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STAFFORDSHIRE & STOKE-ON-TRENT SAFEGUARDING CHILDREN BOARDS

LESSONS TO BE LEARNED BRIEFING NO. 16:
IN RESPECT OF THE DEATH OF DANIEL PELKA- COVENTRY, 2013

What happened?

Just after 3.00am on Saturday the 3rd March a telephone call was made by Daniel Pelka's mother to the ambulance service in respect of Daniel who was then aged 4 years and 8 months old. The ambulance service attended the home and Daniel was subsequently admitted to hospital after having suffered a cardiac arrest. He was pronounced dead at 3.50am. At the time of his death Daniel weighed just 10.7kg[1] (1.68st – dehydrated weight). He was found to be malnourished and also had an acute subdural haematoma[2] 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.

Daniel was 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 lived with his mother and her fourth partner along with his older sibling, known as Anna, aged 7 years and a younger sibling known as Adam, aged 1 year.

On 31 July 2013, his mother and her partner were found guilty of the murder of Daniel and sentenced to a minimum of 30 years each.

What were the circumstances that led up to Daniel's Death?

Daniel's father brought the family to the UK in 2005 and remained with the family until his return to Poland in 2008. During that time the first reported incident of domestic abuse took place. Both adults were intoxicated and were violent and Ms Luczak[3] (Daniel's mother) was pregnant with Daniel. From that first incident and until 2011, the police responded to a total of 27 reported domestic abuse incidents. Many of these were fuelled by alcohol and involved violence which sometimes resulted in injuries to Ms Luczak. Police carried out safe and well checks[4] following each incident and were noted to have said that the *'children were none the wiser'* as they did not witness the violence. It was also suggested Ms Luczak could not live without cannabis and amphetamines but this information was never recorded or shared. What was clear was that Ms Luczak was suffering with depression and was regularly

[1] Average weight for a 5 year old child is 17.7kg (2.8 st).
[2] 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.
[3] (no connection as made between her surname and that of Daniels on GP records
[4] 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.

misusing alcohol; on two occasions she took an overdose resulting in hospital treatment[5].

The family experienced a chaotic lifestyle, with many house moves,[6] some as a result of eviction. 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 would have struggled to maintain a basic level of existence. No assessment ever took this fact into account or considered the impact this would have had on the needs of the children.

Despite the difficulties, both Daniel and his older sibling Anna did attend school but issues began to arise with regard to their attendance and injuries to Daniel. Anna settled in well, making friends and even attending a small group with children of the same nationally. In contrast, Daniel was known to be withdrawn and solemn, showing little interaction with other children. His main difficulty was the barrier caused by his language as he knew less English than a 2 ½ year old. This led school staff to either rely on his gesticulations as a way of communicating, or on Anna and his mother as translators.

It was felt that school was somewhat of a refuge for Daniel. When Daniel was the particular focus of concern, the school failed to keep accurate records and school staff did not collectively nor coherently generate their concerns in respect of neglect into a child protection referral. No attempt was made to speak to Daniel and because of the communication difficulties he became an invisible child and his thoughts, wishes and feelings were not appropriately sought. Furthermore, no assessment[7] was undertaken to determine the level of risk or the needs to Daniel or those of his sister.

Very little was reported about Adam, who was just 7 months old when Daniel died. Whilst pregnant with Adam his mother was consuming alcohol and suffering with bouts of depression. It was not known whether Adam had witnessed any domestic abuse but it is known that the home environment was sometimes a violent place to be. Adam also became a lost child.

In 2011, the school became concerned about Daniels obsession with food as he was taking food from other children's lunchbox and eating secretively. School responded by locking food away as they had been told by Daniel's mother that the reason he was so hungry was due to a medical condition. Unbeknown to the school Daniel was being deprived of food. When confronted about their continued concerns about Daniel being hungry his mother stated that Daniel was getting up in the night and eating plenty of food and this information was taken at face value without being verified.

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[5] The term "toxic trio" is used to describe the co-occurrences of mental health problems, substance misuse and domestic abuse in families and is a common feature in serious case reviews. Children of parents who are affected by the toxic trio are at an increased risk of significant harm.

[6] Evidence from research indicates how children develop certain resilience and coping strategies, coupled with the level of domestic violence. 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.

[7] In this instance the review refers to the assessment in terms of the use of a CAF – Common Assessment Framework

Her ability to draw professional's attention away from allegations of harm is common is most serious case reviews and is known as 'disguised compliance'[8]. In reality he was being beaten and starved. As punishment for stealing food, he was force fed salt, made to sit for a considerable time in cold baths and locked in a room at home with no door handle. The room smelt of urine and had no furniture other than a mattress which was soiled and there was no heater or toys in the room. The 'box room' was apparently used as a form of punishment which was referred to as such in text messages between Ms Luczak and her partner. No information was received that suggested professionals ever saw where Daniel slept.

Throughout Daniel's short life, a string of appointments were made with health visitors, GPs, community paediatricians and the school nurse. Most of these resulted in non attendance, with some cancelled then rearranged. Concerns within the serious case review were raised around the way in which agencies lacked the ability to share information, either through lack of communication, inadequate IT systems, poor record keeping or through assumptions around culture and language. A number of missed opportunities by professionals and agencies enabled the abuse to continue and were contributing factors identified as lessons that needed to be learnt from the review into Daniel's death.

What do we need to learn from this case?

It's hard to imagine what it was like for Daniel and his siblings. What is perplexing is that within all the agency serious case review reports there is no record of any conversations with Daniel by any professional about his home life, his experiences outside of school, his wishes and feelings, or about his relationships with his siblings, his mother and her male partners. **Despite Daniel being the focus of concern for all practitioners, in reality he was rarely the focus of their interventions.** Almost every child who has been the subject of a serious case review over the last 40 years was 'seen' by a professional within days (or hours) of their death.

Simply seeing a child is not protection against harm. **The child needs to be seen, listened to and heard.**

Parents need to be robustly challenged about how their behaviours can have a direct impact on their children, especially when domestic violence and substance misuse is present. Laming' comment following the inquiry into the death of Victoria Climbié about the need for "respectful scepticism" and this is a sentiment also echoed in the serious case review in respect of Peter Connelly's death. Practitioners working with children and their families must remain sceptical of any explanations, justifications or excuses they hear in connection with the potential maltreatment of children.

Treat parents and carers with respect and listen to their information, but always verify the information that they provide via other sources.

[8] Brandon, M. et al. (2008a) **Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005. Research Brief DCSF-RB023 (PDF)**. London: Department for Education (DfE).

Professional Involvement is not the same as engagement. Just because another professional is involved with a child's case does not mean that they are proactively engaged with protecting the child. The danger is that we assume that if a child has a social worker, they are being protected; or if a police officer visited the house after a domestic violence incident, the child is safe.

Always check information out – children are best protected when information is clearly shared across the professionals involved and action is coordinated. Never assume that someone else is doing something when you have a cause for concern – two professionals taking action is better than no one taking action at all.

Parental participation is not the same as cooperation. Don't confuse an apparent willingness to comply with an actual willingness to accept the need to change. The 'rule of optimism' where professionals wrongly assume positive outcomes for children, is more likely to exist when staff feel under pressure and this can be very dangerous for children who are at risk. The 'rule of optimism' rationalises evidence that contradicts progress - so even where the facts show that risk is ongoing or increasing, professionals tell themselves that the opposite is true.

Take the time to stop and critically reflect on your own practice – before every contact with the child or their family be clear about what it is you are hoping to achieve. After the contact take a couple of minutes to ask yourself whether you have met what you set out to achieve.

Also talk to your colleagues to check out practice issues and use supervision as an opportunity to reflect on what action needs to be undertaken to improve outcomes for the child.

<u>Neglect is a relationship issue</u>

Neglect (head lice, poor hygiene, weight loss, lack of supervision, hunger etc) may signal a poor adult-child relationship. All neglect stems from parents prioritising something else over the child's basic needs. Professionals sometimes have the tendency to adopt a 'wait and see' attitude and to wait for a trigger incident before taking action when neglect is suspected.

Ask yourself:

- **What is going on in the relationship between the parent and child that is allowing this to happen?**
- **Assess where the parents' priorities lie?**
- **What individual meaning and value does the parent place on their child?**
- **How aware is the parent of the child's needs, personality, strengths and struggles?**
- **Put yourself in the child's shoes - what is it like to be that child's living in that household?**

Think the Unthinkable

As workers, we should always work with 'healthy scepticism' when dealing with families where children might be at risk. Asking parents and families how they parent should inform the assessment process but it is not always the most reliable way of finding out what is actually happening in the home. Watching parenting in action (setting boundaries, play between parent and child) can add greater depth and understanding to the attachment relationships between the parent and their individual child.

Research tells us:

- **75% of parents do not cooperate with services (includes disguised compliance and telling workers what they want to hear)**
- **Though not consciously, parents often test the resolve of the safeguarding and child protection systems**

Assessment is a Process, Not a One-off Event

Assessment is about understanding the current circumstances for the child and their family and using this to make decisions about what help is required to promote improved outcomes for the child. A good assessment and the decision about the right help required can only be achieved if practitioners understand the child's and their family's history. Practitioners must always use this to inform the current decision making.

Always look at the historical information – what does it tell you about the child's lived experiences so far – how does this impact on the current circumstances and therefore the assessment for the child? Use this information together to identify what the next steps are to promote the best interests of the child.

Always remember that assessments are fluid and should be reviewed when family circumstances change or new information comes to light.

Assessments should not be carried out in isolation. In order to understand the child's experience make sure that you use the information, knowledge, skills and expertise of partner agency colleagues.

Be clear what the plan is and who is coordinating it - is everyone clear about their own roles and responsibilities and how they contribution to achieving the outcomes set out in the child's plan? Ensure the plan is regularly reviewed.

See the child…listen to the child…hear the child.