Coventry City Council

Public report

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

Is this a key decision?
No

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 17th 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.

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Members: Councillor Ann Lucas	Leader of the Council		1 October 2013	1 October, 2013

This report is published on the council's website:
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