Ms Luczak was saying that she had nearly drowned him, but that he was now in bed. A few minutes later, a further text from Ms Luczak said that she would not be hitting Daniel when he later wakes up but that he would be going back in the bath as she had not emptied it from earlier. Both children were logged at school as being sick on this day.
- 4.78** Although Ms Luczak attended the GP surgery on the **7<sup>th</sup> February 2012** for her own health issues, it was not recorded that Daniel was discussed. **On the next day** the class teacher and deputy head wrote a letter “to whom it may concern” which gave concerns about Daniel’s continual consumption of food and that the school had to manage this by locking food away. Concern was also expressed that he nevertheless appeared to be losing weight. The letter was given to Ms Luczak to take to her appointment with the community paediatrician.

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<sup>9</sup> “This framework for children and young people is a shared assessment tool used across agencies in England. It can help practitioners to develop a shared understanding of a child’s needs, so they can be met more effectively. It is an important tool for early intervention and is not for when a practitioner is concerned that a child may be harmed or may be at risk of harm” – The Common Assessment Framework: a Practitioners guide - 2006

- 4.79** The paediatric clinic appointment for Daniel took place on the **10<sup>th</sup> February 2012**, and the paediatrician was given the letter composed by the school – the paediatrician already had the referral from the school nurse. Daniel’s height and weight were taken by the clinic’s health care assistant before he was seen by the paediatrician. His weight was recorded as 13.8kg and his height as 101.9cm which was identified as being on the 9<sup>th</sup> centile.<sup>10</sup> The paediatrician took a detailed history from the mother that Daniel had an excessive appetite and non-stop hunger leading him to steal from lunch boxes and eat from roadside bins. He was also drinking lots of water/fluids and soiling almost every day. He had also smeared faeces over his bedroom. His relationship with his siblings and his peers was, according to his mother, poor with limited interaction and aggression towards his siblings. The paediatrician recorded that Daniel was “not pale” (although in the paediatrician’s evidence at the criminal trial he described Daniel’s skin as pale in colouration), and that there was “no wasting but looks thin”. In other respects Daniel had a normal physical examination with no presenting concerns. Daniel was examined undressed to his underpants and it was noted that he had wet himself at the beginning of the appointment. The paediatrician did not hear Daniel speak any recognisable words.
- 4.80** The outcome of the appointment was that the paediatrician requested further investigations because of Daniel’s excessive appetite and poor weight gain, writing that he was “growing along the 0.4<sup>th</sup> centile”. The paediatrician sought further opinion from a colleague by letter regarding whether Daniel might have difficulties along the autistic spectrum disorder. The referral letter identified that even if there was a medical cause to his slow weight gain that “his obsession with food and communication difficulties needs further assessment”. Tests taken showed that Daniel had a mildly elevated sodium (salt) level and so this test was repeated. Treatment was prescribed for medication because of the possibility of thread worms.
- 4.81** Test results received on the **16<sup>th</sup> February 2012** showed that Daniel was low on iron and zinc and that his sodium levels were normal but at the top end of the range. Following a second set of results being received on the **28<sup>th</sup> February 2012**, the paediatrician unsuccessfully attempted to contact Ms Luczak to explain the results, and so wrote to the GP on the **1<sup>st</sup> March 2012** to request that iron syrup, zinc tablets and vitamin drops be prescribed over the next six months.
- 4.82** The description by school staff in their evidence to the criminal trial of Daniel’s presentation was generally that he was losing weight, and looking pale, particularly **from January 2012 onwards**, and that his clothes were looking baggy on him. He was always however appropriately dressed in clean clothes. He was described as looking normal when he first started school but that his appearance was changing, with one teaching assistant saying that she was “very, very concerned” and that he had become a “bag of bones”.

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<sup>10</sup> If a child’s height is on the 9<sup>th</sup> centile, this means that for every 100 children of that age, 9 would be expected to be shorter and 91 taller. Similarly a weight between the 0.4<sup>th</sup> centile and 2<sup>nd</sup> centiles indicates that around 99% of children of the same age would be heavier than this.

- 4.83** Daniel attended school for the week **27<sup>th</sup> February to 1<sup>st</sup> March 2012** during which time the deputy head explained to the head teacher that Daniel had been prescribed treatment for worms but they agreed to convene a meeting to consider what further could be done. On the **1<sup>st</sup> March 2012**, Daniel was seen to take a piece of half eaten fruit from a bin, although he was prevented from eating it. On Friday the **2<sup>nd</sup> March 2012** Daniel was logged as having an unauthorised absence from school. The school made a telephone call to the home but there was no reply.
- 4.84** Evidence later emerged that the family’s computer at home had been used on the **2<sup>nd</sup> March 2012** to seek information on salt poisoning and of a child not responding. Later in the afternoon there was text communication from Ms Luczak to Mr Krezolek to say that “he’ll get over it” and that there was no point in calling an ambulance because it would “cause proper problems”.
- 4.85** At just after 3.00 a.m. on **Saturday the 3<sup>rd</sup> March 2012** a telephone call was made to the ambulance service and Daniel was admitted to hospital at 3.28 a.m. after having suffered a cardiac arrest and he could not be resuscitated. He was pronounced dead at 3.50 a.m.
- 4.86** There was no immediate consideration of whether the cause of death was suspicious in that the doctors trying to resuscitate Daniel did not immediately recognise that this might be the case. This could be understandable in the circumstances of a distressing resuscitation of a child, with the mother and her partner generating a very convincing picture of being distraught. The initial consideration was that Daniel had died of a previously undiagnosed medical issue. There was a Child Death Review rapid response<sup>11</sup> made to the home on the day of Daniel’s death although this did not immediately identify concerns. Although it would have been normal practice, the paediatrician, (not the same paediatrician who had recently seen Daniel), who did this visit with a police officer, was unable to see Daniel’s body prior to the visit to the home due to time constraints. The home visit did not entail a search of the property, as this was not the purpose of the rapid response process, and the ambulance service had not raised concerns about the home environment. This meant that Daniel’s siblings remained in the family home in the care of Ms Luczak and Mr Krezolek during the remainder of the weekend. Once the paediatrician had viewed Daniel’s body on **Monday 5<sup>th</sup> March**, then his state of emaciation and the bruising to his head raised the necessary concerns and an immediate referral was made to CLYP for a request for Daniel’s siblings to be removed from the home. A Strategy Meeting was convened later that day, following which CLYP gained the parent’s consent to place Anna and Adam into foster care pending further investigations into the cause of Daniel’s death.
- 4.87** At his post mortem on the **6<sup>th</sup> March 2012** Daniel’s weight was 10.7 kg (dehydrated weight) and subsequent investigations found that the cause of death was a head injury, “almost certainly the result of a direct blow to the head”. Daniel was also considered to be grossly

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<sup>11</sup> A process set up to ensure that there is a speedy response to a child’s death by representatives from health and the police visiting the family home in order to glean early information about the child’s death and of any relevant circumstances, and to provide advice and support to the child’s parents/carers. More precise arrangements to manage this process are currently being established within Coventry and Warwickshire.

malnourished and dehydrated with bruising over his body for which no natural cause could be identified. (A total of forty injuries were noted). Daniel also had a very high sodium level. The forensic pathologist concluded that these findings reflected longstanding neglect. The high levels of salt may have been a consequence of the severe head injury. It was found that none of the medication prescribed by the paediatrician three weeks earlier had been used – only one prescription had been obtained but not used whilst another had not been collected.

- 4.88** Ms Luczak and Mr Krezolek were charged with the murder of Daniel on the **9<sup>th</sup> March 2012** and their trial took place during **June and July 2013**.
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## 5. The Children's Experience

- 5.1** Clearly one of the main experiences of the children, especially Anna and Daniel, was in relation to a chaotic lifestyle, with many house moves, and numerous incidents of serious domestic abuse and violence within the home. The domestic abuse also related primarily to three different men, although to what extent the children formed any meaningful attachments to them was not known.
- 5.2** There were no domestic abuse incidents when specific concerns were raised about the care or direct involvement of the children at the time, even when they were said to have witnessed a particular argument or fight between the adults. As many of the incidents were alcohol related with their mother, the male partner, or both being intoxicated at the time, then this would no doubt have further added to the children's insecurity and lack of attention to their needs. In fact seeing their parents/carers out of control when intoxicated was probably a frightening experience. Furthermore "the emotional and psychological damage caused by inconsistency, rejection and verbal abuse that can be experienced by children with alcohol-misusing parents has been highlighted in various studies"<sup>12</sup>. There was no evidence that either child spoke to professionals about alcohol misuse at home and whilst this may have meant that they were not very affected by it, it may have been related to pressure they felt in terms of maintaining a level of secrecy and denial – a pattern of response not uncommon in children of substance misusing parents/carers. It may also have affected the development of friendships for either Daniel or Anna and enforced a degree of isolation in that "many children spoke of embarrassing incidents, involving encounters between friends and a parent under the influence of drink or drugs. Inviting friends home was often viewed as hazardous, due to anxieties about the state a parent may be in or the way that he or she may behave, combined with the importance of keeping the substance misuse a secret"<sup>13</sup>. However, whilst Anna appeared to have developed friendships, Daniel presented as a very isolated child.
- 5.3** Whilst on occasions the Police did "safe and well" checks on the children to determine they were physically safe, and when on one occasion after a significant domestic abuse incident, the Police reported that the children were "none the wiser", this could not have meant that the children were unaffected by the domestic abuse which they had consistently witnessed. According to a recent report<sup>14</sup> "Living with domestic abuse is an incredibly frightening experience for children which communicates that violence is normal, acceptable and an effective way of expressing emotions or resolving conflict." Research studies have demonstrated the impact of domestic abuse upon children and one refuge-based study identified that "as well as distress and fear, children revealed their resilience and coping strategies, for example when moving from home and school, with the consequent disruption

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<sup>12</sup> Parental Substance Misuse and Child Welfare – Kroll, B & Taylor, A - 2003 – Jessica Kingsley Publishers

<sup>13</sup> Parental Substance Misuse and Child Welfare – Kroll, B & Taylor, A - 2003 – Jessica Kingsley Publishers

<sup>14</sup> "Beyond Violence – breaking the cycle of Domestic abuse, Farmer, E and Calen, S – The Centre for Social Justice – July 2012



to their family and friendship networks”<sup>15</sup> To what extent the children developed coping strategies is not known, but it could account for them presenting as outwardly unaffected. Again, a recent national report<sup>16</sup> states that “Evidence suggests that it (domestic abuse) harms infants and preschool children the most, but the harmful effects are often only noticed during the teenage years”. What was clear was that these children lived in a climate of arguing, fighting and drunkenness.

- 5.4** No professional involved with the family understood with any sufficiency the impact which this chaotic household potentially had upon the children. In all there were twenty six separate incidents which required Police attendance up until December 2010. Two large studies of children’s experiences of domestic abuse in this country<sup>17</sup> identified that their experiences of the Police were often negative (except where their actions had resulted in safety), and of teachers and social workers variable. The studies found that adults such as their mothers, family members and adults living nearby were crucial sources of support – far more so than professionals. The frequent house moves and the different male partners would however have meant that there was little by way of consistent support for the children other than from their mother. Although her sister was evident on occasions as a support to Ms Luczak, this did not seem to provide any extra support for the children.
- 5.5** In effect despite Ms Luczak being in a very controlling relationship with her last partner Mr Krezolek, no domestic abuse allegations were reported to the Police by Ms Luczak after December 2010. Whilst this may have suggested that the children experienced a degree of respite from domestic abuse at this time, (and in fact there were no reported incidents for the time following Daniel commencing school in September 2011) nevertheless Ms Luczak did confide to the midwife that more domestic abuse incidents did in fact occur during 2011. Additionally in her later evidence during the court proceedings she alleged high levels of violence to her from Mr Krezolek which was corroborated by Anna in her evidence.
- 5.6** Anna appeared to settle into school quite well and made friends and presented no concerns other than in relation to her poor attendance. The lack of attendance appeared to be more related to her mother’s needs than to high levels of sickness, so in this way the one source of constancy in Anna’s life was compromised. Her school had a small number of other children of the same nationality, and she befriended one in particular. Anna gave no outward presentation of problems at home.
- 5.7** Of all of her family, Anna seemed to have managed the language difficulties the best, and was able to speak both her native language and English. She was helped by the use of an interpreter in school and by attendance in a small group of children of the same nationality. Anna’s language abilities were something of a double edged sword for her, in that on the one hand it helped her to integrate socially within school, but on the other she was often used as

<sup>15</sup> Reference to Hague et al 1996 and Mullender et al 1998, in “Domestic abuse and Child Protection – Directions for Good Practice” Humphreys, C & Stanley, N – 2006 Jessica Kingsley.

<sup>16</sup> “Beyond Violence – breaking the cycle of Domestic abuse, Farmer, E and Calen, S – The Centre for Social Justice – July 2012

<sup>17</sup> McGee, C (200) and Mullwender et al (2002), both which separately interviewed 54 children – both studies funded by the NSPCC.

an interpreter on behalf of her mother and brother, sometimes in a very adult way. For example on more than one occasion she was asked to confirm or explain the cause of an injury to Daniel, once by two police officers. Although outwardly she appeared to manage these events fairly well, they gave her an inappropriate level of responsibility for disclosing abuse within the home or holding on to family secrets. This was no doubt unfair and inappropriate as she was the only source of corroboration of injuries, but also very stressful and must have created issues of divided loyalty for her.

- 5.8** Daniel started school just two months after his fourth birthday and during his time in school was described as quite bright and on the odd occasion was described as a cheeky child although he was more normally described by school staff as withdrawn and solemn and that he had little interaction with other children. His main difficulty was his language in that he had less English than a 2 ½ year old. School staff appeared to have relied on Daniel's gesticulations as the main form of communication and when possible upon Anna and Daniel's mother to provide insights into what Daniel was saying or experiencing. Overall, this may have gone some way to explain that he was a lone child, often playing in isolation, and sometimes displaying very ritualistic behaviours, such as cutting paper into small pieces for long periods. However, there was some evidence that he was slowly progressing in his school subjects. Daniel was said to be very shy, though quite bright and never presented as being naughty or destructive in school although his mother talked of his behaviour problems and aggression at home. In this way, the school was potentially something of refuge for him which gave him some stability. No doubt having his sister in the school was helpful to him. In fact one member of school staff described Daniel as having a very strong bond with his sister with the comment given in the criminal court that the staff member "had never seen a sibling bond like it".
- 5.9** Very little was reported about the baby in the family, Adam, who was just 7 months old when Daniel died. Generally he had not presented with concerns and appeared to be developing normally even though there was evidence of Ms Luczak drinking alcohol and smoking during the pregnancy. It was not known whether Adam had experienced any domestic abuse incident, at least none that were reported, although the house was clearly one with a tense and sometimes violent atmosphere.
- 5.10** It is difficult to speculate what sort of feelings and physical effects Daniel experienced in terms of his issues about food – often referred to as his "obsession". Certainly the eventual post mortem identified that he was very malnourished and had been subject to serious neglectful care. The school were clearly concerned about his weight and how thin he was, his deterioration since starting school, and of his habit of seeking out food at every opportunity, so much so that it was difficult to control. Daniel however never said he was hungry or spoke about his home life. In reality however no professional tried sufficiently hard enough to engage him to enable him to talk about his experiences at home. Additionally at the paediatric appointment three weeks before his death, he did not communicate in any way with the paediatrician. The injuries at the time of his death were evidence of the high level of trauma that Daniel must have suffered in the later stages of his life, and yet he still attended school on occasions and disclosed nothing of concern. Despite arriving at school with facial injuries on at least two, or more likely, three occasions in late

2011/early 2012, no arrangements were made to speak with him directly or formally about these in relation to any child protection concerns. Without proactive or consistent action by any professional to engage with him via an interpreter, then his lack of language and low confidence would likely have made it almost impossible for him to reveal the abuse he was suffering at home, potentially for fear of retribution if he did disclose anything.

- 5.11** Additional information gleaned from the range of evidence which became known to the SCR Panel and was then presented at the criminal proceedings, demonstrated that the children’s experience, especially for the period from autumn 2011 until Daniel’s death in early March 2012, was considerably more traumatic than was known to professionals at the time. From early October 2011 there was evidence that Daniel was on occasions locked in an upstairs “box room” in the house which had no furniture and smelt of urine, but had a damp carpet and floorboards. There was a mattress which was soiled and there was no heater or toys in the room. This was apparently used as a form of punishment which was referred to in text messages between Ms Luczak and Mr Krezolek. Although Daniel was also said to have usually slept with Anna in her room, which was appropriately clean and furnished, it was unclear how often Daniel was made to sleep or stay in the box room. It was later acknowledged by Ms Luczak that it was in this room that Daniel died.
- 5.12** It was evident that Daniel experienced a harsh degree of scapegoating and emotional abuse by Ms Luczak and Mr Krezolek and he was often the sole subject of physical abuse and neglect, which included deliberately depriving him of food, serious physical abuse, feeding him salt and putting him in a cold bath, on one occasion according to Ms Luczak at the time in early February 2012, leaving him temporarily unconscious because he had nearly drowned. There were further disclosures in the court that Mr Krezolek gave out punishments to Daniel which included making him do sit-ups for an hour, or stand in the corner, as well as do squats or running on the spot. What was most concerning was the apparent deliberate way that such punishments were planned in advance. In her statements and in her evidence at the criminal trial, Ms Luczak apportioned responsibility to Mr Krezolek for the abuse and neglect of Daniel saying that if it was found that Daniel had taken other food whilst at school, that Mr Krezolek would not allow him to be fed that evening or that he would be fed salt so as Daniel would vomit up the food that he had taken while at school. This must have been a most terrifying and dreadful ordeal for Daniel to face at the hands of those who should have been caring for him.
- 5.13** It is challenging to describe Daniel as being neglected physically or emotionally, in that this implies some passivity on the part of his abusers. It is apparent that everything done to Daniel was calculated and deliberate, even his non-school attendance. He did not suffer physical neglect in the ordinary use of the term as he went to school clean and well dressed with a packed lunch, albeit a very frugal one. He likely existed in a constant state of stress and anguish as a result of his terrible treatment at the hands of his mother and Mr Krezolek.
- 5.14** After Daniel’s death, it also became apparent from her evidence that Anna had tried to protect him on a number of occasions, recalling how she had hit out at Mr Krezolek more than once to stop him hitting Daniel or making him stay in a cold bath. Therefore throughout the time from autumn 2011 it was apparent that she was very aware of the

abusive experiences of her younger brother but was instructed to say nothing. One of the texts between her mother and Mr Krezolek spoke of the need to remove the door handle from the box room to prevent Anna giving Daniel any food. On one occasion towards the end of January 2012 Ms Luczak told Anna to tell people that Daniel ate more than her and that he needed to be taken to a psychiatrist because he was retarded. What was additionally concerning and placed Anna in an invidious position was that she was used by professionals as a means of enquiring about Daniel and his injuries, for example when asked by police officers about Daniel's fractured arm a year earlier and then later on by the school head teacher to explain some facial injuries that Daniel had.

- 5.15** The intolerable position in which Anna was placed throughout this time, was most stark when at the time of Daniel's death, later evidence suggested that he was taken from the box room after it was apparent that he had already died, and placed in Anna's bed. In her evidence to court, Anna said that her mother had told her about needing something for the next day and had said for her to tell Daniel that too in the morning. This implied that Anna was being primed to "discover" Daniel's body when she awoke.
- 5.16** Anna could make the distinction within her later evidence of her ability to "be brave" to try to protect her brother from abuse, but that she was unable to do the same to protect her mother from Mr Krezolek whom he had hit, according to Anna, "many times, many times". It was also evident that the children had frequent experience of the adults regular drinking and of the violent arguments in the family home.
- 5.17** Daniel's traumatic abusive experiences for the last six months of his life were shocking, and he must have felt utterly alone and worthless for much of that time, being the subject of his mother and step father's anger and rejection. At times he was treated as inhuman, and the level of helplessness he must have felt in such a terrifying environment would have been overwhelming. The extent of his abuse however went undiscovered and unknown to professionals at the time.
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### **Analysis of Professional Practice**

#### **6. The key relevant opportunities for assessment, intervention and decision making**

- 6.1** There were numerous occasions when incidents occurred which in turn generated opportunities for assessments to be undertaken and for decisions to be made about the need for professional interventions. In summary these related to occasions when there were procedural requirements or expectations to intervene, such as ante natal booking-in arrangements and child developmental assessments, or when particular incidents or concerns about the family arose such as the domestic abuse events, hospital attendances and when injuries were noted on Daniel.
- 6.2** In respect of the occasions when assessments could or should have been procedurally undertaken with this family, some of these occurred in respect of the ante natal and post natal involvement of health at the time of the births of both Daniel and Adam. As Anna was born outside the UK, she did not come to the attention of the health authorities until early 2006, (when she was approaching a year old) then there was no involvement in her health care by midwifery services. In fact it was when the health visitor did her “new birth visit” in respect of Daniel that she became aware of another child (Anna) in the family. Although arrangements were set in place for Anna to have her 2 year and 3 year development assessments, Ms Luczak and Anna were not at home on the first occasion and failed to attend on the second occasion. The appointment letters were sent in English and it was not clear if Ms Luczak could in fact understand them. With no apparent follow up of these failed appointments, then the opportunities were lost to assess Anna’s early health and development. Certainly by the second of these occasions in June 2008, there was already a pattern of domestic abuse emerging within the home which the health visitor service had received information about, and yet this was not used as a reason to make more robust attempts to ensure the development assessments were undertaken.
- 6.3** Daniel was however seen by the health visitor for his “new birth visit”, his eight week assessment and for his three year assessment, the latter in July 2010. The first two opportunities were not used to routinely ask about any domestic abuse – apparently it was not expected practice at the time and by this stage there was no reported information held by health visitor about any domestic abuse incidents. However it was appropriate, based on the presenting needs at that time, that the family were identified as needing to be in receipt of health visiting services at the Care Pathway 2 level. The occasion of the three year assessment was however different in that the opportunity was used to discuss domestic abuse with the mother but her response that she had now separated from her partner (Mr A) and the view by the health visitor that Ms Luczak was taking an appropriately protective stance on behalf of the children, reassured her that there were no current safeguarding concerns. There was no evidence in the recent past that Ms Luczak had been able to remove herself from violent and abusive relationships, and so it was somewhat presumptuous of the health visitor to consider that this problem had ceased. Therefore the health visitor needed to be more circumspect in respect of the family’s future and the likelihood of it being free from domestic abuse, and developed further interventions accordingly. Potentially the health visitor could have given stronger advice about how

difficult it is for women to extricate themselves from abusive relationships, and perhaps directed her to receive further advice and support from a more specialist service, such as a Women's Aid service.

- 6.4** In terms of the assessment opportunities in the ante natal and post natal stages in relation to Daniel, overall Ms Luczak's attendances were good and on those occasions she denied any problem with alcohol use. At the time of notification of the pregnancy in relation to Daniel, the health visitor had a domestic abuse notification and yet this did not prompt a home visit. Overall however, from the contacts that were made, no concerns were noted in the ante or post natal stages and there were no other opportunities missed for a more informed interventions on these occasions.
- 6.5** Contact in the ante natal period in respect of Ms Luczak's pregnancy with Adam did however raise a number of concerns when it was apparent that Mr Krezolek was putting pressure on Ms Luczak to have a termination (in April 2011) and soon after this when Ms Luczak attended hospital for significant health problems which had the potential to affect the unborn baby, the controlling nature of Mr Krezolek was very apparent. This was certainly a major part of the reason for Ms Luczak discharging herself from hospital, against advice. These events could have been seen as Ms Luczak showing a disregard for the health of her unborn baby but the situation seemed to be viewed as more about the health and wellbeing of Ms Luczak. Alternatively she may have been anxious about the care of the children in Mr Krezolek's care. The safeguarding midwifery lead was however appropriately involved and information was then sought from the Police which confirmed the hospital's suspicions that there was a domestic abuse background. However, the named midwife appeared to have been reassured that CLYP were conducting a Core Assessment and that there were no current child protection concerns. In this way the true reasons for Ms Luczak's refusals to remain in hospital were never clarified. Also CLYP were too keen to reassure the named midwife rather than consider that the home situation might have changed based on this new concern, and that these circumstances warranted a home visit from them.
- 6.6** When Ms Luczak then failed to attend her next four ante natal appointments, this should have flagged up increased concerns, and yet no proactive response was made to identify why she had failed her appointments or no new concern raised by health staff with CLYP. After a further occasion of Ms Luczak again discharging herself from hospital, she then contacted the community midwife and did disclose domestic abuse in her relationship but claimed that Mr Krezolek was never violent to the children. A referral should have been made to CLYP and Ms Luczak's assurances that the children were safe should not have been taken at face value. This reflected an inappropriate professional view that domestic abuse was not a child protection issue.
- 6.7** A& E Dept. attendances and hospital admissions were also occasions when opportunities presented themselves for assessment or intervention, and Ms Luczak attended A&E on six separate occasions. These occurred between January 2008 and August 2010, with three of the incidents related to alcohol misuse, two involving possible overdoses, and included two incidents of injuries potentially related to domestic abuse. In fact the incident of Ms Luczak's broken finger in May 2010 was a direct result of domestic abuse, although the hospital accepted her explanation of it being accidentally caused. As the incident had

already been dealt with by the Police, it is debateable what more the hospital could have done even if they had challenged the accident explanation. No domestic abuse enquiries were made of Ms Luczak when she had a laceration to her arm from broken glass (November 2010) although unlike the first incident, there was no corresponding domestic abuse episode recorded by the Police.

- 6.8** The most significant concerns from the presenting information were in September 2008 when Ms Luczak took an overdose. On this occasion the possible impact upon her children was recognised and a referral was made to CLYP. There was however no corresponding record in the CLYP file in respect of this referral and no record of any follow up contact with the family by CLYP as a result. The doctor in fact recorded that the duty social worker would do a “safe and well” check that day in response to the referral although the hospital records did not later identify what action, if any, CLYP took. The hospital IMR describes this referral as “good quality”, and it did reflect good practice by the A&E Dept. doctor, but it was very concerning that there is no record of CLYP’s actions in response to this referral. This would be concerning on two fronts, firstly that action was taken but not recorded, and secondly, and of greater concern, that no action was taken at all. In either respect this was a failure in safeguarding practice by CLYP.
- 6.9** Other important opportunities for assessment and intervention were the two occasions when Daniel presented to A&E with injuries, the first in March 2008 with a minor head injury as an 8 month old child, and then when he fractured his arm in January 2011 when aged 3 ½ years old. (The latter will be discussed later in the report). The explanation of an accidental injury was accepted by the hospital on the first occasion and did not lead to any concerns being identified or onward referral to CLYP. It was understandable that the explanation was considered feasible (fell off lap onto a low table whilst changing his nappy) but, if accurate, it did nevertheless reflect careless parenting. The health visitor was notified ten days later which would not necessarily have triggered a home visit response, but when a week later, the health visitor received a domestic abuse notification in relation to the incident when Mr Pelka refused to give the baby back to his mother, then with information already known of previous domestic abuse, this should have triggered a proactive response by the health visitor. There was clearly the potential for the recent injury to Daniel to be seen in a different light with the backdrop of the incidents of domestic abuse, and yet the opportunity was not taken to explore this further.

#### Response to domestic abuse

NB – For ease of reference an Appendix (2) has been created listing all the domestic abuse incidents reported.

- 6.10** Domestic abuse was clearly a major pattern of this family’s lifestyle and occurred in relation to three consecutive different male partners. This not only demonstrated how Ms Luczak was unable to detect abusive relationships and did not learn from previous experiences, but also her own alcohol misuse and occasional violence to her partners, meant that her own behaviours regularly helped to fuel violent altercations between her and her male partners.

- 6.11** There were two key components to an effective professional response to the domestic abuse lifestyle; firstly to acknowledge that this was a pattern of family life rather than an unconnected set of isolated events, and the second was to recognise and respond to the child protection needs of the children who were living within such a violent and chaotic household.
- 6.12** The Police responded efficiently and quickly to each domestic abuse incident that was presented to them and on occasions took proactive follow up action to ensure that incidents did not recur and that the situation had calmed down. This was good practice. What generally needed to follow domestic abuse incidents was onward referral to either the Public Protection Unit (PPU) or Child Abuse Investigation Unit (CAIU) (which is a section of the PPU), which were both specialised sections of the Police force, or for notification of the incident to CLYP and the health visitor. Sometimes there were delays in passing information to and from the PPU and the CAIU. It is important to note that when information was passed to external agencies about a domestic abuse incident, this was a process of notification rather than a referral, leaving the recipient agency to decide upon their response.
- 6.13** Whilst the majority of the domestic abuse incidents were notified to CLYP and health, it is difficult to understand the reasoning for some being excluded from this process, other than the investigating police officers not considering that there were any child protection or welfare concerns. It was also apparent that when notifications were made to CLYP, the timing of these in terms of how long it was between the particular incident and the notification arriving, was also unclear, although the sheer high volume of referrals and backlogs re inputting of the referrals, were likely to have been the main reasons for delays. For example the concerning incident in early April 2008 (No.7) which directly involved Daniel as a 9 month old baby was not referred to CLYP for a further 2 ½ weeks. It was not recorded in the CLYP IMR that the Joint Screening meeting held 12 days after the incident, had discussed the case and the particular incident.
- 6.14** As well as there being inconsistency about notifications being sent by the Police to CLYP, there was also inconsistency by CLYP in their response, and although CLYP undertook an assessment in April 2008 as a result of the recent domestic abuse referral at the time, they had previously been notified of five earlier such incidents over an 18 month period, which had not evoked a response. Although there was little reference to any adverse impact on the children within these, CLYP should have raised concerns with the parents about the pattern of domestic abuse.
- 6.15** The situation was very similar in terms of domestic abuse notifications to the health visiting service who received information about some but not all incidents, often received after a period of 2-3 weeks, (and sometimes more), after the incident took place. Again the response from the family's health visitor at the time was inconsistent, with little evidence of home visits being taken to check on the family situation, and more importantly regarding the welfare of the children. One of the reasons for this was no doubt that because of the time delay in notification, it could have been considered that the urgency had gone out of the situation. Nevertheless, this still should not have prevented follow up contact being made. The family were supposed to have had an enhanced service, but there was little evidence of



this. There was a team meeting of health visitors in January 2009 to discuss the domestic abuse within the family and the discussions appear to have appropriately raised and shared the concerns, which led to a referral being made to CLYP. This was good practice and reflected that the pattern of domestic abuse was being taken into consideration. From this an Initial Assessment was undertaken by CLYP. On this particular occasion a useful proactive stance was taken by the health visitors to the pattern of domestic abuse.

- 6.16** The possible time delay in notification of incidents may also have been one of the reasons for some of the poor responses by CLYP, although in some instances CLYP appeared to have no record that a notification had been received (e.g. Incident No 10). Overall there was evidence of CLYP being inconsistent in their responses to the instances of domestic abuse.
- 6.17** In Coventry a system had been set up to jointly screen domestic abuse referrals on a multi-agency basis and ten such meetings were held during the domestic abuse history of this family, although the CLYP records of work with this family appear not to have made reference to these in any detail. Social work attendance was apparently sporadic at Joint Screening meetings due to staffing problems, but in any event this process was clearly not effective. At some meetings, domestic abuse incidents were being discussed up to 3 months after they had occurred and decisions made were not recorded in order to review actions. In this way the Joint Screening process was inefficient and appeared to be ineffective in this case in recognising the worrying pattern of domestic abuse and violence that had developed and was continuing, and of actions to address it.
- 6.18** Coventry Police won earlier safeguarding awards at that time for their work in this area but whereas practice evolved in other areas of the West Midlands using another screening tool<sup>18</sup> after 2009, the Joint Screening process changed very little in Coventry and had not incorporated into practice since that time, improved systems that were being used elsewhere. At key points of engagement with this family the Joint Screening process was under severe pressure with the Police team reported to be constantly battling with backlogs of referrals, the numbers which ranged from 3,500 – 4,000 referrals each year between 2008 and 2010. Also, a review of Police Force Joint Screening in January 2011 highlighted that there was a backlog of some 600 cases in Coventry and that items from the previous August and September Joint Screening meetings were still unresolved.
- 6.19** The process that existed in respect of the work with this family was not sufficiently formalised, with no agendas for meetings in respect of which families and domestic abuse incidents needed to be discussed. There were ad hoc arrangements about recording decisions or outcomes. The formal written assessment tool was not consistently used, largely because it was not considered necessary to always do so by the experienced officers, and because it would create further work to do so in an already overwhelmed service. Although the Police did background checks on cases/incidents to be discussed, CLYP did not have this prior knowledge and were therefore not sufficiently prepared to discuss cases. This in turn meant that there was unlikely to be full information of agency involvement available to be discussed at the meetings. Agenda setting has now been introduced

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<sup>18</sup> The Barnardos Multi-Agency Domestic Abuse Risk Identification Threshold Scales (Barnardos screening tool), to assess the risks to children/unborn children resident or normally resident in households where domestic abuse occurs.

although it is only recently at the time of writing that CLYP and health (not GPs) know in advance which children are going to be discussed. There has also now been some other resolution of this issue as the Police IMR reports that CLYP staff are now able to access case information they hold, whilst at the meeting, via a link from the use of a laptop.

- 6.20** There seemed to be limited liaison between the Police and CLYP with the Probation service which was involved with Mr A (Ms Luczak's second partner) for the period of a year from January 2009. The initial probation assessment of Mr A that he was "medium risk to his ex-partner" did not appear to change although it was apparent that he was back living with Ms Luczak soon after the offence in January '09 had occurred. Even though the assessment raised the issue of the risk to children because of domestic violence concerns, this did not lead to any fresh assessment or referral to CLYP when it became known shortly after that he was living with "his partner and two young children". It may have been that Probation had not realised that this was Ms Luczak and her children. Also, it was not apparent that within the Joint Screening process that the role of Mr A was considered with regards to the fact that he was under curfew to remain at the family home during the evening and overnight for the period July to November 2009. (Joint Screening meetings were held in August and October 2009). In effect this had the potential to generate tensions which might lead to domestic abuse incidents, and in fact further incidents did occur during this time. Much better liaison was needed with Probation to clarify whether the curfew arrangements were appropriate and to what extent they had been risk assessed.
- 6.21** As a result of an earlier SCR in Coventry in 2008, a Domestic Abuse Pilot had been set up in December 2011 and was seen as a way forward to start bridging the gap between schools' awareness of domestic abuse for individual pupils in schools and to consider how schools work with this information. Progress was reported to Coventry LSCB in July 2012 and noted that it had achieved positive outcomes for children in the schools included in the pilot. In respect of the school which Anna and Daniel both attended, (which was not part of the pilot), they were not aware of the domestic abuse history of this family, but if they had been, then their otherwise positive image of Ms Luczak's parenting may have been brought into question. In fact there were no domestic abuse incidents reported to the Police from the time that Daniel commenced school and only one incident occurred from the time that Anna attended, although there had been numerous incidents during her time in previous schools.
- 6.22** It needs to be acknowledged that the ability to establish an efficient and effective system of domestic abuse notifications to the range of agencies and professionals who would benefit from this knowledge is very challenging. Not only are considerable resources needed to manage the processes, but there are some difficult decisions to be made about when a particular incident warrants notification, for example to a school or a GP, and in clarifying the purpose of sharing the information and their actions as a result. This has not only been a challenge for Coventry but has been so for many other areas. The situation in Coventry has not been helped by their high numbers of domestic abuse incidents.
- 6.23** It was appropriate when accumulative concerns did lead to Initial Assessments (April '08 and Jan '09) and a Core Assessment (Nov'09) being undertaken, although the outcome of each

was that there were either no risks or that improvements in the home situation had taken place and that there were no child protection concerns. These assessments took an unrealistic and naïve stance that domestic abuse would not continue and would not pose risks to the children. Ms Luczak's assertions that circumstances had changed and improved were taken without sufficient challenge and her alcohol misuse was not fully addressed.

- 6.24** In summary therefore most incidents were dealt with in isolation and the cumulative effect of domestic abuse was not sufficiently recognised by any of the involved agencies. The interventions which did take place appeared to do nothing to cease the pattern of alcohol abuse and domestic abuse continuing. Although there were some referrals to domestic abuse specialists and to a local voluntary organisation to provide support, in effect they did not appear to have had any impact. Ms Luczak was in fact asked about domestic abuse on numerous occasions, but usually denied its existence, particularly to hospital and community health staff. On the few occasions when the Police did provide some helpful follow up supportive services, she usually dismissed the need for these. In this way Ms Luczak was generally difficult to engage by professionals, particularly in respect of attempting to resolve the domestic abuse scenarios. This clearly made it more challenging for agencies to intervene in any consistent way, but her assertions could have been challenged more effectively by emphasising the cumulative effect of the domestic abuse not only on her but more importantly, upon the children. Greater involvement of the male partners in interventions was also necessary, but there was little evidence of this in the assessment activities undertaken.
- 6.25** The range of incidents were more fully considered at the Strategy Meeting following Daniel's fractured arm incident in January 2011, and the following Core Assessment was to address the domestic abuse concerns alongside the injury and so it therefore had a broader remit than just to consider the domestic abuse. The assessment however made similar findings to the previous two assessments in that it considered the domestic abuse to no longer be occurring. In fact this may have been a reasonable judgement on this occasion, as no further such incidents were formally reported, although Ms Luczak told the midwife 3 months later of a recent incident when Mr Krezolek had been violent to her (Incident No 27). This disclosure should have led to a referral to CLYP although it appeared that Ms Luczak reassured the midwife that Mr Krezolek would not harm the children and that her relationship was over with him anyway. Whilst such a reassurance may have had some credence if it was the only incident of concern being reported, but this latest violent incident was another in a long line of earlier similar events.
- 6.26** Overall therefore, the response to the domestic abuse, apart from the immediate emergency response by the Police, was inconsistent and the systems in place to address such issues failed to have an impact on the continuation of these incidents over a number of years. Furthermore there was an insufficient focus on the impact upon the children, with the interventions directed towards the adults and upon their needs and actions.

#### Response to Daniel's fractured arm

- 6.27** Daniel's fractured arm when he was 3 ½ years old was a significant injury in terms of its seriousness and potential to have been inflicted non-accidentally. The hospital responded

well to the injury and dealt effectively with Daniel and rightly raised immediate concerns about the injury in relation to the delay in presentation (one day) and in terms of whether the explanation of a fall from a settee could have led to a spiral fracture to his left humerus. This reflected that “A physician should be suspicious if a child is not brought to the hospital immediately after injury and if there is no relation between the trauma described in the history and apparent injuries”<sup>19</sup>. Therefore CLYP were appropriately involved who then also referred the matter to the Police in accordance with procedures. Although there should have been a more joint approach to the following enquiries, they were ultimately dealt with solely by the Police. The social worker had arrived too late for the meeting that was undertaken by police officers with Anna who was said to have witnessed the event, and she confirmed the explanation given by Ms Luczak at the hospital. Whether the social worker’s involvement in the interview would have changed the outcome or obtained any other information from Anna was debateable, but it should have been conducted jointly so as to have had the benefit of bringing the two different professional perspectives to the enquiry.

**6.28** It was appropriate practice that a Strategy Meeting was held the following day, and it was apparent that the background of domestic abuse was given full consideration as the backdrop to this injury. A great deal of attention was inevitably focussed on the cause of the injury, with an initial medical view of it potentially being the result of abuse. This reflected relevant research studies which have found that “spiral/oblique fractures to be the most common humeral fracture type associated with abuse”<sup>20</sup>. The view that the injury could have been accidental rather than non-accidental shifted once the Police enquiries had been made, particularly in relation to Anna’s confirmation of the explanation of the incident as a fall from the settee. To get a definitive medical view of the causation was inherently difficult particularly when “Oblique fractures are observed in falls in which children lean on their elbow or hand accompanied by a torsional movement of the body. According to the intensity of the trauma and the degree of the torsion, this mechanism may also cause spiral fractures”<sup>21</sup>. However the likelihood of the injury being non-accidental could still not be fully discounted in respect of Daniel although ultimately the medical assessment of the injury was that the original explanation of the cause as a fall was “plausible and could have occurred in the manner suggested”<sup>22</sup>. What was not fully explored were the numerous other bruises that Daniel presented with at this time for which the mother could not give any explanation, apart from reference to bicycle accidents. If not considered in detail within the medical examinations, then there should have been more detailed enquiry about them by the Police and then by the social worker in the later Core Assessment. It was inappropriate to have focussed on the main injury without considering that this occurred within the context of other bruises, some quite unusual.

**6.29** The paediatric and orthopaedic consultants reviewed Daniel separately though if they had undertaken this jointly, it might have given a clearer understanding of the situation and of

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<sup>19</sup> Paediatric Fractures of the Humerus – Caviglia, H, et al – Clinical Orthopaedics and Related Research, No. 432 pp 49- 56 - 2005

<sup>20</sup> Humeral Fractures Without Obvious Aetiologies in Children less than 3 years – When is it Abuse?, Strait, T et al, Pediatrics - Official Journal of the American Academy of Pediatrics - 1995

<sup>21</sup> Paediatric Fractures of the Humerus – Caviglia, H, et al – Clinical Orthopaedics and Related Research, No. 432 pp 49- 56 - 2005

<sup>22</sup> Strategy Meeting minutes of meeting on 7<sup>th</sup> January 2011

the strengths of the concerns. The CLYP view however, according to their records, was that the medical view had changed from it being potentially a non-accidental injury (NAI) to the injury being accidentally caused. Also in the Strategy Meeting minutes it is recorded that the Police “were in agreement that the injury caused to Daniel appeared to be of an accidental nature”. It was understandable that in these circumstances, the Police considered that they had no further role at this time. Generally however, there was a shift from clear concerns about NAI to the view of both CLYP and the Police that this was now an accidentally caused injury. In reality however concerns should still have remained about the potential of abuse as the cause of the injury and that an enquiring mind was still necessary in future work with the family. It remained the case that with a fracture of this type, that there was a reasonable likelihood that its cause was the result of abuse. This meant that much relied on the Core Assessment which was to be undertaken, to look at some depth at family relationships and the parental attitudes to the children, and thereby identify any risk factors. However, CLYP’s view that this was now an accidental injury may well have coloured the social worker’s assessment of the family with a less inquisitive approach being undertaken. In fact further enquiry about the injury did not seem to figure as part of the Core Assessment which had a positive outcome and considered that there were no child protection issues.

- 6.30** Overall, the “rule of optimism” appeared to have prevailed in the professional response to Daniel’s fracture and to his other bruises. This appeared to reflect a “tendency by social workers and health care workers towards rationalisation and under responsiveness in certain situations. In these conditions workers focus on adult’s strengths, rationalise evidence to the contrary and interpret data in the light of this optimistic view”<sup>23</sup>. The explanation of the cause of this injury was too readily accepted as accidental and the initial concerns about the injury quickly downgraded – it remained the case that there was delayed presentation of the injury by a day, and that the medical view was that Daniel would have been in considerable pain, and additionally, that based on medical knowledge and research, the most likely cause of an oblique fracture was physical abuse. It appeared that the medical diagnosis or evidence was deferred to as being the most significant to any assessment of whether abuse was a cause or not of the fracture. It was understandable that the medical opinion could not be certain of the causation, and once there was the comment from the doctor that the mother’s explanation could be plausible, this appeared to quickly reduce concerns and actions by the Police and CLYP. In fact there were some inconsistencies in the explanations given. What was missing from the Strategy Meeting was recognition that the medical view was not necessarily the most significant contribution to whether physical abuse had taken place. There were the social factors of family life to take into account, the parent/child relationships, the role of the male in the home etc. which all would have added to the overall understanding of whether there was the likelihood of physical abuse within the home. On the majority of occasions in these sorts of situation, the medical evidence is inconclusive, as it was on this occasion, but to then have accepted this to mean that the injury was accidentally caused, without further robust enquiries, represented that the “rule of optimism”<sup>24</sup> was at play in this situation. It might help to

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<sup>23</sup> Paragraph 96, “Learning lessons from serious case reviews 2009-2010” Ofsted October 2010

<sup>24</sup> This is where a positive stance is taken of a child’s circumstances or level of risk, which is not necessarily supported by the objective evidence or information available.

prevent this occurring in future similar situations, if the medical view was presented as saying that on the balance of probabilities, the injury was likely to be the result of abuse, (according to research), rather than to report that an accidental cause was plausible.

- 6.31** There followed an overly positive approach being taken by CLYP in response to this injury, and CLYP's failure to produce minutes of the Strategy Meeting of agreed findings (which included some of the doubts about the cause of the injury) and of the decisions reached, meant that other agencies were less in a position to challenge the actions by CLYP. In fact there was no distribution of any minutes until after Daniel's death, and the hospital IMR states that they were then found to contain inaccurate information. There should have been the opportunity for the hospital staff to have challenged this at the time which in turn may have affected CLYP's understanding that some concerns re the existence of NAI still remained. The situation was additionally hampered by the lack of any formal report by the hospital paediatrician giving detail of the fracture and associated bruising and of the concerns in relation to their causation. This would have been an essential document to clearly explain the medical position at the time of the Strategy Meeting, even if it was one of being undecided, and as a point of further reference.
- 6.32** In summary therefore, the lack of attention to the detail for the need for meeting minutes and for a medical report compromised the efficiency of the Strategy Meeting process on this occasion, and no doubt the enquiries which were undertaken following the meeting. With the role of Strategy Meetings being a key component of the child protection system, it was concerning that on this occasion it reflected an inefficient process which compromised the later enquiries and assessment with the family. There appeared to be no follow up about the actions by CLYP and of the outcomes from their Core Assessment. Not only should CLYP have provided this information but the other agencies could have chased this up when information did not arrive.
- 6.33** Whilst the health visitor was not invited to the Strategy Meeting, the A&E Dept. had informed her of Daniel's injury and the query of it being non-accidental, on the day of his admission. What then followed over the next five months was the health visitor seeking liaison with the social worker whom she knew was conducting an assessment, making numerous attempts to contact the social worker during this time. The purpose was not only to understand what the assessment was indicating but the health visitor wanted to be made aware of this before deciding on her own input – this was something agreed upon in her supervision a month after the injury. In effect contact was not made with the social worker until four months later in June '11, to be told that the case had already been closed by CLYP. The health visitor's efforts seem to have all been in relation to liaison with the social worker when she should have made contact with the family, seen Daniel and undertaken her own assessment of his situation and developmental progress. 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. Because of the initial query of a non-accidental injury to Daniel, this should have been sufficient for the health visitor to make her own child focussed intervention with the family and it was concerning that no contact was made at all. It would appear that this was because of the readiness to accept that the injury was accidentally caused. Additionally it was not apparent that the health visitor had been asked to contribute to the assessment by the social worker and so in

this way the health visitor was a passive onlooker to the situation rather than a contributor to interventions with the family at this significant time.

### The response to concerns about Neglect and Health

- 6.34** Apart from the poor health and neglect of Daniel in the few months before his death, areas of concern which may have led to neglectful care of the children not only related to the pattern of significant domestic abuse by the adults in the home, but also to the family's experience of housing difficulties and evictions, linked to financial problems and debt, and to significant alcohol misuse. These factors occasionally led to Ms Luczak to suffer depression and on two occasions take overdoses.
- 6.35** All of these factors taken together reflected an inevitable pattern of neglectful care of the children. However it was apparent that the children did not particularly show by their demeanour and presentation at school, that they were neglected. It was said that they 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. Whilst there were instances of clothes sometimes being dirty, this was not necessarily enough to consider that the children were neglected. Generally in fact the children were well dressed. Importantly, neither child spoke of their home situation and did not convey concerns about home life – generally both children seemed to initially settle reasonably well in school. One key area of concern for the schools was the poor attendance by the children, although Ms Luczak did sometimes respond to pressures to improve this – with the benefit of hindsight, this can now be seen as an example of disguised compliance by the mother. It was not apparent that the last school which both children attended was aware of the domestic abuse and chaotic life style at home. If the assessment activity undertaken by CLYP had involved the school, as required by good practice guidelines, then a more holistic picture could have developed for school staff which might have reflected levels of neglect that the children were suffering. Such information could have been passed from the early schools that Anna attended. Although the social worker did make contact with the school in early 2011 in respect of the Core Assessment at that time, this seemed more about seeking information rather than passing it on to the school.
- 6.36** There was no attempt to address Ms Luczak's alcohol misuse, or that of her partners despite the regularity with which it figured as part of domestic abuse incidents. There was clear evidence that this was a significant problem which was highly likely to impact on the children's well-being. Nevertheless none of the assessments undertaken appeared to have identified this as a problem and Ms Luczak's assertions of little or no alcohol misuse went unchallenged. For example in February 2009 she told the health visitor that she was not drinking alcohol (she was pregnant at the time) and that pre-pregnancy, she drank alcohol once a month. This statement bore no relation to the prevailing situation at that time with the domestic abuse incidents during the previous 6 months all relating to significant alcohol misuse (Incident Nos. 8 – 13). Even when it was apparent that Ms Luczak was drinking alcohol during pregnancies, she was not challenged about this even though they contradicted her statements that she had ceased drinking.

- 6.37** Because there was no full assessment of the domestic abuse situation in this family, or more importantly, of the neglect that this caused the children, then there was no attempt by any professional to understand the causation and the role that alcohol misuse clearly played as a contributory factor to the domestic abuse and neglect. The information from the Police, usually notified to both CLYP and the health visitor, contained reference to alcohol abuse as being a major contributor in the vast majority of incidents reported. Nevertheless it was not apparent that this was viewed as a factor of family life and neglect which needed to be separately addressed. The lack of reference to this issue and the acceptance that the adults were able to manage to cease drinking, as contained in the Core Assessment, was not realistic when faced with the evidence. Along with the alcohol abuse was also some episodes of depression for Ms Luczak, although the adult focus of interventions at this time did not recognise the possible impact upon parenting that this may have had. Although the GP was aware of the presence of the two children and some domestic abuse concerns at the time of prescribing anti-depressants, when Ms Luczak failed to attend for a review of her situation and medication, it would have been appropriate for the GP to have alerted the health visitor at that time.
- 6.38** Poor school attendance was also a problem that existed throughout much of the time that the children were at school. Appropriate attempts were made to address this via monitoring the attendance of Anna at weekly meetings during the Spring term of 2011. There were also arrangements to meet with Ms Luczak and to seek improvements which sometimes occurred – it was also realised at that time that Ms Luczak’s poor health and lack of support were reasons given for not getting the children to school. Generally the response to the attendance problems was well thought out in the circumstances and specific attempts were made to engage Ms Luczak in order to increase her commitment to getting the children to school.

#### Assessments and decision making

- 6.39** The assessments undertaken by CLYP in respect of this family were:
- Initial Assessment commenced April 2008 (Para 4.11) – 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 (Para 4.21) – The finding was no further action as Ms Luczak said she could protect the children.
  - Core Assessment commenced November 2009 (Para 4.33) - 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 (Para 4.48 – 4.50) - 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.
- 6.40** As can be seen from the above, the first three assessments wrongly assessed that the domestic abuse had ceased, and yet there appeared to be no connection between them. To



have reviewed earlier assessments would have given accumulating evidence that the domestic abuse was in fact continuing unabated. Although there were no domestic abuse incidents reported to the Police following the final Core Assessment, Ms Luczak nevertheless reported incidents of continued domestic violence (e.g. No. 27) to the midwife and later evidence presented in court, especially Anna's, also confirmed this. Overall the outcome from these assessments would appear to reflect a level of naivety in respect of the understanding of domestic abuse in wrongly believing that it was a pattern which could easily cease, when research shows that this is rarely the case<sup>25</sup>.

- 6.41** The first Initial Assessment was however conducted in a generally thorough manner, and importantly involved the male partner at the time, along with two unannounced visits to the home when the children were seen and other agencies were consulted. However, potentially because of inefficiencies in the timely transfer of information about domestic abuse incidents, then some key incidents were not included in the assessment, which inevitably compromised its findings.
- 6.42** The second Initial Assessment lacked the basic level of analysis and did not pay sufficient attention to the issues of domestic abuse within the family, and the acceptance from Ms Luczak that domestic violence “did not happen often” was clearly not true. Since the earlier assessment, there had been numerous concerning incidents which if checked with the Police would have clarified that domestic abuse was a continuing pattern within the adult relationship. The additional risks associated with Ms Luczak's pregnancy at this time were not recognised, with the eventual naïve finding that “mother appears to have the situation under control and appears to be able to protect the children”. This would tend to reflect that “All too often the focus of child protection assessments are on women, and this means that we are asking women to sort out the problem and operate as our agent, rather than including men and asking them to take responsibility for the violence”<sup>26</sup>. This would therefore further relate to the lack of engagement of the male partner in the assessment. It was particularly concerning that for the time it took to close the case on this occasion, three further incidents of domestic violence took place and yet this did not affect the decision about closure.
- 6.43** Because of the greater depth required of Core Assessments, then these should have been more probing, and as a result should have provided a greater holistic understanding of what was happening in the family. However this failed to be the case with basic analysis missing and no clear reference to the earlier assessments. For example on the previous occasion, Ms Luczak was noted to be pregnant, but there was no reference to what happened to this pregnancy. Also the assessment was largely based on reported information from Ms Luczak and appeared to have resulted from just one visit to the family home. Although the children were seen and were reported as “appeared to be happy with mother”, this gave scant regard to their experiences and needs at this time. This assessment therefore reflected

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<sup>25</sup> “On average a women will return to her partner 7 times before leaving him” – Cooper, C. - Beating the crime – Community Care September 1992

<sup>26</sup> Children living in domestic violence – Towards a framework for assessment and intervention, Calder, C et al 2004 RHS publishing

findings in other Serious Case Reviews of “a failure of agencies to understand, accept and assess the impact of domestic violence on children”<sup>27</sup>.

- 6.44** The second and final Core Assessment, unlike the previous assessments was linked to the injury (fractured arm) to Daniel rather than to mounting concerns about domestic abuse. However, because the collective professional view that had been taken that the injury was on balance likely to have been accidentally caused, then there was little evidence of this being further probed to any significant extent. In reality the consideration that the injury was accidental was not equivocal and yet the optimistic stance taken meant that this was not pursued in the Core Assessment and did not consider the incident in the context of the domestic abuse which had still been continuing at this time with a third male partner. It was a naïve statement in the assessment that “mother and partner are still together” was referred to as a strength/safety issue. If the social worker had used the opportunity in the liaison with the school at this time, to tell them of the domestic abuse background rather than just seeking information from them, then they would have been in a more informed position to relate to the problems later presented by Daniel in school. Additionally, the family had experienced a great deal of mobility in terms of housing, and the fact that one of the risks identified in the assessment was that the family were about to become homeless once again was significant and yet no assistance was offered or proposed in respect of this. Once again at this time Ms Luczak was pregnant and this was not identified as a risk factor.
- 6.45** Although the purpose of assessments is to inform future actions and interventions, in effect no follow-on interventions occurred when there often remained a need for further more specialist work to be undertaken. On two occasions Ms Luczak did not take up services that were offered, although there should have been greater encouragement for her to do so. The reasons for the overall poor quality of these assessments is difficult to explain although the respective IMR does identify the heavy workload that CLYP were experiencing at this time and that there were “high levels of bureaucracy” related to what the social workers were inputting into the computer system, which was said to reduce their time on effective practice interventions. Also the information about incidents of concern was not always readily accessible. 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”<sup>28</sup>
- 6.46** There were two occasions when decisions were apparently reached to set up a Strategy Meeting in response to concerns in January and March 2009, but these did not go ahead, although it was unclear why not. These decisions and any apparent changes to decisions should have been recorded, considering the criteria of concern that would normally be

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<sup>27</sup> Ofsted’s second year of evaluating serious case reviews: a progress report (April ’08 – March 09) published October 2009

<sup>28</sup> Learning Lessons from Serious Case Reviews 2009 – 2010 – Ofsted evaluation of SCRs October 2010

required (i.e. to consider the need for a Sec. 47 child protection enquiry) to reach the threshold for a Strategy Meeting. There seemed to be no reference to whether an initial child protection conference was considered as a possible response to the concerns. With the high numbers of domestic abuse concerns and the high level of violence associated with some, as well as a consistency of alcohol misusing parents/carers, then there should have been formal consideration whether the child protection threshold had been reached.

- 6.47** In terms of current practice, the poor quality of the assessments and the inconsistent response to referrals overall, should change with the recent new arrangements whereby any third contact made into CLYP will be reviewed by a manager to ensure that cases achieve the correct level of priority and are matched against a clear threshold criteria for intervention.
- 6.48** There were also health assessments in this case although the detail of these have been referred to earlier in terms of Daniel’s admission to hospital for his fractured arm and the paediatric assessment in February 2012 is considered in detail later. Other health assessments however should have taken place, for example by the health visitor service in response to the increasing number of domestic abuse notifications. Once again, whilst the lack of timely information about these could have affected assessment activity, the presenting situations should have been assessed, without reliance on CLYP to respond to referrals. The birth of Adam was an opportunity for the health visitor to make an informed assessment at the “new birth” visit stage, but to then classify the family as needing “universal/routine” care was hardly a reflection of the prevailing circumstances and the high vulnerability of a new born baby into this chaotic and at times violent household. This again seemed to reflect an over optimistic expectation of change within the family as well as a focus on the presenting situation only.
- 6.49** 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.

#### Knowledge of and response to adults in the home and of risks they might pose to the children

- 6.50** The role of the fathers of the children and of other significant males in the home, was not understood or addressed throughout the work undertaken with the family and this reflects the analysis of previous SCRs<sup>29</sup> which identified that “Assessment and support plans tended to focus on the mother’s problems in caring for her children and paid little attention to the men in the household and the risks of harm they might pose to the children given histories of domestic violence ...”. For example there was no face to face contact with the fathers or

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<sup>29</sup> Understanding Serious Case Reviews and their Impact – A biennial analysis of Serious Case Reviews – 2005 – 2007 – Brandon, M, et al – DCSF – June 2009

any of Ms Luczak's partners recorded by the health visitors or school nurse, and additionally although the health visitor took details of the family at new birth visits, it remained unclear throughout the records which partner was present at which time.

- 6.51** Opportunities to involve the male partners existed in the four assessments undertaken by CLYP, and in fact there was some good practice in this respect when Mr Pelka was visited at his place of work as part of addressing the concerns in the first Initial Assessment in 2008 about the domestic abuse at that time. The social worker also clearly engaged Ms Luczak and Mr Pelka as a couple at this time. This practice was not however replicated in the two later Core Assessments when the CLYP records did not identify that background checks had been carried out on any of the adults involved in the family. The very limited information obtained about the male partners, and indeed about any other adult in the household, only came from that which was volunteered by Ms Luczak.
- 6.52** During one period of time when Ms Luczak was pregnant with Adam and unwell and regularly attending hospital, the role of her partner at this time (Mr Krezolek, the father of Adam) was apparent in that he was controlling and had displayed anger within the hospital by removing the drip from Ms Luczak's arm and insisting on her discharge. Prior to this time, according to Ms Luczak, he was putting pressure on her to have a termination. The named midwife for safeguarding appropriately checked with the Police what was known about the family, including that the current partner had a criminal record<sup>30</sup>. Although a referral to CLYP eventually followed, their response was inadequate on this occasion. This was a concerning period of time and the response by CLYP on this and other times when domestic abuse occurred at the time of a pregnancy, did not reflect that "The risks of attack during pregnancy are of particular concern and are indicative of highly dangerous perpetrators. These attacks represent a form of double intentional violence as they incorporate both acts of woman abuse and child abuse"<sup>31</sup>
- 6.53** In other respects, what was known about the male partners and contact with them, related to the domestic abuse incidents which were reported to the Police. The first partner known to be part of the family was Mr Pelka (father of Daniel) who resided with the family for approximately three years from late 2005, then Mr A who lived with the family for approximately eighteen months from January 2009, and then Mr Krezolek, (father of Adam) from the summer of 2010 onwards. At the strategy meeting in October 2009, there was a misunderstanding that Mr Pelka was presumed to have used the name of Mr A, or that he had changed his name and was in fact the same person. The health visiting service and CLYP were certainly confused about these details and this tended to reflect the lack of engagement of these male partners by the various professionals at the time. An efficient and well conducted Core Assessment should have identified the family relationships and the roles of the male partners and of their relationship with the children.

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<sup>30</sup> It was not apparent whether the details of his criminal record was in fact shared or given consideration as part of any assessment – Mr Kresolek had two offences of driving while disqualified and one for driving with excess alcohol – leading to him having two periods of imprisonment, on the last occasion being released in October 2007. He was not subject to license supervision upon his release.

<sup>31</sup> Domestic Violence and Child Protection – Humphreys, C and Stanley, N – 2006, Jessica Kingsley

- 6.54** All of these men were involved in the domestic abuse incidents and clearly had the propensity for being very violent, although it was also apparent that Ms Luczak was sometimes the instigator of violence. It was clear that it was the dynamics of the relationships, along with alcohol misuse, which fuelled the domestic abuse and incidents of violence. Nevertheless whenever professionals felt reassured that risks to the children had diminished, there was a reliance on the mother that she was now managing the situation, and for example that her partner was either “now quiet” or that he would not harm the children. “Even when a father or father-figure is clearly identified as a perpetrator of abuse, the focus of assessment and on-going intervention is with the mother and her ability to protect her child”<sup>32</sup>.
- 6.55** Some of the reasons for this may have laid partly in the fact that the male partners were seen as transient figures rather than permanent members of the household, and additionally there were language barriers as all the partners were Polish. The fact that they were EU migrants would have been a barrier to undertaking background checks, but it is questionable whether their status was formally known or enquired about. Additionally as found by a review of Serious Case Reviews; “When fathers were noted to be aggressive to staff and to pose a threat to their safety, it was also possible that fear clouded professional judgement.”<sup>33</sup>
- 6.56** The Police in their investigations of the domestic abuse incidents did however give attention to the part that the male partners played in each incident, sometimes resulting in his arrest for related offences. The purpose of Police involvement was to resolve the particular incidents as they arose and to ensure no immediate recurrence of violence, (which they generally effectively undertook), rather than to develop a longer term view about the role of the father/male partner in the family. This should have been the role of CLYP in respect of their assessment activity and of health professionals as they became involved.
- 6.57** However there were some occasions when the threats posed by male partners to the family were not fully addressed. For example although Mr A was “tagged” for possession of a knife in one domestic abuse incident (No. 12) and sentenced to a three month curfew, his allocated address was back at the home where Ms Luczak (the victim in the assault) and the children were living. In fact he was involved in further domestic abuse incidents during the time that he was under this curfew but this did not trigger an assessment review of Mr A by Probation although they did eventually contact CLYP to discuss their concerns. This lack of attention to the continuing role that he played in the family, whether he was living with them or not, meant that his criminal conviction had not offered realistic protection to Ms Luczak or the children. There was some similarity when at a later incident involving Mr Krezolek in August 2010 (No. 24) he was released back to the family home even though there had been an allegation of rape by Ms Luczak in addition to the domestic incident which had involved a knife and attempted strangulation. The Police IMR recognised that this was poor practice which was adversely affected by there being four sets of officers involved throughout the night that the incidents occurred. The fact that Ms Luczak would

<sup>32</sup> Engaging with Fathers – Practice issues for Health and Social Care – Daniel, B and Taylor, J , - Jessica Kingsley - 2001

<sup>33</sup> Understanding Serious Case Reviews and the Impact – A biennial analysis of serious case reviews 2005-07 – Brandon, M et al June 2009 Dept. for children, schools and families

not support charges, and was content to have him return home was not in itself any guarantee that no further violence would occur, even though there was in fact no further incident recorded in connection with these events.

- 6.58** Whilst Ms Luczak spoke of having a sister in the Coventry area, there was no record of any contact or interviews with her taking place as part of any assessment or involvement with the family, in order to understand what level of support she was able to provide or to add to information about Ms Luczak's male partners.

#### Sensitivity to the needs of the children

- 6.59** Throughout the response by the Police to the variety of domestic abuse/violence incidents, the reference to the degree to which the children's needs were addressed was very inconsistent. In fact in many respects the response by the Police was not child-centred. Whilst the Police IMR confirmed that it was an expectation via the relevant domestic abuse policy that "children living in the location are physically seen and their welfare checked", this was not always apparent. On some occasions there was no reference to the whereabouts of the children, and when they were seen, there were generalised comments such as the children being "none the wiser", "safe and well" or "fine". However there was no evidence to emerge that the children were directly physically harmed within any domestic abuse incident, but the impact on them emotionally was nevertheless potentially significant although not apparently recognised.
- 6.60** Overall this response showed a lack of appreciation of the impact of domestic abuse upon children, and whilst it was of course appropriate to give the adult's presenting behaviours sufficient attention to calm the individual situation, this should not have been at the expense of gaining a clear understanding not only of the wishes and feelings of the children but also about what levels of risk they may still have been under. On two occasions (Incident Nos. 6 and 7) the Police chose to leave the children with the parents although they were clearly intoxicated at the time. Referrals for immediate response by CLYP on these occasions to request particular attention to be given to the needs of the children should have been made, and may well have ultimately helped the adults to understand the link between their behaviours and the risks they were presenting to the children in their care.
- 6.61** Generally the practice by other agencies did not explore the likely impact on the children of the domestic abuse lifestyle within the family or of the considerable alcohol misuse that took place by their carers. The schools were not aware of these incidents at the time they were taking place, so were less able to respond in any knowledgeable way to the children.
- 6.62** Overall there was very little evidence that Daniel was ever spoken to individually alone about his wishes and feelings. Despite his young age, there was a concerning failure to use an interpreter to speak with him about the cause of his earlier fractured arm and his experience of care at home. A key time was also the period when he was exhibiting the obsessive behaviours about food. It was apparent however that school staff did try to communicate with him on these occasions and to be supportive to him, and in doing so developed some understanding of his personality. However, these attempts were not sufficiently sensitive to his needs overall and an interpreter should have been regularly used to aid communication.

- 6.63** Especially on occasions when Daniel was the particular focus of concern, there appeared to be an assumption that he was unable to express his wishes and feelings and that the use of interpreters would be ineffective, when this should have been tried. Potentially greater opportunities on other occasions with different professionals could have been taken to communicate through play or other mediums.
- 6.64** Similarly, no interpreter had been used at the later paediatric assessment in February 2012 because Ms Luczak had declined the need for this because she could by then converse reasonably well in English. This was presumably agreed to because Ms Luczak did not need the interpreter rather than whether Daniel did. The paediatrician however reported that there was no communication with Daniel during this assessment which was attributed to a possible speech delay problem. In effect this was another missed opportunity for a professional to have direct communication with him at an important time.
- 6.65** Additional information came to light that the school sought the help of a teacher from a neighbouring school who could speak Daniel's language, and asked her to speak with Daniel at the height of their concerns about his welfare and what they saw as his secretive and obsessive eating behaviours. This teacher spoke to Daniel about him taking food, but later reported that he was not communicative and she was unsure how much Daniel understood what was being said to him. Daniel was clearly unable to use this opportunity 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. It was less than three days later that he died.

## **7. Events leading up to Daniel's death**

### School concerns about Daniel's "obsession" with food

- 7.1** 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. It was approximately midway through the term that it was brought to the head teacher's attention that Daniel was eating excessive amounts of food, including taking it from other children's lunch boxes and eating secretly. The response of the school to locking the food away was taken in the context that they considered the problem to be a medical one. Two teaching assistants were however concerned about him being hungry. It was not apparent that Ms Luczak was seen as a potential source of Daniel's problems who insisted that Daniel must not eat anything at school other than what she provided for him. She was generally viewed as a caring mother. However one teaching assistant recalled that Ms Luczak always seemed cross with him and that he always walked home twenty paces behind his mother. There were other examples of school staff considering that Ms Luczak as very stern with Daniel and one teacher said in evidence at the criminal trial that she had stopped telling Ms Luczak of Daniel's continuing eating problems at school because of her negative reaction to him as a result. The extent to which the quality of the mother-child relationship played a part in Daniel's problems should have been the subject of greater consideration as having a link with Daniel's presenting problems. Certainly there seemed to be a disparity of views about the mother's parenting ability and attitude to Daniel which was not resolved among school staff, although it was apparent that the prominent view was that she was an adequate parent.
- 7.2** The school staff recognised that Daniel was not growing, and from January 2012 felt that he was losing weight, with one teaching assistant stating in the later criminal proceedings that "he was wasting away", although with the apparent view that the medical aspects of his presentation were being investigated, no school staff member chose to request the school to make a referral to CLYP about possible neglect.
- 7.3** Even though the school seemed to have taken the view that Daniel's problem was a medical one, or at least needed a medical assessment, and accordingly made direct contact with the GP in the new term in January 2012, by then there had already been three failed appointments with the community paediatrician. In fact when Daniel was eventually seen by the community paediatrician, the school assumed it was the result of their communication with the GP, when in fact it was following the earlier referral by the school nurse. There was clearly 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.
- 7.4** It remains unclear what the communication was at this time, in that the deputy head recalled that on the second occasion when she spoke with Ms Luczak about Daniel's eating habits, that Ms Luczak said that she was waiting for a hospital appointment and that the health visitor was involved. According to the respective IMR, the deputy head understood that the school nursing service had been withdrawn and gave this as the reason for



contacting the GP. This was clearly not accurate considering that a school nurse had by this time made the referral to the community paediatrician. In fact the situation was that there was no school nurse located or in attendance at the school because she was off sick during autumn 2011, but there was nevertheless a school nurse who was covering and was able to pick up on school health issues if relevant. Additionally it was recorded that this school nurse made contact with Daniel's class teacher who confirmed concerns about Daniel in that he was "eating and crying like a baby". Also the school had not been forwarded the referral that had been made to the community paediatrician and the school nurse had not gone through the GP to request a paediatric referral, but instead had done this directly without copying the surgery into the referral. Whilst it was not a formal requirement to go through the GP, it would have been good practice to do so, although whether this would have speeded up the eventual attendance at the paediatric appointment is not known but it would have added to the GP's knowledge and potentially helped to supplement the school's concerns that had been made known to the GP by a telephone call from the deputy head. Nevertheless to have had clearer communication between all involved professionals at this time would have helped to ensure a more coordinated approach to dealing with Daniel's presenting problems, at least from a health perspective.

- 7.5** The concerns in respect of Daniel's eating behaviours alongside his lack of growth, and of his apparent difficult behaviours at home, were not able to be effectively dealt with for the period of time from October 2011 to February 2012 partly because of Ms Luczak's failure to engage with the school nurse support worker to address the difficulties in the home and then by the failure to attend the community paediatric appointments. The question therefore was whether other actions could or should have been undertaken to have secured the paediatric intervention at an earlier stage and not allowed Ms Luczak to disengage and not follow through on appointments. With the benefit of hindsight it is recognised that this was a critical time prior to Daniel's death, but the significance of his condition and of his deterioration was not as evident to the health workers, and school staff did not collectively and purposefully generate their concerns into a coherent child protection referral. The school nursing support worker did try hard to chase up Ms Luczak in respect of the paediatric appointments and after the second failed appointment did inform the school nurse (her manager) although it is not clear whether this action heightened the identified risk to Daniel or generated greater urgency. Ms Luczak cancelled two of the three paediatric appointments and then discussed with the clinic the most convenient time for a renewed appointment which turned out to be approximately seven weeks later. This gap did not reflect any increased level of urgency being applied to the situation in terms of greater encouragement for Ms Luczak to agree an earlier appointment. However at this time Ms Luczak 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. If there had been greater and more formal liaison with the school at this time, they would have become aware of the school's increasing concerns and the urgency for a paediatric appointment may then have become more apparent.
- 7.6** It is also important to note that whilst a pattern of failed appointments would raise concerns and no doubt also about the level of urgency for the child to be seen, there was only one such "did not attend- DNA" as the others were cancelled or changed by the mother.

Therefore internal systems did not automatically raise professional concerns, even though the circumstances still reflected an increasingly delayed paediatric assessment.

- 7.7** It was a reflection of the school's concern that the deputy head took the unusual step of having a telephone conversation with the GP in late January 2012, whose advice was to ask the mother to make an appointment. This did not reflect any urgency by the GP in that the school could easily have advised mother to do this without having to contact the GP as a first step. A more proactive response by the GP would have been to make contact with Ms Luczak and to send an appointment. The school apparently used the conversation with the GP to give some detail of their concerns and of the urgent need as they saw it, for Daniel to be seen, and yet the detail of the conversation was not placed on the records and when the mother did not make an appointment, the GP did not inform the school. Although the conversation between the school and the GP was reported by the deputy head to have lasted thirty minutes, it appeared not to have identified a child protection concern – presumably if the school had identified their concerns at this level, they would have simultaneously referred the matter to CLYP. In this way it was not apparent to what extent the conversation with the school had alerted the GP to any significant concerns. There was also some difference of recollection in that the GP did not recall having a lengthy discussion with the deputy head.
- 7.8** It was concerning however that two weeks after the telephone conversation, Ms Luczak attended the surgery on her own in respect of her own health needs, and yet the GP did not take the opportunity to discuss Daniel with her and to ensure, as a minimum, that she was given an appointment to attend with him. The difference in surnames of the mother and Daniel may have made making the connection difficult for the GP, particularly if Daniel's details had been placed on the his file only, although this important information should have been noted appropriately in both the mother's and child's records. Also the content of the discussion with the school should have been written in the mother's records so as to provide the necessary alert. Whatever the reasons for the lack of connection between the telephone call from the school and Ms Luczak's attendance at the surgery, it represented a missed opportunity to directly discuss the concerns about Daniel with his mother and to request her to bring him to the surgery. Whilst the school wrote a "to whom it may concern letter" for Ms Luczak to take to the GP, it was written a day after the appointment that she attended, although she was able to present it to the community paediatrician at the eventual clinic appointment in February 2012. The letter also now reported that Daniel was losing weight and listed all the other concerns. Though well intentioned, the letter therefore did not do anything to speed up the health interventions with Daniel, and the GP remained a passive recipient of information and concerns.
- 7.9** Daniel's loss of weight was a concern and whilst he appeared to present as thin and not growing, without arrangements for him to be weighed, there was no clarity for practitioners at the time about whether he was actually losing weight or not. The initial interventions by the health visitor at this time and then the school nurse and support worker, did not address any weight loss issues. Unfortunately his weight was not taken at his three year developmental assessment in July 2010 and the school nurse similarly did not do this at the time of the referral to the community paediatrician, wrongly assuming that it had been done when he commenced school. This should have been undertaken before any package of care

was being created (i.e. a programme of support and advice from the support worker which was the first action before the paediatric referral). In fact the school nurse did not have any direct contact with Daniel when an assessment by her would surely have been informative before making any decision about future actions or onward referral.

#### The Paediatric Assessment – 10<sup>th</sup> February 2012

- 7.10** Daniel had been weighed at the time of his hospital admission in early January 2011, which at that time was 14.8 kg. When his weight was taken in February 2012 by the paediatrician, he had lost a kilogram. If Daniel had been putting on weight at a normal rate over the 13 months between him being weighed, he should have been at least 3 kg heavier in February 2012, i.e. at about 17.8 kg when in fact he was 13.8 kg. The paediatrician had access to the previous weight although it was not apparent at the February 2012 appointment that this was taken into account. In his referral letter after the appointment there was reference to poor or slow weight gain when in fact there had been weight loss. The failure to assess Daniel's growth properly was significant in this regard, in particular the lack of comparison with previous measurements. An accurate understanding of the weight loss should have raised concerns, especially as there seemed to be a conflict between excessive eating combined with weight loss (or poor weight gain as the paediatrician thought.) As part of the examination, the paediatrician recorded that Daniel was "growing along the 0.4<sup>th</sup> centile" although this was an inaccurate statement as a growth chart was not completed and there had been no link to the earlier weight which was on the 9<sup>th</sup> centile. It would have been accurate to have recorded that his weight on this occasion was on or around the 0.4<sup>th</sup> centile. (Whilst at his post mortem Daniel's weight was only 10.7 kg, this was a dehydrated weight which would not reflect weight loss for the few weeks between his paediatric appointment and his death and could not therefore be used as a comparative weight).
- 7.11** Although Daniel's height was measured at the paediatric appointment, there was no recording of his Body Mass Index (BMI) which would have been a very helpful indicator of Daniel's well-being. A more rigorous enquiry into his growth in terms of height and weight should have been done in a child presenting with excessive eating and low weight, which in effect did not make sense. Taking into account the broader concerns included in his records regarding the earlier hospital admission of the fractured arm, domestic abuse background in the family and Daniel's alleged behaviour problems, then this should have raised questions about the overall level of care of Daniel and his experiences at home and to what extent these might account for his presentation at this time.
- 7.12** This appointment with the community paediatrician was therefore a key opportunity to address the problems being presented by Daniel. It was apparent that a detailed examination took place and it was relevant that the paediatrician sought further tests and consultation with colleagues about the likely cause of Daniel's condition and the additional likelihood of autistic spectrum disorder. Because of apparent signs of threadworm, medicines were prescribed in order to try to treat this. Whilst it could be considered that this was an appropriate examination of Daniel at this appointment, this was in the context of the paediatrician having a view that there was an organic cause for Daniel's symptoms. In the UK however, "worms" do not cause weight loss. It was not considered whether Daniel was acutely unwell or needed hospitalisation and although the paediatrician had been

initially concerned enough to ensure that repeat appointments were made in order to make sure that Daniel attended this appointment, there seemed a level of reassurance when it took place, which was reflected in a review appointment not being setup for a further four months. Whilst the paediatrician's referral letter was copied to the mother and to the school, it was an oversight that it was not copied to the GP, although a separate letter was written two weeks after the examination for the GP in terms of the repeat prescriptions that would be necessary for Daniel.

**7.13** When linked with some of the background information of concerns, then Daniel's presentation, not only in terms of his excessive appetite, but his soiling and other behaviour difficulties as described by his mother, should have alerted the paediatrician to possible emotional abuse or neglect although this line was not pursued as a possible cause. Consequently no contact was made with CLYP in order to discuss the situation and possibly make a referral. It was clear that within the appointment, the paediatrician considered that Ms Luczak presented as an appropriately concerned mother who spoke adequate English for the consultation. Ms Luczak's positive presentation may well have been a key factor in abuse not being identified as a possible causation. Certainly the school had also generally viewed Ms Luczak in a positive light as someone who was concerned for her son. In this way it was apparent that Ms Luczak presented as plausible in her accounts of family life and of her commitment to her children.

**7.14** Whilst it was reported that Ms Luczak's "partner" also attended the paediatric appointment, no record was made of any contribution that he may have made. However the paediatrician's evidence at the criminal trial referred to Mr Krezolek's behaviour at the appointment as "unacceptable" in that he was apparently upset that there was no immediate remedy to Daniel's presenting problems and he had laughed when Ms Luczak had given an example to the paediatrician of the family leaving a restaurant after a meal and Daniel then picking up a chip from the pavement. This should have raised further concerns about the parental attitudes towards Daniel and of his difficulties. Alongside the view that Daniel's main problems were organically caused, the paediatrician also took the view that Daniel had a speech delay, rather than his lack of communication being linked to any emotional context, anxieties or connected to self-esteem issues.

**7.15** Growth failure without organic cause, in association with behavioural difficulties and child abuse has been termed "psychosocial short stature" although it is not classified within psychiatric or diagnostic systems because of its rarity and the possibility that some cases are caused by deliberate starvation. Additionally "hyperphagia" is defined as a persistently abnormal pattern of food seeking or eating behaviour characterised by stealing food at home and school, nocturnal searching for food, and gorging and vomiting when liberal excess of food was available<sup>34</sup>. Psychosocial short stature within one study identified the most common characteristics associated with it as eating problems, behavioural problems and encopresis<sup>35</sup>. Daniel's presentation at this time and the behaviours recorded in respect of him had potentially strong links with psychosocial short stature and/or hyperphagia,

<sup>34</sup> References contained within "A new stress-related syndrome of growth failure and hyperphagia in children, associated with reversibility of growth-hormone insufficiency", Skuse, D et al The Lancet Vol. 348 1998

<sup>35</sup> Recognition of Children with Psychosocial Short Stature: A Spectrum of Presentation, Gohlke, B et al, Journal of Pediatric, Endocrinology & Metabolism, 11, 509-517 (1998)

which in turn had clear components of emotional abuse. However the paediatrician did not consider that with Daniel's height around the 9<sup>th</sup> – 25<sup>th</sup> centile that Daniel was in fact of a short stature. This was understandable in that this height on its own would not be considered as a concern. Also there had been no previous height taken. It was nevertheless appropriate for the paediatrician to have linked this with weight loss and considered all possibilities for Daniel's presenting condition. The failure to apparently make any possible link with abuse and explore some of these rare conditions meant that insufficient urgency was applied to the situation. Considering the background of the family situation and Daniel's presentation, then emotional abuse or neglect as a causation of his condition should have been the subject of enquiry, and at a minimum, viewed at least equally to other possible causes that were being pursued.

- 7.16** The respective IMR and an appendix written to provide further analysis to the SCR process of the paediatric practice at this time, considered that overall the medical investigations were appropriate and that "most paediatricians would have reached a similar conclusion on the evidence available at the time". No doubt the paediatrician was both committed and concerned to do the best for Daniel and did so in the belief that his condition was related to organic causes. However it is difficult to agree that the paediatric assessment was appropriate in that this reflected an opportunity to gain a more thorough understanding of Daniel's circumstances, and that there was a failure to consider child abuse as a differential diagnosis alongside the significant lack of recognition of the weight loss. The relevant guidelines<sup>36</sup> about when to suspect maltreatment refer to the need to "consider" or "suspect" abuse in any clinical presentation. If a holistic assessment of Daniel's circumstances had been made, with the potential of child abuse considered, then this would likely have provided sufficient concerns for a referral to be made to CLYP for an assessment of risk.

#### Injuries to Daniel noticed by school staff

- 7.17** Of considerable concern during this period of time in either late 2011 or early 2012, was that the school noted injuries on Daniel which had not been caused by any accidents in the school. The lack of recording of them by the school was a concern in itself as well as the fact that 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). It appeared that there were three occasions as a minimum when injuries occurred, and that these included facial injuries, and potentially finger bruising to the neck. In fact in the trial, the class teacher said that in her view this was caused by someone trying to strangle Daniel, and that she thought that the mother had done this. On one occasion the head teacher asked Anna to explain a particular injury and what had happened and in response she spoke of Daniel being pushed over by a child on the

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<sup>36</sup> National Institute for Clinical Excellence (N) Guidelines 2009 – "When to suspect maltreatment"

way home. It was inappropriate of the school to use Anna in this way and as a minimum Ms Luczak should have been asked about these incidents. There then followed some muddled communication to arrange for Ms Luczak to be spoken to by the class teacher when she came to the school, but as she was not on duty at the time, this did not happen.

- 7.18** With the background of mounting concerns by the school about Daniel's obsession to seek out food, as well as poor growth and possible loss of weight, it was surprising and very concerning that these injuries were not linked to those concerns. Whether the evidence presented by school staff within the criminal trial was influenced by a level of hindsight is not possible to say, but if there were such concerns about the injuries alongside the background of the other concerns, it is difficult to understand why the school did not coordinate these and ensure that a child protection referral was made to CLYP at the time. Despite considerable individual concerns by school staff, these were not developed into a coherent referral to CLYP. The school missed this clear opportunity to formally raise the level of concerns to the child protection level. 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.

### Summary

- 7.19** Overall, the period of autumn/winter 2011/12 contained a number of missed or delayed opportunities to intervene more effectively to assess and respond to the mounting concerns about Daniel's behaviours, physical injuries, lack of growth and weight loss. Significantly during this time, abuse was not considered as a factor or cause of his problems and no referral made to CLYP when it was apparent that more robust enquiries and assessments of risk between October 2011 and February 2012, would have determined that such an action was both appropriate and necessary from the involved professionals.
- 7.20** Evidence from the criminal proceedings strongly suggested the deliberate way that punishments of Daniel, such as being locked in the box room on his own, making him eat salt, performing physical exertions, and placing him in a cold bath, were planned in advance. These incidents occurred during the last six months of Daniel's life although none of them were known to professionals who were working with the family at this time. It was also clear from this later evidence, that the parents deliberately deceived professionals about what was happening at home, and Ms Luczak was able to present an image of being caring and concerned about her children.

**8. Professional communication, information sharing and liaison in respect of service delivery, including between those working out of hours and across borders?**

- 8.1** The changes of addresses by the family, including moving out of Coventry for a period of time, meant that there were inevitable changes in professionals which for example led to different health visitors and midwives becoming involved. Whilst this meant that professional communication was likely to be a challenging process to undertake effectively, conversely it generated a greater need to be efficient if joined up services were to be offered in a seamless way. The change of addresses as well as a poor commitment by the parents/carers to sustain professional involvement meant that on occasions plans were not followed through. For example the nursery nurse package of care agreed for Daniel was not followed through from July 2010 when the case was transferred to a different locality team.
- 8.2** Somewhat surprisingly however, there were only two GP practices involved, although because of their limited involvement with the family and their lack of any proactive communication with other agencies, they tended to be on the periphery of professional communication. In this way, this should register a concern locally that GP practices are not engaged within the multi-agency professional community in endeavouring to address the needs of vulnerable children.
- 8.3** The professional communication issues in respect of domestic abuse notifications and in respect of the Joint Screening arrangements have already been addressed, although there were some additional examples of professional communication issues in respect of how referrals were made and received by CLYP. The respective health IMR identified that there were numerous attempts by health visitors to contact social workers either to express concerns about the family or to gain updates, but these were often unsuccessful. There were also no acknowledgements of outcome of referrals/contacts made back to health workers following concerns being formally expressed. No reasons were given for this, despite it being a procedural requirement to inform professionals of action taken on receipt of a child care referral.
- 8.4** There was an example of confused and ineffective communication on an important occasion when the hospital midwife wished to make a referral to CLYP following the birth of Adam. 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 Ms Luczak 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. This was poor practice, especially as it was a crucial time when not only was there a vulnerable baby in the home but it reflected the time when Daniel's problems with food and his accompanying lack of growth and loss of weight, emerged. Purposeful intervention at this time could potentially have made a difference in assessing the family situation.

- 8.5** 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. Similarly the school nurse made a false assumption that Daniel's weight and growth had been taken by a colleague.
- 8.6** As with the management of domestic abuse incidents, there were other occasions when formal communication should have taken place, such as at times of formal assessments and the sharing of Strategy Meeting minutes. The poor quality of three of the four formal CLYP assessments meant that ideal opportunities for effective professional communication were lost. There were also occasions of formal handover of information not taking place between health – e.g. the health visitor was unaware of the pregnancy in respect of Adam and there was lack of clarity about the handover process between the health visitor and school nurse in late 2009. There was however generally good communication between the midwives and health visitors.
- 8.7** There were also some good examples of professional communication between the hospital and the community services at times of admissions of either Ms Luczak or when Daniel was admitted with his fractured arm, although on the latter occasion, a discharge summary report would have aided effective information sharing at this crucial time. However the GP IMR identified that information about hospital admissions had not been routinely received. The respective hospital IMR does not however identify this as being a problem.
- 8.8** With the family's move outside of Coventry, this had the potential to significantly compromise communication but in fact there was evidence of some good information sharing by health services and especially when a new hospital outside Coventry was briefly involved in mother's care. It was helpful that the community midwife continued to be involved despite the mother moving outside of Coventry.
- 8.9** 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. Similarly when there was a Strategy Meeting in January 2011, the professionals appeared to not have had access to information of the work completed by another Children's Social Care team whilst the family were living outside Coventry, or of the role of the Police in Warwickshire. In fact there had been three incidents (Nos. 21, 22 and 23) and a resulting involvement of the local social work team, albeit quite brief. In consideration of the long history of domestic abuse by that time, greater attention should have been paid to the likelihood of it continuing in the locality that they had briefly moved to in the early part of 2010.
- 8.10** It was concerning that when information was appropriately shared, it was sometimes not utilised. For example although in the GP records transferred from the first GP to the second GP, there was information from the midwife about domestic abuse incidents, these were not utilised by the GP. In effect therefore the GP as a key professional in providing services



to the family did not know of the domestic abuse and violent background. Similarly, whilst the school received information from Anna's previous school, they did not look at it, and similarly when the Education Welfare Service received records from Warwickshire, they did not consult them. Time should always be taken to review past records before embarking on the delivery of new services. This problem has been highlighted in the review of Serious Case Reviews nationally and identified the development of the "Start Again Syndrome". This relates to past information not being considered or being downgraded by a professional with a preference to "start again" with the family without the benefit of understanding the level of previous concerns or patterns of care or events. This was also evidenced in the repeat but unconnected assessments undertaken by CLYP. However, an example where this pitfall was avoided in this case occurred when the school nurse reviewed past records and recognised the worrying pattern of domestic abuse and accordingly took proactive action.

**9. The extent to which practitioners were knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?**

- 9.1** Generally the IMRs reflected that staff were sufficiently trained and experienced to be able to detect potential indicators of abuse and to know how to respond accordingly. Whilst there were clearly some examples of this within this case, there were nevertheless too many occasions when insufficient attention was paid to circumstances where the children were at risk, especially in relation to the domestic abuse and adult alcohol abuse which was such a feature of the their lives. Of particular concern was the lack of attention to risks at the times of Ms Luczak's pregnancies and at the times of the birth of Adam.
- 9.2** The relevant IMR states that the school which both Anna and Daniel attended had staff which were knowledgeable about the potential effects of abuse and neglect and that a comprehensive training package was available to them. Whilst the evidence from this case suggests that staff, including those at junior levels, recognised the concerns for Daniel, what was missing was a coherent understanding of how to articulate and action those concerns in an effective way. Either this had been missing from training or the designated person in the school had not clarified the child protection responsibilities to other staff. 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.
- 9.3** It was apparent that some of the failings in this case related to systems not working effectively rather than simply to individual errors. Because opportunities were sometimes missed by practitioners to intervene more effectively or to apply a greater child focus to interventions, then this would suggest that the local learning from safeguarding training was not being implemented in practice or that management oversight of practice was insufficient.

**10. Sensitivity to the racial, cultural, linguistic and religious identity – Did the family’s migrant status and housing mobility have an impact on the child/children or on the parents’ capacities to meet their needs?**

- 10.1** There was contradictory information about the degree to which Ms Luczak could speak and understand English and whilst some practitioners clearly believed that her English was poor and needed an interpreter, others considered that her English was sufficient to enable discussions to take place without an interpreter. At times Ms Luczak was being seen when tensions were high, and she may well have been intoxicated at the time, particularly when in contact with the Police, and inevitably these sorts of circumstances would further compromise her linguistic abilities. It was an additional failure of the assessments undertaken that they did not explore or give a definitive view about her linguistic ability. On the vast number of occasions that professionals had contact, on only a small number of occasions was an interpreter used, and letters that were sent to Ms Luczak were generally sent in English. These were often significant in relation to medical appointments and information about how to seek support from domestic abuse situations. Clearly this issue should have been given much greater attention and the lack of doing so likely meant that written communication was potentially ineffective. The Police however were more consistent in their use of interpreters and in sending letters in Polish, when dealing with the adults at times of domestic abuse incidents. Mr Pelka in his interview and contribution to this SCR said that he felt that he was always understood in his dealings with the Police and that he recalled the use of interpreters on such occasions. This was good practice.
- 10.2** Sometimes family members or the male partner was asked to act as interpreter, and whilst their use, particularly at times of an emergency or when a crisis situation arose was a pragmatic and understandable way to deal with a situation, overall it should have been balanced with opportunities to discuss the presenting situation in a more controlled and calm setting with an interpreter. Working Together states that “Family members or friends should not be used as interpreters, since the majority of domestic and child abuse is perpetrated by family members or adults known to the child”<sup>37</sup>. This primarily refers to the key points of intervention with families when child protection enquiries are being undertaken which did not consistently apply in this case apart from the incident when Daniel fractured his arm. On this occasion agency records made no reference to the use of an interpreter at such a critical time, and in fact when the Police interviewed Anna to corroborate the version of events given by the family at the hospital, although it was thought that Anna had a reasonably good command of English, on occasions she reverted to Polish at which point a friend of Ms Luczak was used to translate. (Anna was interviewed in the friend’s home). This was not acceptable, could have compromised confidentiality, and Anna may not have felt that she could talk openly about her home life.
- 10.3** It was not clear if interpreters were used with Ms Luczak and Mr Krezolek regarding this incident, but even at his age of 3 ½ years, Daniel should have been seen alone with an interpreter in an attempt to clarify his version of events and to try to gain some understanding of his relationship with his mother and Mr Krezolek. It could therefore be

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<sup>37</sup> Para 10.8, Working Together to Safeguard Children – Dept. for Children, Schools and Families, March 2010

argued that the Working Together statement that “All children, whatever their religious or cultural background, must receive the same care and safeguards with regard to abuse and neglect”<sup>38</sup> was compromised because of the lack of any meaningful interview being undertaken with Daniel at this time and on later occasions when concerns about his welfare began to mount.

- 10.4** 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.
- 10.5** 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. In respect of migrant families, “The erosion of cultural and personal identity makes it hard for individuals to pursue their conception of a good life and construct a coherent sense of personal identity, which can lead to a wide range of psychological and social problems, for example depression, unhappiness, anger, a sense of meaninglessness and poor family cohesion”<sup>39</sup> Certainly Ms Luczak periodically suffered with depression and regularly misused alcohol but the reasons for this or of any cultural context was never understood. As far as was known, Ms Luczak only had relationships with Polish men who themselves may have had challenging issues to deal with as immigrants to this country. It was concerning that there was never any real attempt to understand these issues in order for more meaningful interventions to be developed.
- 10.6** The extent to which the domestic abuse and the alcohol misuse by the parents/carers was potentially related to any cultural factors was again not explored. Ms Luczak generally denied domestic abuse apart from when she was in the midst of an incident or had been drinking, but then she usually later denied its existence and refused to support the Police in completing any investigation once the crisis had passed. The advisor to the SCR Panel on the Polish culture did not consider that domestic abuse was more prevalent in the Polish community than any other but explained how a mother would be more reliant on income from a partner because of her lack of recourse to public funds. This level of dependency may of course have created more difficulties for Ms Luczak to extricate herself from violent relationships. Once again the failure of the assessments undertaken with the family to address any of these issues reflected poor practice. Whilst a feature of alcohol misusing parents is to put considerable energy in hiding the problem from professionals, “the issue of secrecy looms large for ethnic minority groups when it comes to accessing services. Seeking

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<sup>38</sup> Para 10.13, Working Together to Safeguard Children – Dept. for Children, Schools and Families, March 2010

<sup>39</sup> Culture and Child Protection – Reflexive Responses – Connolly, M, et al – Jessica Kingsley 2006

help outside the community can be problematic for a range of cultural reasons, since admitting to substance misuse problems may lead to exposure and censure<sup>40</sup>.

**10.7** Within school, Anna was helped by joining a language group which provided much needed help to develop her use of the English Language and no doubt helped her to integrate into school life more effectively. The down side of this was that she was occasionally inappropriately used as a translator for her mother and to speak on Daniel's behalf. In respect of Daniel who was regarded as a quiet and shy boy in school, it was not apparent to the school staff whether this was part of his personality or reflected his inability to speak English. It was unclear why Daniel was not occasionally given access to an interpreter, which was not apparently difficult to arrange. Perhaps his young age and consideration that he may ultimately have special educational needs, meant that it was not thought that the use of an interpreter would be useful. The paediatrician in fact considered that Daniel had a speech delay problem. Whatever the reason, Daniel should have been afforded the opportunity to use an interpreter. Surely this would have been a valid course of action at the time of the mounting concern about his welfare in late 2011/early 2012, even if the concern was viewed primarily as a medical problem.

**10.8** Whilst the school which both Anna and Daniel attended had a high proportion of children from ethnic minorities (66.1%), and a high percentage of children who did not have English as their first language (64.4%)<sup>41</sup>, just 8 children of the 188 in the school were from Poland. It was clearly therefore a challenge for the school to meet the requirements of a wide range of cultural and linguistic needs of its children. However whilst there was clearly attention and concern about Daniel and his health and developmental needs whilst in school, greater attempts to communicate more effectively would clearly have been significant in helping to address these problems.

### **11. Were senior managers or other organisations and professionals involved at points in the case where they should have been?**

**11.1** In respect of the services provided to the family by health practitioners, it was apparent that A&E, hospital staff and midwifery staff did discuss the family appropriately with senior managers and safeguarding leads. In this way in terms of Ms Luczak's ante natal care and during Daniel's admission for the fractured arm, relevant managers and specialists were effectively updated and directly involved as necessary. Whilst one of the health visitors discussed the family with her team leader on one occasion, there were other situations when the circumstances would have benefited by consultation or guidance from a manager. This may have prevented some of the missed opportunities for intervening more proactively from occurring.

**11.2** Whilst CLYP records identified that there was management oversight of this case, this must be questioned particularly with regard to the failure to address the poor quality of three of the four assessments undertaken. The respective IMR author considers that the assessments must only have been given cursory attention, possibly because the social

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<sup>40</sup> Parental Substance Misuse and Child Welfare, Kroll, B and Taylor, A – 2003, Jessica Kinglsey

<sup>41</sup> Figures relate to January 2012

workers involved were considered to have significant experience or that workload pressures had a significant impact.

**12. Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?**

- 12.1** Overall, procedures were said to be broadly adhered to by agencies although there were some notable exceptions in terms of the completion of assessments and the inconsistent response to referrals by CLYP. Additionally it was more about the application of the procedures in practice and their efficiency, rather than failures to adhere to them completely. Examples included the Strategy meetings, and whilst domestic abuse notifications were usually appropriately made, the timing of this was erratic and there was a failure by the agencies to consider the accumulative effect of these incidents.
- 12.2** Case recording, not only for CLYP, was frequently problematic and often not in line with procedures. Significant pieces of information were not always fully evidenced, for example the referral to CLYP by the midwife at the time of Adam's birth was not recorded, and in terms of information about domestic violence not being recorded sufficiently on the child's health records. The issues about the lack of school child protection records have already been addressed. Overall these examples of poor record keeping were very concerning and demonstrated a failure of the most basic aspect of child protection work. It was important therefore that the respective IMRs separately addressed these issues.

**13. Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resource issues such as vacant posts or staff on sick leave have an impact on the case?**

- 13.1** The existence of difficulties between agencies, such as the Joint Screening process has already been addressed in the report. In respect of individual agencies, neither the school nor the Education Welfare service was suffering from staffing or capacity issues although the high level of staff changes in the latter was felt by the school to be unhelpful. Police similarly did not raise any issues of internal organisational difficulties which had an impact on practice other than the significantly high numbers of domestic abuse instances to which they were required to respond.
- 13.2** In April 2011, Coventry Community Health Services were integrated with Coventry and Warwickshire Partnership Trust at which time the service was placed on the corporate risk register due to significant staffing and recruitment difficulties. There had been historical under resourcing of the health visiting service, and the respective IMR appendix identifies that in early 2011 there was a target set for a significant increase in the health visitor establishment, with the average caseload for a health visitor being 600 in Coventry, whereas the national recommended caseload was 400. In this way it can be seen that when working with this family, (who appeared to not reach a threshold of child protection concerns), how they were likely to get a diminished service in these circumstances. Clearly the

interventions by health visiting services in this case need to be viewed within this concerning context. Additionally, the mobility of the family did present challenges to the health visiting service to keep track of them and to provide timely interventions. Hospital based services did not appear to be adversely affected by any organisational difficulties.

- 13.3** The IMR for CLYP identified internal organisational issues which may have impacted on the quality of the social work practice that was delivered to the family. Apart from a perceived over bureaucratic system felt by staff to create obstacles to good practice, those interviewed for this SCR identified high levels of workload in the referral and assessment service with a high conversion rate of referrals into cases. Difficulties were experienced in transferring cases into the longer term and specialist teams, leading to a backlog of work and less time afforded to new cases coming into CLYP. Although high levels of stress were reported among social work and operational managers, CLYP was nevertheless fully staffed with low levels of absence and sickness.

#### **14. Summary of Findings**

- 14.1** This case raised particular questions about the ability of the different agencies to address domestic abuse, other than the immediate response of diffusing a situation. This in itself was of course very important and such quick interventions may well have been instrumental in preventing situations getting further out of hand. Nevertheless, there was a greater need to develop an effective understanding of why it was happening and of the impact upon the children. On occasions, professionals demonstrated a degree of professional naivety in respect of domestic abuse regarding whether it was likely to cease or of the possible impact upon the children, none of which was challenged on an inter-agency basis or by management oversight. Instances of concern tended to be viewed in isolation with a lack of attention to the patterns which were developing.
- 14.2** In consideration of whether his tragic death was predictable or preventable, it could be argued that had a much more enquiring mind been employed by professionals about Daniel's care, and they were more focussed and determined in their intentions to address those concerns, this would likely have offered greater protection for Daniel. There needed to have been a greater focus on his day to day experiences, with concerns about his injuries responded to in accordance with procedures, as well as more holistic and probing assessments undertaken at earlier stages, (for example at the time of Daniel's fractured arm). Professionals would then have had a much greater chance to identify concerns and risks to the children, and respond accordingly at the time they were happening.
- 14.3** 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. Reviews of serious case reviews have identified that serious head injury as a cause of death or serious injury to a child has been a most common feature for those children who are aged one year and under, whereas Daniel was approaching five years of age. No one professional, with what they knew of Daniel's circumstances, suspected or could have predicted that he would be killed.
- 14.4** Whilst there were committed attempts by school and health professionals to address Daniel's health and behavioural issues in the few months before his death, too many opportunities were missed for more urgent and purposeful interventions to consider abuse as a possible causation of his problems. It was clear that the school were very concerned about Daniel's apparent obsession with food, and alerted health professionals to respond to this. However they did not link the injuries which they identified on him with these overall concerns. In this respect, the range of interventions provided by a number of agencies did not prove sufficient in themselves to protect Daniel.
- 14.5** Whilst there were instances of good practice in this case, it was disconcerting that the themes about lessons to be learned which have been identified in this report, tended to

reflect the findings of many Serious Case Reviews nationally. For example, poor quality assessment practice, the failure to maintain a child focus to interventions, as well as a failure to engage significant males and not to take a holistic view of the concerns being presented, occurred within this case but have all been raised numerous times before. Systems failed to support effective practice in terms of facilitating good communication processes as in the domestic abuse Joint Screening and in the use of Strategy Meetings, as well as some of the administrative systems which appeared to create difficulties for practitioners. In this way 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.

- 14.6** 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. Similarly for CLYP, high levels of workload in the referral and assessment service with a high conversion rate of referrals into cases created considerable pressure on the service. Difficulties were experienced in transferring cases into the longer term and specialist teams, leading to a backlog of work and less time afforded to new cases coming into CLYP. This potentially led to some of the practice with this family being delayed and not being sufficiently challenging or robust as it should have been. Also when actions were agreed at a multi-agency level, there was no chasing up of these by partner agencies.
- 14.7** This was a complex case for a number of reasons and it would be too simplistic to identify failings by individual practitioners as the reasons why Daniel was not protected. No individual practitioner works in a vacuum and that was true for this case in that the actions or inactions by individuals was at least partly informed by the management support and advice they received, the efficiency of the systems and processes within which they were working, the training they received, and their workload and organisational context. Nevertheless for future learning, it is important to try to identify some of the reasons why Daniel's abuse was not recognised and acted upon earlier by practitioners who came into contact with him. These were likely to have included:
- Ms Luczak presented as plausible in her concerns, presented on many occasions as a capable and caring parent (when not in the midst of domestic abuse incidents) and took an assertive stance with professionals. Her manipulation, avoidance of contact with practitioners, deceit and actions (as well as that of Mr Krezolek) were not recognised for what they were and her presenting image was too readily accepted.
  - Ms Luczak's male partners did not regularly present themselves to practitioners and were hardly ever the focus of proactive intervention or enquiry.
  - There were no specific concerns about the care of either Anna or Adam; in fact at times they were viewed as well cared for. This did not fit with the pattern that neglect usually impacts upon all children in a family.



- It is relatively rare in cases of child abuse that one child is singled out and scapegoated in the way that Daniel was. The apparent good care of the other children appeared to give a false reassurance that Daniel's problems were not related to abuse.
- Daniel's presentation of scavenging for food and his excessive eating when he found any sort of food, as well as being linked to weight loss, was rare to see in a child, and assumptions were then too readily made that his problems were medically based.
- Compared to other forms of abuse, emotional abuse is the most difficult to detect.
- In these circumstances, the practitioners involved were not prepared to "think the unthinkable" and tried to rationalise the evidence in front of them that it did not relate to abuse. The words of a philosopher were particularly relevant in this case in which he says "we see things not as they are, but as we are"<sup>42</sup>. If practitioners were not prepared to accept that abuse existed for Daniel, then they would not see it.
- No concerns were expressed about the care of Daniel to CLYP or to the school by neighbours or the community. If there were, then these might have added weight to the mounting concerns.
- Neither Anna nor Daniel ever expressed any concern about their care at home.
- Multi agency child protection systems such as Joint Screening for domestic abuse, Strategy Meetings, recording requirements and assessment practice, sometimes failed to support effective coordinated interventions between organisations and practitioners.

**14.8** The above list is not meant to explain away the lack of protection that Daniel was afforded by professional interventions, or to give excuses for such practice. It aims to give some possible insight into the way that a particular set of circumstances and dynamics can lead to referrals for child protection not being made and ineffective interventions undertaken which are not sufficiently child focussed, by practitioners who were otherwise committed in their wish to address Daniel's needs and protect him. Unlike the UK, some countries have a process for mandatory reporting of child care concerns to government departments<sup>43</sup>, which raises the question that if it existed here, whether injuries seen upon Daniel would have been independently reported by individuals to the authorities.

**14.9** Of particular note was that without English as his first language and because of his lack of confidence Daniel's voice was not heard throughout this case. Whilst some school staff were able to give helpful descriptions of Daniel in their observations of him in class, overall there is no record of any conversation held with him by any professional about his home life, his experiences outside of school, his wishes and feelings and of his relationships with his siblings, mother and her male partners. In this way despite Daniel being the focus of concern for all of the practitioners, in reality he was rarely the focus of their interventions.

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<sup>42</sup> Emmanuel Kant – German Philosopher 1724 - 1804

<sup>43</sup> "Mandatory reporting is a terms used to describe the legislative requirement imposed on selected classes of people to report suspected cases of child abuse or neglect to government authorities" Australian Government – Institute of Family Studies – July 2013

## 15. Lessons Learned

- 15.1** When concerning childcare incidents take place or a crisis arises for a family, these provide key opportunities to intervene at a time when parents may be responsive to change, or children are able to speak of their experiences. To not take proactive interventions at such times will create missed opportunities to protect the children, which may not recur again in such circumstances. Each opportunity which presents itself to protect a child must be taken.
- 15.2** Reassurances by parents about domestic abuse ceasing and that the children are not affected, need to be robustly challenged and responded to with respectful uncertainty by professionals.
- 15.3** Sole reliance on a parent's explanation of events and views about family relationships and associated risks to the children, must be balanced with the presenting objective information available or evidence sought to support or challenge parental assertions. To not do so will potentially leave children at continuing or un-assessed risk.
- 15.4** Domestic abuse/violence is always a child protection issue and must always be approached with this as the mind-set of professionals.
- 15.5** No assessment of risks within a family or to a particular child can ever be effective without direct engagement of that child as an integral part of the professional interventions, and in working hard to gain an understanding of their experiences, wishes and feelings. There must be a child focus to all interventions.
- 15.6** To focus on concerning incidents in isolation and only deal with the "here and now" will not make it possible to take a holistic approach and therefore consider other similar incidents or other concerns at the same time. To be too incident-focussed will mean that the ability to develop an understanding of patterns of behaviour and family lifestyle will be seriously compromised.
- 15.7** Professional accountability for record keeping, timely reports and recording of key actions from multi agency meetings, is central to professional childcare practice, and to fail to complete appropriate records will significantly compromise inter agency working and reduce the collective ability of agencies to protect children.
- 15.8** Any facial injuries to a child must be viewed with concern, with physical abuse needing to be actively considered as a possible cause, and clear records, interventions or referrals made accordingly. To have no efficient system to collect and collate details of such injuries and actions will compromise later attempts to protect a child.
- 15.9** Even small units of service delivery to children and families, such as small schools, require a robust system to ensure collation of child protection concerns and appropriate actions, rather than rely on informal forms of communication within a small staff group.

- 15.10** Whilst a prominent injury to a child will inevitably attract the greatest professional attention (as occurred with Daniel’s fractured arm), the injury must be seen in the context of any other injuries or bruises, however minor they may be, and for their causation to be separately and then collectively considered.
- 15.11** For professionals from Children’s Social Care or the Police to defer to medical staff for the provision of the primary evidence to confirm or otherwise whether an injury to a child was the result of abuse or not, could be unhelpful, particularly when no definitive view one way or the other can be given. To do so could lead to any following investigation being inappropriately downgraded and implies that other aspects of the child life are less significant for the purposes of assessing the existence of child abuse.
- 15.12** When faced with significant and complex concerns about a child’s welfare, it is essential that professionals “think the unthinkable” and always give some consideration to child abuse as a potential cause of the presenting problems. To not do so would be a disservice to the child involved and potentially leave him/her at increasing levels of risk.
- 15.13** Professional optimism about a family and of their potential to change or improve their parenting must be supported by objective evidence and that any contra indicators have been fully considered prior to any optimistic stance being taken.
- 15.14** For any professional to make a decision about their own interventions based on assumptions about the actions or views of other professionals without checking these out, is professionally dangerous practice.

## **16. Overview Report Recommendations**

### **Domestic Abuse**

- 16.1** There must be a review of the systems which currently exist for the notification and sharing of information in respect of domestic abuse incidents within families to ensure that they generate effective outcomes in relation to the safeguarding of children. The review should particularly focus on:
- the timeliness of notifications,
  - the agency to which they should be distributed, including schools,
  - the importance of a focus on the needs and safety of the children,
  - the efficiency and effectiveness of the joint screening processes and the responsibility for agreed outcomes, and
  - how repeat domestic abuse incidents need to be responded to more holistically.
- 16.2** In order for the LSCB to understand and identify how to improve the multi-agency response to domestic abuse notifications, particularly in respect of the safeguarding of children, then an audit process must be developed to judge how individual agencies respond to notifications which they receive, and as a result, what changes are needed to improve the ways in which agencies individually and collectively ensure that the protection needs of the children involved are being addressed by such responses.
- 16.3** The LSCB needs to demonstrate a clear cohesive understanding of the scope of early help and prevention work to support children living with domestic abuse.

### **Referral and Assessment**

- 16.4** The LSCB will need to be assured by the provision of evidence that assessments undertaken by Children's Social Care appropriately involve and consult with other agencies and professionals in the completion of such assessments and do so in a timely manner.
- 16.5** The LSCB must be assured that Strategy Meetings/Discussions are being efficiently and accurately recorded with actions clearly identified for individual agencies or professionals to undertake, and that the record and listed actions are distributed to the relevant agencies in a timely fashion.
- 16.6** In instances within a Strategy Meeting/Discussion when medical opinion is inconclusive regarding whether an injury was accidentally or non-accidentally caused, then the follow up interventions with the family must continue to include the child protection concerns as factors and address them rigorously until any new information or assessment discounts them.
- 16.7** Children's Social Care need to assure the LSCB, via an audit of compliance, that effective processes are in place to ensure that there is appropriate and consistent feedback to professionals who make safeguarding referrals, of the work undertaken in response to those referrals.

### Training

- 16.8** The LSCB must consider the need to initiate multi agency training or generate professional development opportunities in respect of the detection and identification of severe emotional abuse and neglect in children and young people, and include the details from this case to enhance the learning. The training will need to provide clarity regarding the responses necessary to address such abuse.
- 16.9** The LSCB will need to review the adequacy of multi-agency and individual training in respect of domestic abuse and its impact upon children, and promote that such training in the future includes their role in any revised systems for joint screening of domestic abuse concerns.
- 16.10** The LSCB must review the adequacy of child protection training for school staff in terms of its sufficiency of provision, its take up and of its effectiveness in improving and developing child protection practice.

### Schools

- 16.11** The LSCB must be assured by the Local Authority that education settings which are under their control, and assured by governing bodies for those schools which are not maintained by the Local Authority, have: -
- a robust system for recording any injuries or welfare concerns identified or noticed about a child by staff, and of necessary actions to address those concerns
  - and that the role and responsibilities of the designated professional for safeguarding are clearly understood and utilised effectively.

NB: An additional report prepared by the consultant utilised to consider the role of education in this case, will need to be provided to CLYP in order that they can more rigorously develop the learning in respect of safeguarding in schools.

### Health

- 16.12** The LSCB should monitor developments within the Coventry health visiting provision in ensuring its progressive delivery of the Healthy Child Programme in line with increased health visiting capacity. The Local Area Teams representatives of NHS England on the LSCB will need to ensure that the LSCB receive updates on the progress of such developments.
- 16.13** Paediatricians and other medical staff who are required to assess the welfare of children who present with unclear concerns, should always consider child abuse as a differential diagnosis as part of an holistic assessment of the child. The LSCB will need to be assured by the relevant health body that this practice has been consistently adopted.

### Issues of culture and language

- 16.14** The LSCB should develop a protocol which will help to ensure that individual agencies consistently utilise interpreter services with families who do not have English as a first language and especially in cases where there are concerns about the welfare of children. The protocol will need to stipulate that interpreters must be used to interview children alone or to enable them to understand their wishes and feelings, when they are the subject of safeguarding concerns.

#### Overall learning

- 16.15** The lessons learned from this SCR and detailed in paragraphs 15.1 – 15.14 must be disseminated to relevant staff working with children throughout Coventry, and a process identified to ensure that these lessons have been learned and as far as possible be integrated into safeguarding practice. Particular opportunities should be afforded to those individual practitioners, managers and their teams who were directly involved with Daniel and his family, to consider the findings from this SCR in a learning environment, identifying how to use this as a supportive experience to develop and improve safeguarding practice of children in the future.

NB: Additionally the LSCB may wish to develop further actions or recommendations based on the analysis of practice in this case and which are deemed pertinent to Coventry.

**Ron Lock**

**4.9.13**

## APPENDIX ONE

### Ron Lock Independent Consultant in Safeguarding Children

Ron Lock has been in child protection social work for 40 years and had a long career with the NSPCC as a front line practitioner, operational manager and senior strategic manager. In 2001, he left the employment of the NSPCC as a Regional Head of Child Protection Services to become an independent safeguarding consultant.

Since that time, Ron Lock has specialised in Serious Case Reviews (SCRs) and has been commissioned as either the Independent Chair or Independent Report Author of more than 70 Serious Case Reviews on behalf of 30 different Local Safeguarding Children Boards (LSCBs). Based on this work he has been commissioned to provide further consultancy and analyses of outcomes of SCRs and delivered training at a national and local level on undertaking effective Serious Case Reviews.

Most recently, Ron Lock has developed a new SCR process to accommodate systems methodology, called a Partnership Learning Review and this is currently being used by three LSCBs to complete their SCRs.

Since September 2008, Ron has been the Independent Chair for Bournemouth and Poole LSCB.

### Dr Neil Fraser *FRCPEdin & Lond, FRCPCH*

Dr Fraser is a Consultant Paediatrician with more than 40 years' experience of child protection. He is currently the Designated Doctor for Safeguarding for Herefordshire, where he has worked for 30 years. He has also been a part-time Consultant Paediatric Endocrinologist at Birmingham Children's Hospital (now retired) and he is an Honorary Senior Clinical Lecturer of Birmingham University.

### Dr Lynn Perry

Lynn has a degree and postgraduate degree in psychology. She trained as a primary teacher and was a head-teacher within a few years in several schools. Lynn has also provided support to schools in either Serious Weaknesses or Special Measures. In all of her headships, managing complex safeguarding issues was a constant part of her role.

For the last 4 years Lynn worked in a northern LA as the Senior Adviser for Safeguarding in Education. In this role Lynn has had considerable experience of LSCB work and particularly SCRs.

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## APPENDIX TWO

<b>Main Domestic Abuse Incidents reported to the Police</b>				
No.	Date	Incident	Actions by Police	Involvement of children
1	1.11.06	Incident between Ms Luczak and Mr Pelka – Ms Luczak said to have threatened Mr Pelka with a knife after he slapped her – Mr Pelka accepted a caution – both were drunk	DV notification received by HV on 1.11.06 CLYP record incident reported to them on 13.3.07	Ms Luczak said to be pregnant with EP's first child- no reference to Anna
2	16.12.07	Ms Luczak and Mr Pelka drunk and fighting – reference to Ms Luczak threatening him with knife – both released without charges	No onward referral	Anna and Daniel present but not witnesses – were left with maternal aunt
3	26.12.07	Arguments and threats made between Ms Luczak and Mr Pelka	“Referral completed”?	
4	8.1.08	Ms Luczak drunk in street + had taken an overdose because partner had left her	No Further Action (NFA) by Police	No reference to the children
5	13.1.08	Ms Luczak and Mr Pelka drunk and arguing in the street – Ms Luczak refused to go home, leaving children in care of Mr Pelka	Referral to health	Safe and well check by police reported no concerns
	29.1.08	Joint Screening convened – previous incidents discussed between Police and CLYP	Initial Assessment to be undertaken by CLYP	No reference to children or to completed IA
6	1.3.08	Ms Luczak and Mr Pelka drunk and fighting	Risk assessment but no referral to CLYP	Police checked - safe and asleep upstairs
7	6.4.08	Ms Luczak claimed that Mr Pelka was refusing to give her baby back – Ms Luczak drunk and uncooperative, Mr Pelka sober and calm	Referral to CLYP on 24.4.08 (they noted that notifications of 5 previous incidents had been received)	Children described as safe and well
	18.4.08	Joint Screening convened – note “nothing was changing”	Initial Assessment to be undertaken	
8	17.8.08	Ms Luczak very drunk and called Police – no offences recorded	Health notified on 3.9.08	
9	19.11.08	Mr Pelka reported that Ms Luczak had arrived at his home with the children because she had been arguing with her new partner Mr A who had been drinking heavily and had smashed up the home.	Police Internal referral only?	Ms Luczak and children remained o/n with Mr Pelka
10	24.11.08	Ms Luczak and Mr A fighting and drunk – Mr A arrested on suspicion of assault	Referred to Police Child Abuse	No reference to the children in

		although he claimed Ms Luczak assaulted him.	Investigation Unit (CAIU), CLYP and Health (received by health on 9.12.08) – No record of notification on CLYP records	Police report although later CLYP records state Ms Luczak holding Daniel in her arms in a distressed state.
11	13-17.12.08	Incidents reported of threats and drinking which involved Ms Luczak – situation not clarified - Calls from neighbours	No internal Police referral or to external agencies	
12	7.1.09	Alleged threats with a knife – Mr A arrested for possession		Neighbour reported children were crying
	16.1.09	Joint Screening	Incident of 7.1.09 discussed between Police and CLYP	
13	11+17.1.09	Incidents of drunkenness and arguing	NFA or onward referral although referral by health visitor led to an Initial Assessment	
14	8.3.09	Ms Luczak drunk and claimed she had been assaulted by her “ex-partner” – would not cooperate with Police	Referral to CLYP-HV notified on 26.3.09	“safe and showed no signs of distress”
	25.3.09	Joint Screening		
15	9.5.09	ML claimed she was being beaten – calls made in early hours of morning	Referral to Police Public Protection Unit (PPU) Health received notification on 16.9.09	Children reported to be present but not reported to be seen by the officers
16	1-2.6.09	Adults fighting in the home	No onward referral	No reference to the children
17	27.7.09	Ms Luczak claimed to that Mr A was drunk and abusive Ms Luczak received minor injury	Situation assessed as high risk on 30 <sup>th</sup> July and information shared with CLYP and health	Witnessed by the children but said to be unharmed and well.
18	28.7.09	Mr A returned to the home and smashed a window		
	14.8.09	Joint Screening		
19	18.9.09	Ms Luczak and Mr A assaulted each other – ML drunk	Information shared with Health (23.9.09) and CAIU – Strategy Meeting held on 23.10.09	Mr A’s brother to the home to care for the children who appeared “fine with no issues”
	12.10.09	Joint Screening – the most recent		

		incident discussed was 9.5.09 (No. 15)		
20	5.11.09	Mr A had called at home and made threats – not able to gain access	Health notified 7.3.11	
21	2.3.10	Warwickshire Police – threats made by Mr A	Referral to Children’s Social Care team (Bedworth)	“children in household”
		MARAC Meeting –Warwickshire		
22	6.4.10	Further claims s of threats and harassment by Mr A	Referral to Children’s Social Care team (Bedworth)	Concern children caught up in situation and of emotional abuse
23	2.5.10	Incident with new partner Mr Kresolek – arrested for assault – Ms Luczak had broken finger from being shut in the door	Referral to Children’s Social Care, (Bedworth)	Children present
24	8.8.10	Incident with knife between Ms Luczak and Mr Kresolek – also attempted strangulation - Ms Luczak received minor injury. Allegations of rape and of indecent images on computer also made.	Contact made with CLYP Emergency Duty Team – Health notified 7.3.11	
25	27.12.10	Ms Luczak and MK drunk and fighting	No onward referral to CLYP	Reported as “none the wiser”
26	29.12.10	Neighbour call that Ms Luczak locked children in house and lots of screaming and shouting. Ms Luczak not located until the following day after unable to get access to the home	Referral to the PPU Health received notification 30.12.10 and 7.3.11	No record of children spoken to or examined
	12.1.11	Joint Screening	Discussed incidents in Dec’10	
27	11.7.11	Ms Luczak reported to the midwife that Mr Kresolek had tried to strangle her and pulled her hair	Incident not reported to Police and no referral made to CLYP.	

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# APPENDIX THREE

## Individual Management Review Recommendations

### West Midlands Police

1. Ensure that all parties to MADAT review current procedures and practice and implement all necessary changes to ensure the MADAT conforms to the agreed Barnados Screening Tool model.
2. West Midlands Police, Public Protection Headquarters Staff will undertake a review of screening processes to identify a corporate approach which will satisfy the needs of both the police and partners by adopting standard operating principles across the force. This review will include consistency of intelligence checks, joint screening agendas and processes to enable proper monitoring, tracking of referrals and a procedure to escalate an item to more senior staff or managers.
3. To ensure that whenever children are present during a domestic abuse incident or are resident in the household, Police officers carry out appropriate checks, both physical and intelligence, to ensure those children are safe and well. They must obtain details of all adults forming a part of the household in whatever capacity, whether permanent or temporary.
4. To ensure that learning from this IMR is made available to all officers and staff and that this leads to improved safeguarding practice. West Midlands Police will produce a suitable distance learning product which clearly explains the responsibility of officers to not only ensure that children are “Safe and Well” but to address the impact of domestic abuse on those children’s emotional wellbeing and development.
5. West Midlands Police will identify the key letters sent out by PPU’s in response to domestic abuse and joint screening and provide staff with a database of letters translated into the most widely spoken languages across the region.
6. The phrase “contact and monitor” which is used by the Coventry MADAT team will cease to be used because it does not accurately reflect actual practice. A more appropriate term will be adopted.

**Coventry PCT / Coventry and Rugby CCG**

**Note from the 1st April 2013 the PCT is no longer a Statutory Body. The statutory responsibility is undertaken by NHS England, area team, the CCG and Public Health within the Local Authority.**

1. The PCT/CCG should review the current contract for the health visiting services to ensure it delivers its service according to the Health Child programme in line with the trajectory of increased health visiting capacity.
2. The PCT should through its Quality Review Arrangements ensure that all providers have a robust process in place for the receipt of and action on domestic violence notifications. In particular that the 'Nurse Advisor for Domestic Violence and Abuse' service is providing timely information to Health Visitors, School Nurses, Midwives and GPs.  
In addition a review of how information from domestic violence screening process is shared with GP's should be undertaken and process developed to ensure relevant information is shared
3. Discussions should take place between the PCT and CWPT with the aim of establishment of regular meetings between a member of the Health Visiting team and the GP practice as a forum for discussing vulnerable families.
4. The PCT should ensure that it is assured that the walk in centre includes a requirement to routinely notify attendance of children to GP and to notify health visiting or school nursing of any concerns and record the name and relationship of the person attending with the child

## **Coventry City Council Children Learning & Young People's Directorate Schools and Academies**

1. Head teachers should ensure that school staff including attendance officer, learning mentor, SENCo and senior management within school should meet twice per term to discuss children with a number of different concerns, particularly those children who are not the subject of an open common assessment framework intervention, have difficulties with attendance, where English is a second language or where there are special educational needs.

### **Children and Families First Service**

2. The head of the education welfare service should ensure that supervision arrangements for staff include checking records for, and the discussion of previous attendance history or family difficulties such as domestic violence.

### **Schools and Academies**

3. Head teachers should ensure that school records are checked and all information is passed to children's social care when the school is contacted in relation to a child or family assessment.
4. Head teachers should ensure that, within the context of existing procedures, the views and feelings of all children are always ascertained and where English is an additional language, particularly for very young children, using the translation service if necessary
5. Head teachers should put in place procedures to log formally all contact with parents and external agencies and any logs should be kept on the child's confidential file. This should include written logs of any meeting arranged with parents and any follow work needed as a result or if the meeting is rearranged
6. Head teachers should put in place procedures to ensure Contact with external services such as health services are always formally logged by the school and letters of concern sent directly to the appropriate professionals and not via the parent.

### **Children's Social Care**

7. A second tier officer in liaison with senior police colleagues should ensure that an effective screening system for domestic violence notifications is in place and appropriately resourced which provides weekly referrals into the RAS. Management information should be generated from this system and provided to the senior management team for information and action as necessary.
8. A quality audit of newly commenced core assessments should be undertaken by officers no lower than third tier to determine if the inadequacy of the assessments found in this case are systemic. The results should be reported into the senior management team for information and action where necessary

9. A quality audit tool should be put in place by service managers to provide a quality exemplar for team managers to use in their supervision of staff undertaking Initial and core assessments.
  
10. A review of the overall current workload of the referral and assessment service should take place, headed by a senior manager. The review should address the overall capacity of the service against current demand and ensure that any resource/demand mismatch is addressed



## **GP's/Coventry and Rugby CCG**

1. Coventry and Rugby CCG safeguarding lead to work with other health services, social care and police leads to develop a system whereby GPs receive information on domestic violence.
2. GPs to use the recommended READ codes for child safeguarding to alert other Health professionals of their concerns.
3. GPs to have robust systems in place to alert other relevant Health professionals, across the health economy, when safeguarding children concerns are identified.  
i.e. Community Midwife, Health Visitor, School Nurse or other known to be involved with the child e.g. Community Mental Health Nurse). GPs to have regular meetings with their named Health visitor in the practice so that concerns can be raised.

## **Coventry and Warwickshire NHS Partnership Trust**

1. All relevant services within CWPT to be reminded of Coventry Safeguarding Board Children's Social Care Thresholds and Practice Standards and to revisit this document.
2. To review the Guidance for Health Visitors, School Nurses and other Health Professionals on receipt of West Midlands Police Violence Information this should include all;
  - Children present at the incident and those who live within the house hold and that information is contained within
  - All of these children records
  - Clarification of MARAC process across Coventry and Warwickshire and Professional; Domestic Abuse. The role of the Named Nurse.
3. Baseline height and weight assessments to be completed when working with a child with feeding/eating difficulties e.g. height and weight, child protection concerns. This is especially important when a child is referred onto another practitioner when these measurements can be used as comparators, for example in the outpatient setting
4. At the point of transfer of records from health visiting to school nursing service when a child has needs or there are professional concerns there should be a face to face contact between professionals. The transfer summary form should also be completed.
5. Health staff explore with social care where cases are closed where health continue to have safeguarding concerns. Professional to escalate these concerns as per escalation policy where agreement and resolution can not found.
6. All relevant staff within CWPT to learn from lessons from this SCR

## University Hospitals Coventry and Warwickshire NHS Trust

1. Maternity have specific guidance for managing domestic violence and abuse in pregnancy and in the postnatal period, this requires updating and should be expanded to incorporate guidance for referral into adult safeguarding services.
2. Maternity managers and matrons should be supported to develop expertise around the impact of domestic violence and abuse whether this is suspected or disclosed. This will enable them to provide safeguarding supervision for midwives working with families where concerns have not yet reached the threshold for child protection referral and to facilitate effective decision making in relation to assessing thresholds of needs.
3. A report or discharge summary should be written contemporaneously after an admission of a child with an injury which is initially suspected to be non-accidental in nature, if the admission leads to discussions with Social Care or the Police
4. When there is an injury requiring joint paediatric and orthopaedic care, the paediatrician and orthopaedic surgeon should jointly review the child and discuss the injury, looking at the X Rays and digital photographs together. This review should be documented in the medical records.
5. Emergency department processes for routine questioning around domestic violence and abuse and the recording of this data should be embedded. The safeguarding adult lead intends to undertake an audit within the emergency department during June 2012 to test whether standard domestic violence and abuse identifying questions are being consistently asked. The report from this audit should be presented at safeguarding vulnerable adult and children committee and should inform the work plan of this committee

**Minutes of the Meeting of the Education and Children's Services Scrutiny Board (2)**  
**held at 2.00 p.m. on 26<sup>th</sup> September, 2013**

Present:

Board Members: Councillor Akhtar  
Councillor Bains  
Councillor Blundell  
Councillor Clifford (Chair)  
Councillor Hetheron (substitute for Councillor M Mutton)  
Councillor Lakha  
Councillor Mrs Lepoidevin  
Councillor Mrs Sweet (substitute for Councillor Mrs Abbott)  
Councillor Thomas

Co-opted Members: Mrs S Hanson  
Mrs K Jones  
Mr R Potter

Other Members Present: Councillor Sawdon

By Invitation:

Councillor A Lucas – Leader  
Councillor P Townshend – Deputy Leader  
Councillor G Duggins – Cabinet Member (Children and Young People)  
Councillor J Innes – Deputy Cabinet Member (Children and Young People)  
Councillor C Fletcher – Chair of Scrutiny Co-ordination Committee  
Councillor D Kershaw – Cabinet Member (Education)  
Councillor Gingell – Cabinet Member (Health and Adult Services)  
Councillor Andrews – Deputy Leader of Conservative Group

A Weir – Independent Chair for Coventry Safeguarding Children Board  
Dr N Fraser – Independent Chair of the Serious Case Review Panel  
R Lock – Independent Author for the Serious Case Review Overview Report  
M Dalton – Independent Chair for the Serious Case Review Sub Committee  
J Barnes – Executive Nurse, NHS Coventry & Rugby Clinical Commissioning Group  
S Doheny – Director of Nursing, NHS England  
A Nicholson – Borough Commander, West Midlands Police  
T Bacon – Detective Superintendent, West Midlands Police  
M Radford - University Hospitals Coventry & Warwickshire NHS Trust  
Dr S Binyon – Medical Director, Coventry & Warwickshire Partnership NHS Trust  
R Newson – Chief Executive, Coventry & Warwickshire Partnership NHS Trust

Employees (by Directorate):

Chief Executive's: M Reeves (Chief Executive), V Castree, A West

People: B Walsh (Executive Director), D Haley, S Roach, M Godfrey, L Sanders

Resources: C Forde, M Rose, S Bennett

Apologies: Councillor Mrs Abbott  
Councillor M Mutton

**19. Chair**

In the absence of the Chair, Councillor Mrs Abbott, in accordance with paragraph 4.5.10 of the Constitution, the meeting was chaired by Councillor Clifford, Deputy Chair of the Scrutiny Co-ordination Committee.

**20. Declarations of Interest**

There were no disclosable pecuniary interests declared.

**21. Daniel Pelka Serious Case Review**

The Scrutiny Board considered a Serious Case Review (SCR) report of the Coventry Local Safeguarding Board regarding Daniel Pelka. A briefing note attached to the SCR report provided background information, presented the findings and explained the next steps. The report would also be considered at an Extraordinary Meeting of the City Council to be held at 2.00 pm on Thursday 10th October, 2013.

Daniel Pelka was murdered in March 2012 by his mother and stepfather. Following their conviction in July 2013, and subsequent sentencing in August 2013, the Daniel Pelka Serious Case Review (SCR) report was published on Tuesday 17th September 2013.

In line with statutory guidance a SCR was commissioned to investigate and analyse the circumstances into Daniel's abuse and death. A SCR is held whenever a vulnerable child had died or been seriously injured or impaired and abuse or neglect was known or suspected to have been a factor. The purposes of this SCR reflected the relevant government guidance at the time to: -

- Establish what lessons were to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- Identify clearly what those lessons were both within and between agencies, how and within what timescales they would be acted on, and what was expected to change as a result; and

## APPENDIX 2

- Improve intra and inter-agency working to better safeguard and promote the welfare of children.

The SCR report made 15 recommendations to local partners, covering domestic abuse, referral and assessment processes, training of staff, practice in schools and health as well as the requirement to disseminate messages to the Children's Workforce.

The Scrutiny Board questioned the officers and the invited panel of partners, including Amy Weir, the Independent Chair for the Coventry Safeguarding Children Board and Ron Lock, the Independent Author for the Serious Case Review Overview Report, about issues raised in the report which included:

- Progress and actions
- Issues relating to domestic violence
- Referral and assessment, information sharing and communication
- The Voice of the Child
- Learning lessons, action and accountability

The Scrutiny Board's questions were detailed and responded to in depth by the appropriate people present, the discussions included:

1. Progress and changes already made within the City Council and partner agencies following Daniel Pelka's death that had already made a difference to concerns expressed in the report and the monitoring of progress.
2. Responses to a letter from the Children and Families Minister (Edward Timpson) which had expressed concerns about information recording, information sharing and assessments.
3. Ensuring that Child Protection issues were considered in conjunction with information relating to reported domestic violence incidents and alcohol misuse.
4. Sharing of information between agencies.
5. Audit Processes and Quality Management systems in place when agencies respond to domestic abuse.
6. The impact of changes to police capacity on partner agencies.
7. The SCR's recommendation that the Council provide assurance that Safeguarding was clear and robust and the fact that an Ofsted inspection report had given assurance that the school Daniel attended had good safeguarding procedures.
8. Amending reporting protocols /guidance for School staff.
9. Head Teachers procedures for contact with external services.
10. The linking of assessments made by different agencies such as social care, and midwives.
11. The criteria for conducting investigations (Section 47) and Child Protection Case Conferences.
12. Record keeping and use of Information Technology.
13. 'The Voice of the Child' improvements to relevant paperwork so that a section acts as a reminder when assessments were made to ensure that we view the 'Life of the Child through the Eyes of the Child'.
14. The future strategic role of the Local Safeguarding Children Board and

## APPENDIX 2

Terms of Reference.

15. Leadership and performance management of the Local Safeguarding Children Board.
16. Responsibility for following up actions from recommendations in previous Serious Case Reviews.
17. Quality assurance of information shared.
18. Quality of work rather than completion in order to meet targets.
19. Recruitment and retention of social care key staff, caseloads and volume of work and whether resources matched demand.
20. Learning from this case, the importance of empowering staff and how this would be achieved within the different agencies.

During the discussion it was agreed that the following documents would be shared in written format with the Education and Children's Scrutiny Board (2):-

- Evidence of progress and changes within the City Council referred to by the Executive Director, People, Coventry City Council.
- The Executive Nurse, NHS Coventry & Rugby Clinical Commissioning Group agreed to circulate the outcome of an audit undertaken to review the actions implemented following domestic violence recommendations made as a result of previous Serious Case Reviews.
- The Director of Education and Inclusion agreed to look at the cause of the time lag from a previous Serious Case Review recommendation which indicated that information about domestic violence should be shared with schools. The recommendation was first made in 2008 and it was reported that a pilot had only recently begun.
- The Independent Chair for Coventry Safeguarding Children Board agreed that a written response would be more appropriate to questions regarding the strategic role of the Local Safeguarding Children's Board and terms of reference, along with Leadership and Performance Management details of the Board.
- The Independent Chair for Coventry Safeguarding Children Board agreed to provide information on following up actions of Serious Case Reviews, including monitoring which recommendations had been implemented and responsibility for the implementation of actions.

In addition:

- The Independent Chair for Coventry Safeguarding Children Board agreed to consider publishing the response to the Children and Families Minister following formal agreement.
- The Local Safeguarding Children's Board agreed that including a section for 'The Voice of the Child' in any relevant paperwork would be an excellent idea.

At the invitation of the Chair, Councillor Clifford, Councillor Mrs Lucas, Leader of the Council, addressed the meeting and gave a commitment that any recommendations from both the Scrutiny Board's meeting and the Extraordinary Meeting of the City Council on 10<sup>th</sup> October 2013 would be adopted by the City Council.



**RESOLVED:-**

- (i) That reports on progress be received by the Education and Children's Services Scrutiny Board (2) in 3 months and 6 months' time.**
- (ii) That the City Council be requested to give consideration to any further recommendations they wish to make at the Extraordinary Meeting of the City Council on 10<sup>th</sup> October, 2013.**

**22. Any Other Items of Public Business**

There were no additional items of business.

(Meeting closed: 4.15 p.m.)