Lessons Learned and practice pointers

- Domestic abuse/violence is always a child protection issue and must always be approached with this as the mind-set of professionals - ***ensure referral is made to Children's Social Care***
- 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 – ***seek advice and consider referral to Children's Social Care***
- 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 – ***request an interpreter if child speaks little or no english***
- 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 – ***ensure all incidents are recorded and referred to. It is important that staff are aware of how to log incidents, reports and actions appropriately and how to raise concerns.***
- 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 - ***ensure recording systems and processes are robust and maintained. It is important that staff are aware of how to log incidents, reports and actions appropriately and how to raise concerns.***
- 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 - ***ensure recording systems and processes are robust and maintained. It is important that staff are aware of how to log incidents, reports and actions appropriately and how to raise concerns.***
- 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 - ***ensure recording systems and processes are robust and maintained. It is important that staff are aware of how to log incidents, reports and actions appropriately and how to raise concerns. It is vital that staff receive safeguarding training (NSCB Safeguarding Training Programme can be accessed via www.northumberland.gov.uk/SafeguardingChildren or by calling 01670 623164)***
- 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
- 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 – ***always take advice or consider referral to Children's Social Care***
- 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's life are less significant for the purposes of assessing the existence of child abuse.
- 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 – ***ensure a referral is made to Children's Social Care***
- 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 – ***Seek advice and consider referral to Children's Social Care***
- 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.
- 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 potentially dangerous practice.

Keeping Children and Young People Safe from Harm, Abuse and Neglect

Northumberland Safeguarding Children Board

Highlighting Lessons from Serious Case Review

National

Date of Review: September 2013
Local Authority: Coventry LSCB
Name: Daniel Pelka

Outline

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 sibling 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.

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.

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.

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.

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.

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.

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.

Summary of Findings

Domestic abuse
Professionals were naïve about the impact of domestic abuse on children. This is always a child protection issue and schools should always refer to Children's Services

The child's experience
Professionals appear to have lacked an 'enquiring mind' about Daniels care. Daniel was never spoken to about his life and the services of an interpreter were never sought.

Understanding possible causes of problems
Abuse was never considered as the cause of Daniel's difficulties. The School and Health service appear to have made attempts to address his health and behavioural issues but failed to make links between the injuries noted on him and other concerns, such as Daniel scavenging in bins.

Consistent use of systems and processes
The findings in this report echoed the findings in many other Serious Case Review reports-

- poor quality of assessments
- failure in maintaining a focus on the child
- failure to engage with significant males, and
- failure to take a broad view of concerns.

There was a belief that agreed systems and processes were sufficient to protect children and reliance that such systems were robustly used. In reality the systems and processes were not consistently applied and assumptions were made amongst professionals that someone else was taking responsibility for Daniels plight.

Caseloads
Health visitor caseloads were judged to be too high and may have prevented sufficient attention to the needs of the family. Similarly Social Workers caseloads in the referral and assessment team were high with a high conversion of referrals to allocated cases. There were also difficulties in transferring cases from the referral team onto longer term teams which resulted in a log jam. The review concludes that this potentially led to some practice with Daniel being delayed and insufficiently challenging

The review notes that no individual practitioner works in a vacuum and states 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'.***
The findings suggest that some of the probable reasons Daniel's abuse was not recognised and acted upon earlier by practitioners are likely to have included:

- His mother presented as plausible in her concerns, and a capable and caring parent. She was also assertive in her interactions with professionals. Her manipulative and avoiding behaviour were not recognised for what they were and her presenting image was too readily accepted.
- The significant males in Daniels life avoided professional contact and therefore were not sufficiently considered.
- The apparent good care of Daniels siblings provided false reassurance that Daniel's experiences were not as the result of abuse.
- Daniel's obsession with food linked to weight loss was unusual and resulted in professionals readily assuming the problem was medically based.
- Professionals did not 'think the unthinkable' and therefore didn't consider abuse as a possibility.
- There had been no concerns expressed by neighbours or the community.
- Neither Daniel nor his sister raised any concerns about family life.
- Multi agency child protection systems sometimes failed to support effective coordinated interventions between organisations and practitioners.
- Emotional abuse is difficult to detect.
- Daniel's voice was not heard throughout this case. Significantly overall there is no record of any conversation held with him 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. English was not Daniels first language, but this should not have prevented the child from being heard by those who should have protected him.