

Daniel Pelka Serious Case Review, Coventry LSCB

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Summary

The overview report of the Serious Case Review of the events leading to the death of four year old Daniel Pelka, published by Coventry Safeguarding Children Board, highlights the opportunities missed by a number of agencies to protect him. Although specifically aimed at identifying gaps and leading to improvements in child protection in Coventry, like all SCR reports it identifies issues that will be of relevance elsewhere. Indeed, both the DfE and Ofsted (which was responsible from 2005 until 2012 for evaluating SCR overview reports) have publications which highlight the nature and importance of learning from SCRs. This briefing focuses on the major findings of the Daniel Pelka overview report, especially those of potential relevance to other areas, and the reaction the case generated – which includes a petition with 50,000 signatures seeking a new law to make it mandatory for people working with children to report suspected abuse.

Overview

Four year old Daniel Pelka was murdered by his mother and her partner in March 2012, after a period of sustained abuse. The overview report of the Serious Case Review (SCR) of the events leading to his death, published by Coventry Local Safeguarding Children Board (LSCB), highlights opportunities to protect him that were missed by a number of agencies. It concludes that, 'No one professional, with what they knew of Daniel's circumstances, suspected or could have predicted that he would be killed.' Nevertheless, in reviewing the events which led to Daniel's death from an inflicted head injury, the SCR identifies a number of occasions when the actions, or inactions, of individuals, and/or failings in the effective working of systems, contributed to the failure to protect him. Daniel's mother and her partner were found guilty of his murder, and sentenced to a minimum of 30 years in prison. The case attracted widespread coverage and comment in the media.

Children and Families Minister Edward Timpson has written to the Chair of Coventry LSCB asking her to set out how it is proposed to deepen the analysis begun in the SCR and address *why* particular failures occurred – a step he says is critical to improving child protection practice across the country.

This briefing focuses on the major findings of the overview report, especially those of potential relevance to other areas; it does so largely through (accurate) selective quotes from the report. The 'Comment' section looks at the reaction the case generated – which includes a petition with 50,000 signatures seeking a new law to make it mandatory for people working with children to report suspected abuse.

Briefing in full

The SCR was commissioned by Coventry LSCB in line with the requirements of the statutory guidance *Working together to safeguard children* (which was revised with effect from April 2013 – see ‘Related briefings’; this was after much of the SCR had been completed). Each agency which 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’. It was not possible to finalise the SCR process, or to consider publication of the overview report, until after the criminal proceedings were completed in August. Both the independent chair of the SCR panel and independent author of the report 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 new information to the SCR panel (and included information which had been unknown to professionals involved with the family at the time they were working with them). The report includes this evidence, where relevant, along with additional information from verbal evidence of involved professionals at the criminal proceedings.

The report is in sections: a brief summary of the case and findings; the SCR process; factual information; the children’s experience; analysis of professional practice; events leading up to Daniel’s death; and professional communication, information sharing and liaison in respect of service delivery. It concludes with a summary of findings, lessons learned and recommendations.

Factual information

Daniel’s father, Mr Pelka, brought the family (Daniel’s mother, Ms Luczak, and her daughter Anna) to the UK from Poland at the end of 2005, and remained with the family until the end of 2008, by which time Anna was approximately 3½ years old and Daniel was just over a year old. A second male (referred to as Mr A) then lived at the home from late 2008 until mid-2010 and Ms Luczak’s third partner (Mr Krezolek) moved in 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 subject to criminal charges along with Ms Luczak.

Over 16 pages, the report sets out chronologically the family’s involvement with a range of agencies from Ms Luczac first registering with a GP in Coventry in March 2006 through to Daniel’s death on 3 March 2012, Ms Luczac and Mr Krezolek being charged with his murder on 9 March, and their trial during June and July 2013. An Appendix lists 26 incidents of domestic abuse, many of which involved drunkenness, between November 2006 and the end of 2010. (Coventry Children’s Social Care is part of the Children, Learning and Young People Directory, and is referred to in the report as CLYP.)

The factual information section is detailed and complex, and does not lend itself to general summary; the following is a selection of key points. It refers to five multi-agency domestic abuse Joint Screening Meetings (established in Coventry in 2006 to enable the key agencies of police, CLYP and health to share information, discuss the children involved and review the family history). It also refers to two initial assessments, neither of which resulted in further action: on the first occasion, the case was closed after ‘the parents have acknowledged that a continued pattern of domestic abuse would present a significant risk of harm to the children’ but the parents had ‘implemented strategies to minimise this risk’; on the second, the outcome ‘was that no further action would be taken as it was considered that Ms Luczac could protect the children’. A core

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assessment in 2009 also 'concluded that the children were safe in Ms Luczac's care', since it was believed that Mr A had left the home.

The circumstances of a spiral fracture of Daniel's left arm in January 2011 are set out, including a referral to CLYP and confirmation by Anna to the police of the account of Daniel's injury given by her mother. A core assessment was completed in February 2011, which concluded that the domestic abuse between the couple was no longer an issue, but noting that the family was about to be evicted due to rent arrears; it also 'noted a positive interaction between the children and their mother and with Mr Krezolek'. The case was closed in May.

A number of concerns arose around the time of Ms Luczac's pregnancy (including the community midwife being told of several further incidents of domestic abuse). Baby Adam was born in August 2011 and, prior to discharge, the midwife contacted CLYP and discussed concerns with the duty officer (this conversion was recorded on Adam's CLYP file only).

Daniel commenced at the same school as Anna on 14 September. On 12 October, the school nurse made a referral to the community paediatrician, following a review of Daniel's health records in school and after a joint home visit by the school nurse and the school nursing support worker. Ms Luczac explained that Daniel had aggressive behaviour towards her and had an excessive appetite and was a secretive eater, with speech and language delay and possibly learning difficulty. Daniel was not seen during this visit. Three appointments made with the community paediatrician were cancelled by Ms Luczac or missed. During November 2011, the school made their concerns known to Ms Luczac about Daniel's continued obsession with food, the education welfare officer (EWO) made a home visit in mid-December, and the head teacher wrote to Ms Luczac about Daniel's attendance, which was below 64%.

Evidence later presented for the care and criminal proceedings indicated that on 7 October there was the first reference (in a text message from Mr Krezolek to Ms Luczac) to a specific room in the house used to put Daniel in, which remained unknown to professionals working with the family until after Daniel's death. The first reference to use of salt in the home occurred in a text message on 21 October, though it was not clear what the use was.

The report describes Daniel's obsession with food, and how this was raised with Ms Luczac on two occasions from January 2012, and records that between December 2011 and February 2012 there were occasions when Daniel was seen with facial injuries – though 'because of a lack of appropriate recording of such injuries within the school, it is unclear what injuries and when'. None of these injuries were reported to CLYP or the police. On 25 January, the deputy head contacted the GP by phone about the concerns over Daniel's eating habits and the GP advised her to ask Ms Luczac to bring Daniel into the surgery; the deputy did this the following day, and believed that Ms Luczac understood the need to do this. The deputy head and Daniel's class teacher wrote a letter 'to whom it may concern' about Daniel's eating habits and the fact that he appeared to be losing weight, and gave this to Ms Luczac to take to her appointment with the community paediatrician on 10 February 2012. The outcome of the appointment was that the paediatrician requested further investigations, and prescribed medication because of the possibility of thread worms. The paediatrician was unable to contact Ms Luczac to explain test results, so wrote to the GP on 1 March to request that iron, zinc and vitamins be prescribed over the next six months.

Daniel attended school for the week from 27 February to 1 March 2012, and the head and deputy agreed to convene a meeting to discuss what further could be done; on 1 March, Daniel was

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observed taking food from a bin (but was prevented from eating it). On Friday 2 March, Daniel was logged as having an unauthorised absence; the school made a phone call to the home, but there was no reply. Evidence later emerged that the family's computer at home had been used on 2 March to seek information on salt poisoning and a child not responding.

Just after 3am on Saturday 3 March a call was made to the ambulance service, and Daniel was admitted to hospital at 3.28; he was pronounced dead at 3.50am. The report explains that there was no immediate consideration of whether the cause of death was suspicious ('with the mother and her partner generating a very convincing picture of being distraught'), but once the paediatrician (not the same one who had seen Daniel recently) viewed Daniel's body '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'. At the post mortem on 6 March, it was found that the cause of death was a head injury 'almost certainly the result of a direct blow to the head'. Daniel was considered to be grossly malnourished and dehydrated with bruising over his body; he also had a very high sodium level. The forensic pathologist concluded that these findings reflected longstanding neglect. On 9 March, Ms Luczak and Mr Krezolek were charged with the murder of Daniel.

The Children's Experiences

'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... 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... 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... What was clear was that these children lived in a climate of arguing, fighting and drunkenness. No professional involved with the family understood with any sufficiency the impact which this chaotic household potentially had upon the children.'

There were no reported incidents of domestic abuse after December 2010, though Ms Luczak told the midwife that more incidents did in fact occur during 2011 and, in her evidence during the court proceedings, she alleged a high level of violence to her from Mr Krezolek, which was corroborated by Anna.

Anna appeared to settle into school quite well, where the only concerns were related to her poor attendance ('which appeared to be more related to her mother's needs than to high levels of sickness'); she gave 'no outward presentation of problems at home' and 'seemed to have managed the language difficulties the best', being able to speak both her native language and English – 'something of a double edged sword for her' as 'she was often used as 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...'

Daniel started school two months after his fourth birthday, and was described as quite bright and, on occasion, as a cheeky child – 'although he was more normally described by school staff as withdrawn and solemn', with little interaction with other children; he had less English than a typical

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2½ year old. Daniel was said to be very shy and ‘never presented as being naughty or destructive in school although his mother talked of his behaviour problems and aggression at home’.

Very little was reported about the baby, Adam, who was 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 Luczac drinking alcohol and smoking during the pregnancy.’

The eventual post mortem identified that Daniel was very malnourished and had been subject to serious neglectful care. The school was clearly concerned about his condition and behaviour, and deterioration since starting school. ‘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 experience at home... 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.’

‘It is apparent that everything done to Daniel was calculated and deliberate, even his school non-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... After Daniel’s death, it also became apparent from her evidence that Anna had tried to protect him on a number of occasions... 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.’

Analysis of professional practice

‘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.’

The report gives examples such as: the failure to follow up robustly two failed appointments for Anna’s 2 year and 3 year development assessments (letters for which had been sent in English), despite a pattern of domestic abuse being apparent by the second of these occasions; the absence of a proactive response following Ms Lucsak’s failure to attend four antenatal appointments; the failure to make a referral to CLYP when Ms Lucsak disclosed to the community midwife that there was continuing domestic abuse, but there was never violence to the children (an assurance which shouldn’t have been taken at face value, reflecting an inappropriate professional view that domestic abuse is not a child protection issue). ‘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 on the CLYP file in respect of this referral and no record of any follow up contact with the family by CLYP as a result... 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.’

‘As well as there being inconsistency about notifications [of domestic abuse incidents] being sent by the Police to CYLP, there was also inconsistency in by CYLP in their response... Although there was little reference to any adverse impact on the children with these [notifications] CLYP

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should have raised concerns with the parents about the pattern of domestic abuse... 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.' Ms Luczak was asked about domestic abuse on numerous occasions, and usually denied its existence... 'but her assertions could have been challenged more effectively by emphasising the cumulative effect of the domestic violence not only on her but more importantly upon the children. Greater involvement of the male partners in interventions was also necessary... there was an insufficient focus on the impact upon the children, with the interventions directed towards the adults'.

A lengthy account of the response to Daniel's fractured arm when he was 3½ years old describes it as 'a significant injury in terms of its seriousness and potential to have been inflicted non-accidentally'. A key factor raising concern had been the one-day delay in presentation, but '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... 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, 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... Overall, the "rule of optimism" appeared to have prevailed in the professional response to Daniel's fracture and to his other bruises... 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" was at play in this situation.'

CLYP subsequently failed to produce minutes of the Strategy Meeting of agreed findings and the decisions reached, and there was no formal report by the hospital paediatrician giving detail of the fracture and associated bruising, and the concerns around their causes. This 'compromised the efficiency of the Strategy Meeting process' and 'compromised the later enquiries and assessment with the family'. There appeared to be no follow up about the actions of CLYP and of the outcomes from their Core Assessment. There was also a significant issue around the role of the health visitor, who was awaiting the outcome of the CLYP assessment before deciding her own input – but '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 report sets out further causes of concern arising from housing difficulties and evictions, linked to financial problems and debt. '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... Importantly, neither

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child spoke of their home situation and did not convey concerns about home life... 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 on from the early schools that Anna attended. Although the social worker did make contact with the school early in 2011 in respect of the Core Assessment at that time, this seemed more about seeking information than passing it on to the school.'

Of the four assessments undertaken by CLYP in respect of the family between 2008 and 2011, the first three '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.' The report is critical of the Core Assessments, 'with basic analysis missing and no clear reference to the earlier assessments... 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 reported as "appeared to be happy with mother", this gave scant regard to their experiences and needs at this time. This assessment therefore reflected findings of other Serious Case Reviews of "a failure of agencies to understand, accept and assess the impact of domestic violence on children".' Overall, it comments that '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 the knowledge of and response to adults in the home and of risks they might pose to the children, the report says, '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...'

On sensitivity to the needs of the children, the report describes an inconsistent approach by the police who responded to domestic violence incidents, and a lack of appreciation of the impact of domestic abuse on children. 'Referrals for immediate response by CLYP on [two] 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.' It says that '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 behaviour 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. 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.'

Events leading up to Daniel's death

The report explores in detail how several significant issues were dealt with: the school's concerns about Daniel's "obsession" with food; the Paediatric Assessment in February 2012; and injuries to Daniel noticed by school staff. It summarises the position in these words: '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. 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.'

Professional communication, information sharing and liaison in respect of service delivery and other aspects of practice

The report acknowledges that changes of address by the family, including moving out of Coventry for a period, led to inevitable changes in the professionals involved, but says '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'.

Issues raised in this section of the report include: the peripheral nature of engagement of GPs within the multi-agency professional community addressing the needs of vulnerable children; failures by CLYP to acknowledge outcomes of referrals/contacts made back to health workers following concerns being formally expressed; confused and ineffective communication over the midwife's concerns about domestic abuse, including CLYP's advice not to make a referral and their failure to record the contact; assumptions being made by some professionals about the actions or views of others without checking them; the poor quality of three of the four formal CLYP assessments; failures to make use of information when it was appropriately shared (eg. GP records, school records and Education Welfare Service records). On this last point the comment is made that '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".'

On the extent to which practitioners were knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns, the report highlights the lack of attention to risks, especially the risks to the children arising from the domestic abuse and alcohol abuse, at the times of Ms Luczak's pregnancies and around the time of the birth of Adam. It comments that '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

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safeguarding training was not being implemented in practice or that management oversight of practice was insufficient.'

The report also highlights the failure of the assessments to explore Ms Lucsak's linguistic ability, observing that an interpreter was used on only a small number of occasions and that letters were generally sent in English – often on significant matters such as medical appointments and how to seek support on domestic abuse (though the police were more consistent in their use of interpreters and sending letters in Polish). It also comments on Anna being used inappropriately as an interpreter (and a source of information on Daniel's fracture, without access to an interpreter), and on the failure to use an interpreter to talk to Daniel himself, alone, about his situation.

On whether senior managers or other organisations and professionals were involved when they should have been, the report says, '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... 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. 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 workers involved were considered to have significant experience or that workload pressures had a significant impact.'

On whether the work in the case was consistent with each organisation's and the LSCB's policy and procedures, the report says that overall, procedures were said to be broadly adhered to by the agencies, with 'some notable exceptions in terms of the completion of assessments and the inconsistent response to referrals by CLYP'. It also says that 'case recording, not only for CLYP, was frequently problematic and often not in line with procedures'.

On organisational difficulties, staffing and resources, the report has already addressed the difficulties between agencies such as the Joint Screening process. Here it observes that '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... 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'.

Summary of findings

‘This case raised particular questions about the ability of the different agencies to address domestic abuse... 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.’

‘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... 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... 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.’

The report concludes that ‘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.’ Points listed include the following (summarised):

- Ms Lucsak presented as plausible in her concerns and often as a capable and caring parent; her manipulation, avoidance of contact with practitioners, and deceit were not recognised for what they were
- Mc Lucsak’s male partners seldom presented 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, which did not fit with the pattern that neglect usually impacts on all children in a family
- it is relatively rare in cases of child abuse that one child is singled out as Daniel was; the apparent good care of the other children appeared to give a false impression that Daniel’s problems were not related to abuse
- Daniel’s presentation of scavenging for food and excessive eating when he found some, linked to weight loss, was rare in a child and assumptions were then too readily made that his problems were medically based
- practitioners were not prepared to “think the unthinkable” and tried to rationalise the evidence in front of them
- no concerns were expressed to CLYP or the school by neighbours or the community, and neither Anna nor Daniel ever expressed any concern about their care at home

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- multi-agency protection systems sometimes failed to support effective coordinated interventions between organisations and practitioners.

The report makes clear that this list is not meant to ‘explain away the lack of protection that Daniel was afforded’ nor to offer excuses, but ‘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 to address Daniel’s needs and protect him’. It is pointed out that ‘Unlike the UK, some countries have a process for mandatory reporting of child care concerns to government departments, which raises the question that if it existed here, whether injuries seen upon Daniel would have been independently reported by individuals to the authorities’ (see ‘Comment’ below).

The final paragraph of the report, before listing 14 lessons learned and 15 recommendations, reads:

‘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.’

Lessons learned and recommendations

A link is provided to the full report, through which readers may readily access the list of lessons learned and the report’s recommendations (which relate to Coventry, though will also be of relevance elsewhere); these are expressed succinctly, so do not lend themselves to summary.

Comment

As reported in the overview above, Children and Families Minister Edward Timpson has asked the Chair of Coventry LSCB to look into *why* failures identified in the SCR occurred – so there is likely to be further public consideration of this tragic case in due course. This is particularly likely given that SCR overview reports are already required (under the revised and previous statutory guidance) to set out why things happened, or didn’t; so the Minister’s dissatisfaction with this aspect of the report is clear.

Meanwhile, an online petition with more than 50,000 signatures calling for a new law to make it mandatory for professionals working with children to report suspected abuse was handed into No. 10 just ahead of publication of the SCR report. Deputy Prime Minister Nick Clegg (to whom the petition was addressed) was [reported](#) as saying, “The problem in this and unfortunately in other previous cases is that individuals can fall between the cracks”, adding that such a law (which exists in a number of countries) was “not necessarily” the solution, but that “If it’s the only way we can prevent this tragedy of this poor boy happening to other children then of course we will consider it”. Children’s Minister Edward Timpson said that mandatory reporting “wouldn’t have helped Daniel”, adding that “We know from those countries which do have mandatory reporting it doesn’t necessarily make children safer, and it can actually make them less safe – we know they have higher death rates for children, for example.”

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Elsewhere, Andrew Webb, President of the Association of Directors of Children's Services (ADCS) commented: "This SCR has identified concerns relating to information sharing and communications between professionals working across a range of agencies - teachers, social workers, health professionals, police. One consequence of not sharing information was that nobody had a complete picture of Daniel's life, but nobody knew the extent of the physical abuse Daniel had suffered until after his death. If a SCR identifies issues of concern in respect of the performance of individual professionals then employers and/or the relevant professional registration bodies must take a view on whether further action is required, and whether the employing organisation had provided sufficient support. There is much speculation as to whether a system of mandatory reporting of professionals' concerns of abuse and/or neglect would help to protect more children. There is little evidence that professionals do not currently report their concerns to local authority children's social care." He cited evidence from ADCS research of a 15% increase in referrals between 2007/8 and 2011/12, with abuse and neglect being the predominant reason for referral.

Children's Commissioner for England, Maggie Atkinson, said the SCR "highlights similar failings to those we have seen before in relation to the deaths of other children... Every person who works with children in England needs to take note of it and act on the findings...".

But the British Association of Social Workers (BASW) expressed concern that SCRs are not being properly shared with all child protection social workers. A survey of BASW members showed that 25% of respondents never get to read SCRs when they are published; 67% "only sometimes" get to read the actual recommendations (17% never do); and 97% of the 238 respondents would like to see all SCRs stored in a central location, providing continuous easy access. BASW Chief Executive Bridget Robb said, "We'd like to see better use of [SCRs] as a learning opportunity for all professionals tasked with protecting children... Rather than the present ad hoc distribution of SCRs, where hard pressed staff are expected to read and interpret findings on their own and in their own time, we'd like to see structured podcasts for professionals produced by the authors of the SCRs so that professionals can hear the common messages...". The Association is urging that SCR reports each contain key lessons for all professionals involved with children's services, as opposed to specific recommendations for the organisations involved in a single case.

The Government published its revised statutory guidance document, *Working together to safeguard children*, earlier this year (see 'Related briefing'), which includes guidance on SCRs and the establishment of a national panel of independent experts to advise LSCBs on SCRs, and to report to the Government on how the system is working. Perhaps, in the interests of maximising learning from SCRs, the panel should consider the points raised by BASW and advise Ministers accordingly. (In the meantime, LAs in receipt of this briefing may wish to ensure that it is circulated as appropriate.)

External links

[Coventry Safeguarding Children Board documents](#)

Related briefing

[Working together to safeguard children – revised statutory guidance](#) (April 2013)

For further information, please visit www.lgiu.org.uk or email john.fowler@lgiu.org.uk