



# DANIEL PELKA REVIEW RETROSPECTIVE DEEPER ANALYSIS AND PROGRESS REPORT ON IMPLEMENTATION OF RECOMMENDATIONS

23<sup>rd</sup> January 2014

Jane Wonnacott

Independent Consultant – In-Trac Training and Consultancy Ltd

David Watts

Independent Safeguarding Consultant - Via Safeguarding  
Solutions Ltd.

## Foreword

Coventry Safeguarding Children Board is pleased to publish the independent report of the deeper analysis into the circumstances of the death of Daniel Pelka in March 2012 and in doing so demonstrate our determination to be open and transparent about our work. Alongside the deeper analysis of practice up to March 2012, we are also publishing, in part 2 of this document, a report detailing the progress we have made so far in improving practice within Coventry.

The deeper analysis was completed at the request of DFE Minister, Edward Timpson, following the publication of the Serious Case Review in September 2013. The analysis was led by an experienced, independent expert Jane Wonnacott and supported by a small team of professionals who reflected the various disciplines which had been involved in the case.

The report sets out a detailed analysis of how services were operating up to 2012 and addresses the issues set out by the letter from Mr Timpson.

- why information was not effectively recorded
- why information was not shared
- why four separate assessments by social care failed to identify the risks to children before he was murdered by his mother and stepfather.

The report makes clear how profoundly Daniel's death affected everyone and how there is a tremendous determination across Coventry to understand why some of the systems in place which should have protected Daniel were flawed and why some of the individuals did not deliver the standard of practice required.

Part 2 of this document was written by another independent safeguarding expert, David Watts and provides a summary of progress made by partners on implementing the recommendations of the Serious Case Review up to the end of December 2013. Work has started on all 15 recommendations; 7 have been completed in full and 8 others require further action and monitoring by partners and the Safeguarding Children Board.

All the partners on the Coventry Safeguarding Children Board have accepted the findings of the deeper analysis report and have reaffirmed their commitment to continue to implement all the actions required to address the 15 Serious Case Review recommendations.

The Coventry Safeguarding Children Board will continue to challenge partners and to insist that effective action is taken to continue to improve safeguarding in Coventry and to keep children safe.

Amy Weir  
Independent Chair  
Coventry Safeguarding Children Board

# PART 1

## A DEEPER ANALYSIS OF THE FINDINGS OF THE DANIEL PELKA SERIOUS CASE REVIEW

Jane Wonnacott  
Independent Consultant  
In-Trac Training and Consultancy Ltd

## 1 INTRODUCTION

- 1.1 Following publication of the serious case review into the death of Daniel Pelka, the Parliamentary Under Secretary of State for Children and Families wrote to the Chair of Coventry Safeguarding Children Board on 16<sup>th</sup> September 2013 requesting a deeper analysis of the reasons why practice failures had occurred. This deeper analysis was asked to look specifically (but not exclusively) into:
1. Why was basic information not recorded properly both within and between agencies
  2. Why was information needed to protect Daniel not shared between the relevant agencies
  3. Why did four separate assessments by children's social care all fail to identify the risk to Daniel and what was the oversight of those decisions?
- 1.2 In response to the letter, the Chair of the Safeguarding Children Board commissioned a project team comprising professionals with expertise in safeguarding practice in police, health, education and children's social care. This project team was asked to conduct a deeper analysis with a requirement that a report should be available before Christmas 2013. All members of the project team were completely independent of the case and had no previous links with agencies in Coventry.
- 1.3 This report is not intended to repeat the findings of the original serious case review but sets out to seek to explain in more detail why specific practice failures occurred *at that time*. Continuing work is being carried out by Coventry Local Safeguarding Children Board to rectify the practice problems identified within the serious case review and this work is set out in part 2 of this document.

## 2 PROCESS

- 2.1 A project plan for the deeper analysis was agreed by the chair of Coventry Safeguarding Children Board with senior managers from the police, relevant health organisations and children's social care. A senior manager in each agency was asked to act as project lead and facilitate the implementation of the project plan within their organisations. This included inviting practitioners still working in Coventry who had been involved with Daniel and his family to meet members of the project team. It was the choice of individual practitioners as to whether they attended and the team were very grateful that so many of them chose to do so.
- 2.2 A large number of those who were directly involved in the case have been seen. Others working in those services were also spoken to in order to widen our understanding of the context in which events occurred. However, there have been some limitations to this process. There are some people who are subject to other investigative processes; some

of those chose not to attend or to do so in a restricted manner. In addition, there were some difficulties in organising a few of the meetings. All of this has resulted in some frustration for the team but we are still confident that for the most part we have been able to cover most of the issues required to answer the why questions.

- 2.3 No individual discussions were held with staff from Daniel's school, as the education consultant on the project team had already been commissioned, via the Council's Education Department, to speak to school staff. It was not appropriate to repeat this exercise and findings from the interviews have informed this report. The education consultant has also been a full and active member of the project team.
- 2.4 As well as talking to individual practitioners, the project team worked with a number of focus groups from each organisation (including schools) in order to gain a broader understanding of the context within which similar work takes place.
- 2.5 Information obtained during the process was grouped using an adapted version of the root cause analysis model developed by the National Patient Safety Agency<sup>1</sup>. These factors focused on:
  1. The nature of the family.
  2. Individual practitioners (knowledge, skills and expertise).
  3. Team factors (cultures, workload, quality of management supervision and support).
  4. Inter and intra professional communication.
  5. Organisational and strategic factors affecting practice.
- 2.6 This report sets out an overarching summary and then specific findings as they apply to the three specific questions asked by the Children's Minister.

### **3. Summary of Findings**

#### *Recording within and between agencies*

- There were delays in recording information on social work records resulting in the social worker carrying out the first initial assessment not having access to all the relevant information about domestic violence. This was due to the challenges involved in managing the volume of information in relation to domestic violence and insufficient administrative support within children's social care.
- There were unacceptable delays in circulating the minutes of the strategy meeting that considered Daniel's broken arm and there was insufficient management oversight to make sure that these were circulated. Delays were not unusual at this time mainly due to work pressures within children's social care including insufficient administrative support.
- There were no family records within community health services resulting in a situation where the school nurse and health visitors did not have a full picture of the family

---

<sup>1</sup> Root Cause Analysis Toolkit, 2004. <http://www.nrls.npsa.nhs.uk/resources/?entryid45=59901> (accessed 13.12.13)

circumstances. The lack of a full picture was exacerbated by central allocation of health visitor tasks such as developmental checks or new birth visits, resulting in a lack of consistency in work with the family.

- The fact that there was no expectation within health that children's height and weight was plotted over time (for example on a centile chart) and a record kept within their file meant that there was no means of the various health professionals having an easily available visual record that compared Daniel's good progress in his early years with dramatic decline in the year prior to his death.
- Recording systems within the school were used inconsistently and did not bring together all information into a central place in order to enable an accurate assessment of need and risk. This was due to lack of effective leadership within the school and insufficient school focused training and external scrutiny in relation to the development of safe effective child protection systems.

#### *Information sharing and communication*

- Staffing pressures within health visiting, a delay in receiving information from the police and lack of clarity regarding their role resulted in the health visiting service routinely treating domestic violence notifications as 'for information only'. Health visitors in receipt of information that should have worried them relied on the police assessment and social workers visiting, rather than being proactive and visiting the family themselves.
- The use of language including that it was "plausible" that the spiral fracture to Daniel's arm was accidental had a disproportionate impact on decision making at the strategy meeting. This is not a criticism of the doctor using the term at that time but point of learning for the future.
- Poor standards of communication relating to problems with information sharing systems between acute hospital trusts and community health services, and the separation of midwifery records from other parts of the system meant that risks relating to mothers mental health and her behaviour whilst pregnant was not known to health visitors or the GP. Such information would not be available within the parent held records. This combined with a lack of a family record within health meant that previous concerns about Daniel were not known to the health visitor carrying out a pre birth visit in respect of Adam.
- Information exchange at the point Daniel started school was adversely affected by the reliance on paper records within health visiting, the use of an electronic system within school nursing and term time working arrangements for school nurses.
- Communication between the school nurse and the school was adversely affected by the fact that she was not the usual school nurse for that school and did not know the most appropriate person to speak to. She also did not have the usual informal opportunities to see Daniel within school.
- Insufficient training for staff within the school meant that they were unclear of their role in the child protection process, who to go to with concerns and what to do if their concerns were not heard within the school environment.

#### *Assessments within children's social care*

- There was pressure on the referral and assessment team in children's social care as a result of staffing problems elsewhere in the service. Management action to improve the consistency of assessments within a pressurised service was misinterpreted by teams

as condoning the production of core assessments which were of poor quality and lacking in detail.

- There was a lack of effective management oversight within children's social care due to an over-reliance on experienced workers and supervisors who were not sufficiently trained and supported to deliver reflective supervision.
- Social workers had received insufficient training on the role of the social worker in assessments where a combination of domestic violence, alcohol misuse and parental mental ill health presents a risk to children.
- The social worker undertaking the second core assessment had received insufficient training in direct work with children including the use of interpreters.
- The culture at the time of the second core assessment was described as “a core assessment is the answer to everything” indicating insufficient understanding of the role of the core assessment as part of section 47 (child protection) enquiries.

#### *Other Assessments*

- The assessment by the community paediatrician was an opportunity to explore whether abuse was one possible explanation for Daniel's symptoms. It has not been possible to explore in any detail why this did not happen although the paediatrician reports that their actions were partly influenced by poorly kept hospital records, no centile charts within the records and a lack of strategy meeting minutes giving a fuller explanation of the circumstances surrounding Daniel's fractured arm.
- Assessments within the school failed to bring together all known information and identify risk of abuse due to fragmented information gathering and recording systems within the school. In addition appropriate professional judgement was not used in the decision not to refer Daniel's situation to Children's Social Care.

## **4 WHY WAS BASIC INFORMATION NOT RECORDED PROPERLY BOTH WITHIN AND BETWEEN AGENCIES?**

### *Children's Social Care*

- 4.1 In relation to domestic violence referrals, social work managers attended regular joint screening meetings with the police where domestic violence incidents involving children were discussed. At these meetings decisions were made as to whether a referral to children's social care was needed. Up to 25 cases could be discussed in one meeting and referrals and information on open cases were then entered on the children's social care records by the social work manager. Due to limited administrative support this process could take up to two days to complete. In Daniel's case, a delay in entering information meant that the social worker carrying out an initial assessment did not have all relevant information, including allegations about mother's alleged violent behaviour.
- 4.2 Within children's social care the use of chronologies was not common place and these were not recorded on the child's file and used to inform practice. This was partly due to the change to a computerised recording system which did not easily facilitate the

compilation of a type of chronology that was a useful aid to assessment. As a result, the full extent of the seriousness and extent of the difficulties in the family – particularly of domestic abuse incidents – was not and could not be easily and fully appreciated at a glance. It also meant that connections between what was happening at different points and in terms of contact by other agencies with the family – particularly as and when new concerns arose.

- 4.3 When a midwife called children's social care with concerns when mother was pregnant with Adam, the social worker failed to link these concerns with the previous records relating to Daniel, including his broken arm and the family's significant domestic violence history. The project team have scrutinised the electronic record and this can only be explained as human error by a stressed social worker in a team working under considerable pressure. This error may have been made more likely by an approach within the team, which aimed to manage the pressure of work, by only taking immediate referrals where it was absolutely clear that they reached the threshold for children's social care.

### *Health*

- 4.4 Recording within the health visiting service was evident but it still relies on a paper-based system and there are no family records linking all the children in the family. Therefore, when the health visitor carried out a new birth visit in respect of Adam she was unaware of previous concerns regarding domestic violence in the family or concerns about Daniel's broken arm. She was unable to record mother's description of Daniel's behaviour and eating problems on Daniel's file at the time as it was boxed up awaiting transfer to the school nursing service and therefore not easily accessible to her.
- 4.5 The practice of routinely recording a child's height and weight on a centile chart and keeping a copy of the chart in the child's health visiting/school nurse record was not common practice within Coventry. There was therefore no visual record that compared the good progress in Daniel's early years with the dramatic decline across the centiles in the year prior to his death. This lack of use of centile charts is mirrored within the acute hospital and although Daniel had weights recorded on admission and in clinic, again, there was no visual record of these.
- 4.6 Another factor contributing to poor recording of baseline height and weight measures was the fact that weight had not been recorded at the developmental check (which took place at home) due to the health visitor having no scales available. This was because there were not enough scales for each health visitor to have one set each.
- 4.7 There are no family records within health visiting or school nursing in Coventry which link the information about the separate children in the family. This meant that although information was recorded on Daniel's records in relation to domestic violence, the health visitors or school nurses working with other children in the family would not have this information. There were therefore missed opportunities for links and connections to be made about the experience of all the children in the family.
- 4.8 The project team found several examples where the level of detail in letters to GPs from the hospital was limited. For example, the letter to the GP as a result of the fracture to



Daniel's arm referred only to the nature of the injury and the fact that follow up appointments had not been attended. It did not refer to any consideration of potential non accidental injury or the strategy meeting. This information was therefore not available to the GP at a later date when Daniel was referred due to eating "problems". It has not been possible to explore with the individual doctors why this was although discussions with others in the system has suggested that minimal detail in letters from acute trusts to GPs and health visitors is not uncommon practice.

- 4.9 Midwives do not have access to all the records pertaining to the mother that are held within the hospital and externally, including accident and emergency records. They were therefore unaware of Daniel's admission with the spiral fracture which in this case resulted in those attending the strategy meeting not being aware of mother's pregnancy. Within GP practices midwives and GPs use the same record system but they record in different areas of that system, which had the potential for significant information held within one area of the record only being accessed by some staff on a selective basis.

### *Education*

- 4.10 The serious case review identified poor record keeping within Daniel's school especially in respect of recurrent injuries. This meant that a number of different injuries and at different times were not coherently or sequentially recorded to show the pattern which was emerging over time. The true significance of what was happening and any action which should have been taken following each incident was not written down. Whilst the development of effective systems is the responsibility of school leaders overseen by Governing bodies, there had been no specific training for designated safeguarding leads which focused specifically on the details of setting up a safe child protection system (including recording). There had been a reliance on multi agency training which designated leads are expected to disseminate throughout the school. Whilst such training is important in developing an understanding of the signs and indicators of abuse and working together across agencies, it does not provide the detailed information that all school staff need in relation to identifying concerns and sharing and recording information within the school.

### *Police*

- 4.11 The project team found that basic information about Daniel was well recorded within the relevant police files, however these files were not always reviewed by a manager. For example the police investigation into Daniel's broken arm was not reviewed by a senior manager and there was therefore no external challenge to the process of investigation or to the decision-making at the strategy meeting. This was because the senior police officer was on holiday and the investigating officer therefore signed off their own investigation. The files within the joint screening team were well kept and showed the reasons for decision made. However, there is again little evidence of managerial oversight, most probably because the officers within the team were considered to be experienced officers and experts within the field. However, training profiles indicate that they had minimal specialist training and were left to run a pressurised service with little

opportunity for development or supervision and management or oversight of their work.

## **5. WHY WAS INFORMATION NEEDED TO PROTECT DANIEL NOT SHARED BETWEEN THE RELEVANT AGENCIES?**

- 5.1 It should be remembered that from time to time a great deal of information was shared between professionals, particularly in relation to domestic violence, but the information was not sufficiently understood in terms of risk to Daniel or the other children. When information was not shared this was mainly as a result of individual professionals not realising the significance of the information they held, along with information systems that did not facilitate the sharing of information. Important factors affecting the degree to which significance was understood related to experience and training of individual staff, workload and management oversight, as well as the capacity of mother to present well to professionals.

### *Police*

- 5.2 The project team were told that Coventry has the highest rate of domestic violence in the West Midlands and West Midlands Police also have the challenge of working with seven different Local Authorities. Managing the flow of information about domestic violence was therefore a challenge, both within the police force and with partner organisations. Sending information to others will not protect children if those in receipt of information are overwhelmed or unsure about how to understand its significance for their role and there was evidence to suggest that this was the case particularly in relation to the health visiting service. This is explained further below.
- 5.3 In Coventry in 2008-9 the process for managing domestic violence incidents involving children was that front line police officers attending an incident would complete a risk assessment in relation to the severity of the incident and grade the risk as low, medium or high. It is important to note that this risk assessment tool was a generic one for use in all domestic violence incidents whether children were present or not. It is not designed to assess risk to the children. The quality of information gained at this point was therefore crucial in determining subsequent responses by other in the system. One issue that may have adversely affected the understanding of officers and quality of risk assessments was the fact that English was not mother's first language. Officers also told us that it was the case that after 5pm there was no easy access to an interpreting service. Officers had to rely on a language line which involves handing over their radios to the adults involved; something that that they are understandably reluctant to do especially when dealing with potentially violent individuals.
- 5.4 The use of language is important in communication across professions. The risk assessment forms often contained the phrase that the children were 'safe and well' (which was the term in general use at the time in the police service) to describe the children. This gave a falsely optimistic view of the impact on children living in situations of domestic violence to other professionals reading this information. They assumed it

meant much more than it ever could, since it was based on the brief encounters police had with the children; and on some occasions, they did not see the children at all.

- 5.5 Where children were involved, communication by West Midlands Police with children's social care regarding domestic violence was via the joint screening meeting. The joint screening team had been set up in Coventry in October 2006 and involved two police officers reviewing all police domestic violence notifications. An administrator from social care was based in the police team and carried out agency checks prior to a meeting which took place 2/3 times a week between a social care manager and the police officer. At this meeting cases were reviewed and decisions made, including whether a referral was needed to children's social care for an initial assessment or whether the case had reached the threshold for section 47 enquiries and a strategy meeting was needed. Health visitors were directly sent notification of all cases involving children. The domestic violence incidents within Daniel's family were regularly discussed at this screening meeting and it therefore had the potential to be an effective means of communicating between police and children's social care. An initial assessment by children's social care in April 2008 and a core assessment in November 2009 were both a direct result of discussion at a screening meeting.
- 5.6 The effectiveness of this communication was however diminished due to pressure on the team as a result of an increase in domestic violence incidents. A report to Coventry Safeguarding Children Board in September 2010 noted that in 2009-10 the number of days between a domestic violence incident and screening was 15 days and this number was gradually increasing. This delay resulted in social workers and health visitors often being unaware of domestic violence incidents until sometime after the event.
- 5.7 Information exchange by police officers at the strategy meeting which took place as a result of the spiral fracture to Daniel's arm did ensure that most of the relevant information regarding domestic violence was known to the meeting. However the pressures on the joint screening team meant that information from Warwickshire Police regarding a MARAC<sup>2</sup> meeting that had taken place whilst the family were briefly in their area in 2010 had not been processed and was not available to the meeting. It is possible that this may have added weight to the need to initiate a child protection investigation under section 47.<sup>3</sup> It was however communicated to the social worker soon afterwards and should have influenced the core assessment that was being carried out.

### *Health*

- 5.8 The delay in processing domestic violence notifications resulted in health visitors receiving the information some time after the event and often the documents arriving in batches. An already over-stretched health visiting service viewed notifications as 'for information only' and health visitors mainly relied on the grading given by police officers to determine whether they should take further action such as visiting the home. A risk

---

<sup>2</sup> A MARAC is a Multi-Agency Risk Assessment Conference. At a MARAC, local agencies meet to confidentially discuss high-risk victims of domestic violence who are living within the local area to identify what safety and support mechanisms can be put in place for the victim and families.

<sup>3</sup> The National Child Measurement Programme (NCMP) measures the weight and height of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight children and obese levels within primary schools

assessment grading designed to assess risk to the victim was therefore used by health visitors to decide whether a response was needed in relation to the children.

- 5.9 One health visitor commented that when domestic violence notifications first started coming from the police into health, there was no policy guidance as to what to do with them and there was no expectation that domestic violence notifications from the police were for anything other than information. There was no system of these being screened by an experienced health professional, although health visitors could contact their domestic violence lead nurse if they had concerns. Workload pressures affected health visitors' capacity to process and respond to information and it is clearly the case that during 2008-9 there was no expectation that families where there was recurrent domestic violence might need to be visited and a CAF considered. It is well documented in letters sent by the Chair of the Safeguarding Children Board to the Primary Care Trust at the time, in mid 2011, that there were concerns that the low level of staffing within the health visiting service was adversely affecting child protection practice.
- 5.10 The use of language by health professionals in sharing information at the strategy meeting appears to have been significant in the way that their views were interpreted by others. The doctor's comment that mother's description of the injury was 'plausible' appears to have been a major influence in the decision not to pursue section 47 enquiries and it would have been more helpful if the doctors had simply stated that both an accidental and non-accidental cause were possible. It is likely that this combined with the fact the Anna had corroborated her mother's account resulted in the meeting losing sight of the potential significance of the bruising as well as the fracture and the fact that mother had delayed bringing Daniel to hospital. Information about previous domestic violence (including that perpetrated by mother) was brought to the attention of the meeting and the focus shifted from events surrounding the injury to the issue of domestic violence.
- 5.11 Ineffective written communication between acute hospital trusts and community services has been referred to above. In addition to the communication from the hospital consultant to the GP in relation to Daniels' broken arm, on two occasions information from the accident and emergency department regarding mother's overdose and attempt to run out in front of an ambulance did not reach the health visitor. This would have raised the health visitor's level of concern, prompted a visit and, when domestic violence notifications were received, most likely have resulted in liaison with children's social care. Social workers may then have been aware of this incident at the time of the first initial assessment. There is a completed fax form in the health visitor notes from accident and emergency outlining the incident, however, unlike every other document in the health visitor file there is no date stamp indicating when this was received by the surgery. The lack of effective use of the paediatric liaison role is reported to be likely to have exacerbated communication problems and would have been an important addition to a reliance on paper based communication methods.
- 5.12 The period when mother was pregnant with Adam tested the capacity of the health system to link up emerging concerns about one child (the unborn baby) with other children in the family (Daniel and Anna). Sadly, problems with information sharing within health contributed to information about mother's pregnancy with Adam becoming lost at the time of the fracture to Daniel's arm. Midwifery information was only available to other professionals within the hospital if requested and the health visitor did not have an

overall picture of family circumstances mainly due to the central allocation system within health visiting. This system means that when a case becomes inactive it effectively has no health visitor; (although one can always be allocated should issues arise for the parent or other professionals) when next activated it may be allocated to any health visitor covering that area. The health visitor who liaised with children's social care after the fracture was not the same one who had visited the family in July 2010 and carried out a developmental check on Daniel and was unaware of the pregnancy. All of this resulted in a serious lack of consistency in staff dealing with the family which made it much more difficult for a coherent and critical assessment to be made particularly when outwardly the household was clean and tidy and there was obviously food available for the children.

- 5.13 Communication systems between health visiting and school nursing did not facilitate effective exchange of information across the two services. The accumulating concerns in relation to the family as a whole were therefore not recognised as potentially needing either a CAF assessment or, potentially, referral to children's social care. The reason for this was threefold. Firstly, at the time the health visitor conducted a new birth visit in relation to Adam and mother expressed concerns about Daniel's behaviour and eating problems, Daniel was about to start school and all his records were boxed up awaiting transfer from health visiting to school nursing. Whilst there was a system in place the health visitor did not identify potential risk to Daniel from the single event that had come to her attention and the system for retrieving records was not used. Secondly, school nurses work term time only and were not available for a face to face discussion at the time of the new birth visit. Thirdly, communication between the health visitor and school nurse was further hampered by the fact that they do not share the same database/case recording system resulting in delays whilst health visitor paper records are transferred and scanned into the school nursing records.
- 5.14 Midwifery staff who were concerned about mother's behaviour on the ward did attempt to find out whether mother was known to police or children's social care, but the response that a core assessment had recently been carried out took the focus away from the current behaviour within the hospital. At the time communication systems between hospital midwifery departments and health visiting services were ineffective. It has not been possible to understand clearly why this was although it is likely that the severely under resourced health visiting service and lack of time to develop effective working relationships may have been a contributory factor. The impact of ineffective communication was that when the health visitor carried out the new birth visit and mother spoke to her about problems with Daniel, she was unaware of the incidents that had taken place in the hospital. The 'start again' approach to the new birth visit by the health visitor was further exacerbated by the system of central allocation within health visiting, described above since the health visitor conducting the new birth visit did not know the family. There are no family records and she did not have Daniel's records as he was starting school the next month and they were already boxed up for the school nurse. The health visitor therefore visited knowing nothing about the previous domestic violence or possible non-accidental injury to Daniel.

- 5.15 Within midwifery services there was a child protection meeting with the named nurse<sup>4</sup> every Wednesday. The role of this meeting was to analyse critically all child protection cases and if a referral had been made to children's social care the case will be discussed. However, in respect of mother's pregnancy with Adam no referral was made and the case was not deemed to be child protection. It therefore may not have been a priority for this meeting and there appear to be no other mechanisms in place for supervision and oversight of cases that are borderline child protection.
- 5.16 The school nurse who responded to the referral from the health visitor was not the school nurse allocated to Daniel's school (she was off sick). She was an experienced professional who had attended relevant training in relation to safeguarding and domestic violence. She was persistent in arranging to see mother at home and recalls mother presenting as a "loving mum" who asked the appropriate questions and was not resistant to the idea of a referral to the paediatrician. Mother's capacity to present as extremely plausible therefore deflected the school nurse from any suspicion that Daniel's behaviour was linked to neglectful parenting or abuse and did not prompt communication with children's social care.
- 5.17 The culture within the school nursing service appears to be one of working with parents and the project team were told that it is not unusual for the child not to be seen. School nurses do not routinely do height and weight measurements as this is done as part of the National Childhood Measurement programme.
- 5.18 The role of the school nurse was influenced by the fact that the school nursing service in Coventry was under pressure; the school nurse in this case being responsible for double the average number of schools identified in a survey of state school nursing in 2005. Pressures resulted in less time being available to follow up individual children. The system has been put further under pressure by the increase in the number of domestic violence notifications arising now from these being sent to school nurses for all children, not just those where there are under 5's in the family.
- 5.19 Effective communication can depend as much on relationships between individuals as on systems. Although an experienced professional, the school nurse was not the one assigned to the school and did not have the day to day relationships with individuals which would have influenced whom she chose to speak to. She called the school to discuss Daniel but was unaware that the class teacher was relatively inexperienced and that systems within that particular school meant that the class teacher did not have the whole picture. She has also commented that if it had been her allocated school she would have popped in and spoken to the teacher and seen Daniel.
- 5.20 Communication with the community paediatrician was hampered by hospital records which were not well ordered and did not contain baseline information about Daniel's growth and development. The lack of strategy meeting minutes within the records as they had not been sent out by children's social care also meant that the assessment was not informed by full information about the spiral fracture.

---

<sup>4</sup> A senior nurse with particular responsibility for promoting good practice in relation to safeguarding children within their health trust.

### *The School*

- 5.21 The reason why the school did not share information about their concerns regarding Daniel seems to have been as a result of poor leadership and practice and a fragmented child protection system within the school which meant that different staff were responsible for different aspects of care. For example different people had responsibility for child protection, health and attendance, the concerns about Daniel were not effectively communicated across the staff team and there was no formal mechanism for gathering information together across the school.
- 5.22 Staff within the school cannot recollect any training which assisted them in recognising the signs and indicators of abuse and some were unclear about who fulfilled the role of designated child protection officer. The result of this was that even where staff may have had concerns about Daniel they were not sufficiently equipped to communicate their concerns directly to the appropriate person and/or were not confident to question why a referral to children's care had not been made or advice from children's social care sought.
- 5.23 Where systems are ineffective harm can be mitigated by a system of external scrutiny and challenge. In this case there is no evidence of effective external scrutiny or challenge to the school leadership regarding their communication systems from either the local authority or the governing body.

### *Children's Social Care*

- 5.24 Issues relating specifically to communication and information sharing by children's social care are dealt with in section 6 of this report since they relate to assessment practice. There clearly were some issues about missed opportunities for communication with other agencies and of assumptions being made incorrectly about the significance of some information which was shared with children's social care.

### *Communication and joint working between police and children's social care*

- 5.25 When West Midlands Police sent two officers from the child abuse investigation team to the hospital following the fracture to Daniel's arm, they spoke with mother and her partner and then visited Daniel's sister, Anna, who was staying with a friend. Anna confirmed the account of Daniel's injury given by mother. It is a matter of professional opinion as to whether it was best to see Anna swiftly or whether it would have been best to plan a joint interview with a social worker and an interpreter the next day. There are arguments for and against each course of action. We were, however, told that joint visits between social workers and police officers were 'not part of the culture', and one social worker commented that the joint training (Achieving Best Evidence) is a waste of time, as social workers are only used to sit behind a one way screen and are hardly ever involved in interviews with children. There are reasons for this, including making sure that the best evidence is obtained where a criminal prosecution is likely, but this approach to joint working means that in this case no consideration was given to the advisability of working jointly to plan conversations with either Anna or Daniel. The focus was on potential criminal prosecution and corroborating mother's account rather than planning a joint

interview that could have explored broader issues relating to the experience of Anna or Daniel within the family.

This issue about the token involvement of social workers in interviewing children with the police was also raised as an area for improvement in the Ofsted Safeguarding and Looked After Children Inspection in 2011.

## **6. WHY DID FOUR SEPARATE ASSESSMENTS BY CHILDREN'S SOCIAL CARE ALL FAIL TO IDENTIFY THE RISK TO DANIEL AND WHAT WAS THE OVERSIGHT OF THOSE DECISIONS?**

- 6.1 By the time of the first initial assessment in April 2008 there had been seven domestic violence incidents, including two where mother had been allegedly threatening Daniel's father with a knife. Alcohol had been a feature on all occasions. However, it seems there was a delay in the information from the screening meeting being entered onto the social work record, resulting in the social worker who carried out the initial assessment being unaware of the extent of the violence.
- 6.2 The social worker who completed the first initial assessment was experienced in working with domestic violence and it is clear that, had she known about mother's alleged use of knives, this would have changed her assessment and most likely escalated the case to child protection. Instead, she knew that the joint screening process had not escalated the case to one of child protection and approached the initial assessment in line with guidance which was that an initial assessment was a *brief assessment*<sup>5</sup> designed to determine whether services were required and/or whether a more detailed core assessment should be carried out. The social worker has now reflected that the use of alcohol was not given sufficient weight and believes that one factor influencing this was that in 2008-9 there had been a recent influx of Polish families into the area and professionals were unfamiliar with working with the community.
- 6.3 The second initial assessment and the core assessment carried out during this period were of very poor quality and part of the problem with the core assessment was that it relies on self-reporting by mother and little or no information from other agencies. There was evidence that the health visitor tried to call the social worker but when she did not receive a response, she made no attempt to visit the family herself, probably due to the pressures on the health visiting service outlined above. It has not been possible to speak to the social workers involved with these two assessments as they are no longer working within Coventry. However, it is clear that the knowledge and skills of the individual practitioners carrying out effective assessments was not of the required standard and this was not identified through management and supervision processes. The social worker who carried out the core assessment was a newly qualified worker and the manager who supervised and signed off the assessment was an agency worker whose contract was not renewed.

---

<sup>5</sup> *Framework for the Assessment of Children in Need* Para 3.9



- 6.4 An additional factor that was likely to have influenced the assessment process at this time was that the referral and assessment team had only been formed as a Citywide team in 2008. Neighbourhood teams were expected to take on longer term work but due to staffing problems they were not able to take on all the cases that needed to be transferred to them. Senior managers decided that all core assessments should be completed within referral and assessment. Although the referral and assessment team was the most stable in terms of staffing, this decision put additional pressure on the team who struggled to maintain both quality and the quantity of work required. Practice standards were developed in September 2009 as part of a LSCB thresholds document in order to assist staff in focusing on the most important elements of initial and core assessment. These standards were not in place at the point that both initial assessments were carried out and it is not clear how well staff had been trained in their use by the time of the first core assessment in November 2009.
- 6.5 The second core assessment was a pivotal moment in the case when there was the opportunity to recognise that Daniel was being physically abused within the family. Mother was by this time living with MK, her partner who along with mother was eventually convicted of Daniel's murder. The core assessment took place after the investigation into the spiral fracture to Daniel's arm and the approach to the assessment would have been influenced by the fact that the decision had been not to continue with section 47 enquiries.
- 6.6 The knowledge and skill required to undertake social work assessments where there is a presence of substance misuse, parental mental ill health and domestic violence is significant in this case. From a review of the training records the social worker carrying out the core assessment had not attended any of the training on offer in relation to assessing parental substance misuse or mental ill health and had only completed one domestic violence course in 2006, five years previously. They had also only attended one half day session on interviewing children in 2008. If these records contain all staff development activity this is not an adequate level of training for this complex work. The use of assessment frameworks to consider the impact of these factors in children in the family was not evident. None of the assessments carried out by children's social care used any tools to assist practitioners in this task<sup>6</sup>. It is widely accepted as good practice that evidence based tools should be used to inform complex assessments so this is a significant gap in practice both within the local system but also by the individual practitioners involved.
- 6.7 According to the relevant Government guidance - *Working Together* - in 2011 a strategy discussion should be held whenever there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm<sup>7</sup>. One of the purposes of the strategy discussion was to decide whether section 47 enquiries should be initiated and therefore a core assessment be undertaken under section 47 of the Children Act 1989 and plan how any such core assessment should be carried out. The conclusion of the meeting in respect of Daniels' injury was that there was no need to initiate section 47 enquiries but that a core assessment should be carried out under section 17 Children Act 1989. This is an important distinction as it identified Daniel as a child potentially in need of help and

---

<sup>6</sup> These might have included the risk assessment tool developed by Barnados for children living in situations of domestic violence and the resilience and vulnerability matrix (DOH *Child's World Training Materials*)

<sup>7</sup> HM Government ( 2010) *Working Together to Safeguard Children*\_Para 5.56

services, rather than a child also at risk of, or possibly suffering significant harm. Although theoretically the core assessment process may have been similar whichever route was taken, the fact that this was a child protection case would have allowed potential risk of harm to have been clearly on the agenda in discussion with mother and alerted other professionals to the risks. When problems emerged in mother's next pregnancy and she later began to describe problems with Daniel's behaviour and eating patterns, this could have been understood within the context of a child who had previously been considered to be at risk of or possibly suffering harm.

- 6.8 The strategy meeting minutes noted that 'it was felt that an in depth assessment of the family was required before ending our involvement'. This indicates that the mind of children's social care had been made up that this was not a child protection issue but the concerns about domestic violence should trigger a core assessment in line with practice standards at that time<sup>8</sup>. These standards stated that a core assessment should be carried out where 'children subject of strategy meetings who live in families where there is chronic neglect and domestic violence and where the current circumstances and the strategy meeting assesses that risks fall just short of the need for formal Child Protection Enquiry'. The project team were also told that the prevailing culture within children's social care at the time was 'a core assessment is the answer to everything' and this is likely to have influenced decision-making at the meeting.
- 6.9 The situation was further compounded by a very poor core assessment. The context for the work had not significantly changed from the time of the first core assessment as there was still pressure on referral and assessment due to problems within the neighbourhood teams. Senior managers were aware that there was a variation in the standard and length of assessments and the practice standards issued in 2009 were designed to develop a more consistent and proportionate approach, whilst maintaining important elements of the assessment such as reflecting the views of the child. Unfortunately, an unintended consequence of this was that the term 'thin core' became to be used to describe a slimmed down approach to the core assessment process and seems to have become translated in practice into assessments which did not even meet basic standards. As part of this project, ten assessments from this period were audited and only one was rated as good, indicating that this was a more widespread problem than in this particular case.
- 6.10 Coventry had adopted the signs of safety approach to their work. This should include working openly and honestly with parents and developing plans with the family to keep the child safe. However, because this assessment was not starting from a position of recognising danger to the child there was no such open honest discussion with mother. Two signs of safety rating scales were completed and recorded within the documentation which indicated high risk, although the final conclusion and outcome did not reflect this and the decision was to refer to Citizens Advice Bureau and close the case. The human tendency to use information that confirms an already formed point of view is well documented in the literature<sup>9</sup> and in this case, despite the social worker recording evidence that indicated a high level of concern, the case was closed.

---

<sup>8</sup> Coventry Safeguarding Children Board, Children's Social Care Thresholds and Practice Standards: September 2009.

<sup>9</sup> For example Munro (2008) *Effective Child Protection* London: Sage

- 6.11 The focus of the core assessment became housing issues since mother was about to be evicted from her accommodation. The exploration of the impact of domestic violence on the family became lost, even though during the period that the core assessment was being carried out the family were discussed at another joint screening meeting and the papers from this meeting would have been passed to the social worker. This meeting had the information that when, in 2010, mother had lived for a time just over the border in Warwickshire, concerns about domestic violence had been such that she became subject to discussion at MARAC.<sup>10</sup> This information should also have been known to the health visitor, as the MARAC minutes clearly state that the health visitor was to be asked to offer support. No attempt was made to gather further information from Warwickshire during the core assessment process.
- 6.12 Supervision which helps the practitioner to reflect critically on their practice is crucial, particularly in relation to avoiding behaviour which only seeks information to confirm the dominant view. Effective supervision did not take place within children's social care. One reason for this was that the senior practitioner was regarded as a safe pair of hands and the team manager trusted their judgement. The project team were told that within the referral and assessment team in children's social care workloads were high but social workers received regular supervision. However, staff also reflected that where their manager is also under pressure staff do not wish to burden them with their own stress and complain about an unmanageable workload. Reflective supervision for all social workers, whatever their level of expertise, is crucial and training records indicate that the team manager had not had sufficient training or development in this aspect of their work.

## **7. OTHER ASSESSMENTS**

- 7.1. As well as the assessments carried out by children's social care the assessment by the community paediatrician was another opportunity to identify the abuse being experienced by Daniel at that time. This was explored as fully as possible in the serious case review although questions remain as to why the consultant did not conclude that abuse was one possible explanation for Daniel's symptoms. It has not been possible to understand in any depth why specific conclusions were reached about Daniel although the lack of strategy meeting minutes in the medical records meant that a full picture of the issues discussed at that meeting was not readily available. The haphazard nature of the hospital notes and no centile charts within the record also hampered the assessment at this point.
- 7.2. Assessments within the school were also ineffective at identifying risk and understanding the significance of significant weight loss combined with reoccurring injuries. This has been discussed above as being partly driven by a failure of systems within the school to collate all available information. There was also an error of judgement in not referring Daniel's situation to social care.

---

<sup>10</sup> A MARAC is a Multi-Agency Risk Assessment Conference

## 8. CONCLUSION

- 8.1. It is clear from talking to staff in Coventry that the death of Daniel has affected them deeply and there is a great resolve to try and understand why the systems that were in place to protect children failed in this case, and why some individuals did not succeed in delivering the standard of practice required. There is a strong commitment to work towards improving practice in the future. Almost inevitably there are no easy answers since it is a combination of factors that came together at particular points in time, alongside parents determined to cause harm to a child that resulted in the tragic outcome.
- 8.2. Human error cannot be eliminated from child protection work and professionals under pressure, poorly supervised or lacking in the right training or experience may from time to time make mistakes. There were examples of errors in decision-making which have been explained as being due to professionals trying to juggle too many competing priorities. The lack of effective management and supervision, partly due to the managers themselves being under stress, compounded the likelihood of error. There is a clear need for strong leadership within all organisations in relation to the management of risk where expectations exceed the resources available.
- 8.3. The type of abuse inflicted on Daniel by those caring for him is extreme and outside the experience of most professionals. It is therefore an unusual case that tests the effectiveness of child protection processes and reveals weak spots which, for the majority of children, will not have such devastating consequences. Despite the extreme nature of this case there has, however, been the opportunity to learn from a closer examination of why the system did not protect Daniel. It is hoped that this information can be used to strengthen child protection practice both in Coventry and elsewhere.
- 8.4. There are no additional recommendations that need to be made from this analysis since the original recommendations cover all key areas. This analysis does however provide additional detail for Coventry Safeguarding Children Board which will be used to hold agencies to account in respect of the work they are doing to improve both systems and individual practice.

**PART TWO:**

**DANIEL PELKA REVIEW  
PROGRESS REPORT  
ON IMPLEMENTATION OF  
RECOMMENDATIONS**

**(DECEMBER 2013)**

David Watts  
Independent Safeguarding Consultant - Via Safeguarding  
Solutions Ltd.

## **1. Introduction**

- 1.1 This report updates the CSCB on progress made by partners on the implementation of recommendations arising from the Daniel Pelka review conducted by Ron Lock and published on 17<sup>th</sup> September 2013.

## **2. Methodology**

- 2.1 Further to the interim report provided to the Board dated 18<sup>th</sup> November 2013, the author has met again with key partners to reflect upon the progress made on the fifteen recommendations within the last four weeks.

These have included senior personnel from Coventry City Council (in respect of Children's Social Care and Education action), West Midlands Police, NHS England, Coventry and Rugby Clinical Commissioning Group and University Hospitals Coventry and Warwickshire NHS Trust.

The author was not able to meet with Coventry and Warwickshire NHS Partnership Trust but had a detailed and useful telephone conference call to discuss the recommendations.

- 2.2 The following analysis briefly summarises key improvements identified and also areas requiring further action. A more detailed breakdown of partner responses against each of the fifteen recommendations from the published review report is also provided.

## **3. Key Evidence of Improvement**

- 3.1 Since the last progress report key partners have agreed in principle to develop a Multi-Agency Safeguarding Hub (MASH) to improve the effectiveness of multi-agency working in relation to suspected child protection cases, including cases involving domestic abuse. This will comprise a co-located team of professionals and is planned for implementation by September 2014.
- 3.2 An interim process with identified professionals meeting at least twice weekly to discuss specific cases has been developed until the MASH is operational and this is planned to commence January 2014.
- 3.2 Police report that all backlogs in circulating domestic abuse reports to partners have been eliminated, thus improving the timeliness of information sharing.
- 3.3 A system of providing domestic incident reports to schools has been implemented and guidance given to schools' safeguarding leads advising how to respond/action.
- 3.4 Key partners have assured the CSCB that where cases are unclear as to the presence of non-accidental injury, these will continue to be regarded as potential child protection concerns and be treated as such until such time as a definitive diagnosis can be made.

- 3.5 Audit processes across the partnership have been amended to improve scrutiny of practice as highlighted by the SCR report.
- 3.6 There has been ongoing work on the rationalisation of the early help strategy across the children's partnerships in Coventry. This is expected to be finalised in January 2014.
- 3.7 Senior membership of the multi agency Domestic Abuse Sub Group has been determined and the Group will be meeting in early in January 2014 to provide specific focus and leadership on domestic abuse issues arising from the review.
- 3.8 A review of child protection processes and training in schools has been undertaken and the findings of audits undertaken by the Council and by CSCB will be analysed in January 2014.
- 3.9 CSCB partners have identified and utilised a range of methods to disseminate the findings of this review across the children's workforce.

#### **4. Key actions requiring attention**

- 4.1 The impetus created by this review must be maintained, particularly in relation to the development of improved information sharing and decision making processes such as the MASH. CSCB to be provided with quarterly progress reports from participating partners. **Timescale: Within three months**
- 4.2 The specific work on the domestic abuse process undertaken by the Domestic Abuse Task Group will ensure that the weaknesses highlighted in the review are being addressed in a coordinated way. The CSCB will require periodic reports on progress. **Timescale: Quarterly reports from Task Group to CSCB**
- 4.3 The work commenced on rationalising the early help strategy must result in a more transparent and coherent programme with partners across the children's workforce who clearly understand their roles and responsibilities. **Timescale: Quarterly progress reports from Chair of Promoting Children and Young People Well Being Group**
- 4.4 The quality of assessments carried out in Coventry must continue to improve. CSCB to continue to conduct multi agency audits to assess the quality of these and partners to provide periodic evidence of regular audits of practice to ensure continued focus. **Timescale: within three months**
- 4.5 The CSCB safeguarding audit of schools to be analysed in January 2014 and findings and actions disseminated. **Timescale: Within three months.**

4.6 The findings of audits undertaken by health partners in relations to specific recommendations from this review to be shared with CSCB to show the level of improvement in safeguarding practice. **Timescale: within six months.**

## 5. Recommendation 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 agree outcomes, and
- How repeat domestic abuse incidents need to be responded to more holistically

5.1 The first recommendation by the SCR author challenged partners to review the efficacy of the current notification and multi-agency screening process and has been the focus of significant activity, particularly within the police and children's social care, following on from a multi-agency review of the screening process earlier in the year.

5.2 The police have reported that there is now no backlog of domestic abuse incident reports and that staffing levels have been increased to ensure that all incidents are being reviewed quickly and overseen appropriately by dedicated staff and a qualified detective. Social Care has recruited dedicated practitioners and administrative staff to the screening process, as well as creating an additional team in referral and assessment to provide additional capacity to respond appropriately and quickly.

5.3 There is a secure process in place now to share all incidents involving children with schools and guidance options on how schools should respond back to social care has been circulated to safeguarding leads. Also there is a pathway for those practitioners in health to receive the information, although this is currently only an interim measure and guidance on how this should be interpreted and acted upon across the health economy still requires further clarity.

5.4 To enhance the effectiveness of the screening process further, commitment has been gained between police and social care to create a Multi-Agency Safeguarding Hub in 2014 and funds have been sought and agreed from the PCC Innovation Fund to assist in this development. Partners in health, probation and education are also being approached to become part of this multi-agency co-located approach.

5.5 It is expected that the MASH will become operational by April 2014, but in the interim period an agreement has been made to have a 'virtual MASH' operational by January 2014 with police and social care and other partners meeting on a twice weekly basis to review cases and decisions.



## **6. Recommendation 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.

- 6.1 The CSCB completed a multi-agency audit to look at the responses by agencies from domestic abuse notifications and this information has been used to bring about some of the changes identified. Partners were also asked to comment on how they have embedded response to notifications into their own audit processes.
- 6.2 Social Care explained their performance management process around referrals which includes analysis of referral volume, timeliness of response and effectiveness of outcome. These have been reviewed and tightened in response to the SCR report.
- 6.3 Police referred to a process they have initiated that ensures 28 day audits of the screening process, with a first dip sample being undertaken by end of December 2013. This will then become normal monthly practice. Three monthly reviews will be undertaken at senior management level.
- 6.4 The Hospital Acute Trust has incorporated the findings of the Pelka review into their safeguarding audit (Laming audit) which they conduct periodically within the Trust. The next audit is planned for January 2014.
- 6.5 In addition, the multi-agency Domestic Abuse Task Group has reviewed its membership and will be meeting in early January 2014 to address key issues from the review.
- 6.6 CWPT have reviewed and amended their domestic abuse policy to ensure that the Trust Health Visitors, School nurses and other appropriate services e.g. Adults mental health services act upon Domestic Abuse notifications from West Midlands Police and that this includes; documenting children present at the incident in all the children's records. In addition to within the Trust safeguarding training programme lessons learnt from this case are disseminated which also includes clarification of the MARAC process and staff are conversant and act accordingly upon the receipt of a West Midlands police notification form. To ensure this is embedded in practice an audit of compliance is on the Trust safeguarding Teams audit work plan for May 2014

### **Further Action identified:**

- 6.7 Agreement to be made regarding 28 day dip sample review at management level to include Police, Social Care and Health. Findings to be reported to CSCB periodically.
- 6.8 CSCB to receive quarterly progress reports from the Domestic Abuse Task Group.

## **7. Recommendation 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.

- 7.1 Again there has been activity in this area to address the issue of early help and prevention when dealing with children living with domestic abuse. Most notably Social Care described the development of increased capacity around support, accommodation and perpetrator programmes.
- 7.2 A revised model of support and accommodation services is being commissioned which has been co-designed with providers. An increased financial commitment for resources has been agreed to develop a single point of access for accommodation, support for domestic abuse survivors and their children and access to perpetrator programmes. This is all planned to commence by May 2014.
- 7.3 Social Care also described their increased commitment to the CAF process by increasing the number of CAF co-ordinators working with schools to achieve improvements in the level of early intervention, including those families experiencing domestic abuse.
- 7.4 However, with regard to the coherent understanding of the early help and intervention process in Coventry, there remain some gaps across the partnership. A discussion at the October 2013 summit of Chief Executives highlighted the need to revise local practice.
- 7.5 Work is underway to rationalise the early help strategy, which currently sits between the Joint Commissioning Group (Prevention and Early Intervention Sub-group) and the CSCB (Promoting Children and Young People Well Being group). A draft strategy has been developed to merge the activities of these two groups and a meeting is planned for early 2014 to agree this and progress the early help agenda in Coventry.

### **Further Action identified:**

- 7.6 The CSCB will continue to focus attention on the efforts to engage all partners with the early help agenda and request periodic progress reports on the work being undertaken to rationalise the strategic focus across the various Coventry partnerships.

## **8. Recommendation 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.

- 8.1 Audits undertaken since the death of Daniel Pelka have shown that whilst improvements have been made Social Care acknowledge that some variable practice remains and they are working hard to remedy this.

- 8.2 Work has been initiated between the CCG and Social Care to improve communication with GPs. GPs and social workers were surveyed to identify the barriers to information sharing and inter professional working between the two groups and a focus group was held between social workers and GPs to seek resolution to the issues. The report of the findings of this piece of work should be used to inform practice development once received by the CCG and Social Care.
- 8.3 Social Care also report that the awareness raising workshops for staff following the introduction of the single assessment in the summer of 2013 has reinforced the need for good quality consultation and checking with partner agencies.
- 8.4 Social Care has reinforced this by increased reference in one to one supervision and in team meetings, though observed practice of practitioners and by the revision of the agency's own S47 audit process to provide senior managers with performance data in this area.

**Further Action identified:**

- 8.5 CSCB to be provided with performance data from Social Care within the next three months which outlines the findings of s47 audits and identifies improved performance in partner involvement with assessment.

**9. Recommendation 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.

- 9.1 Social Care has assured the CSCB that practice in this area has now been amended and handwritten notes of discussions and decisions made are distributed to attendees at the end of the meeting. These are followed up by typewritten notes. This has been confirmed by a health representative who has attended the strategy meetings.

**10. Recommendation 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.

- 10.1 All partners have considered how they might ensure that child protection concerns remain a focus following inconclusive medical opinion on cause of injuries.

Social Care has clarified the need for cases to continue at s47 level in such instances and this practice has been disseminated to staff through workshops, supervision and guidance. This has not yet been built into Social Care quality assurance audits of practice but has been highlighted for inclusion for practice audits undertaken from January 2014.

- 10.2 Police also report that this practice has been disseminated to child abuse officers. In addition key messages from the Pelka review (thinking the unthinkable, hearing the voice of the child, what constitutes a safe and well check) are being incorporated into a six minute briefing to all officers and this will be disseminated not only in Coventry but across the West Midlands Police service.
- 10.3 Health providers talked of reiterating the need for continued vigilance. The Acute Trust has amended its safeguarding audit to ensure that clinical advice meets the Royal College of Paediatrics and Child Health requirements.
- 10.4 CWPT have reviewed and amended documentation pertaining to consistency to children's health records pertaining to 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 and reported when the child is referred onto another practitioner when these measurements can be used as comparators, for example in the outpatient setting.

**Further Action identified:**

- 10.5 Partners to consider how best they can identify these cases in order to evidence how child protection concerns can remain an active part of the ongoing enquiry and assessment and inform the CSCB of how they will be monitoring this in 2014.

**11. Recommendation 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.

- 11.1 Social Care report that this issue has been disseminated to staff and that a manual process is currently in place to respond to referrers concerns. However it is acknowledged that this system could be more robust and there continues to be variable practice in this area. This is corroborated anecdotally from other partners, most notably from education professionals.

**Further Action identified:**

- 11.2 It is suggested that Social Care investigates whether there are alternative methods of providing responses to referrers, including whether the electronic social care integrated child system can generate electronic letters that could be utilised.
- 11.3 It is also suggested that the agency's audit process be amended to analyse the efficacy of the current system of communication and audit evidence of compliance be made available to CSCB at regular periods.

**12. Recommendation 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.

- 12.1 Following early drafts of the review report the CSCB commissioned an external provider to deliver multi agency training in this area. Sessions were delivered in February, April, June and December.
- 12.2 Emotional abuse and neglect are discussed at every level of CSCB multi-agency training.
- 12.3 The CSCB Training Sub-Group has discussed the key lessons arising from the review and disseminated these to individual partners for cascade training within agencies.

### **13. Recommendation 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.

- 13.1 The CSCB reviewed and amended its specialised training in this area for the SCR report findings. Scenarios have been developed which take attendees through a domestic abuse incident and how the joint screening process is incorporated in the referral and assessment system.
- 13.2 The CSCB and Council have also run sessions on the Barnardos assessment tool and the Domestic Abuse, Stalking and Honour Based Violence (DASH). This is being cascaded to other staff commencing early 2014.

### **14. Recommendation 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.

- 14.1 A review is currently taking place between schools, the Local Authority and the CSCB to consider how best to meet the specific training needs of the education workforce. This is due to be completed by 31/12/13 and a report will be submitted to the CSCB in early 2014 to propose how to quality assure the training offer to schools.

### **15. Recommendation 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.

15.1 A city wide safeguarding audit has been instigated by the CSCB to address the questions posed in this recommendation. The findings will be analysed following the closing date which is the end of the current term. An analysis report will be presented to the Board based upon the self reporting from schools and any actions arising from this analysis will be addressed in the action plan.

## **16. Recommendation 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.

16.1 Health representatives have made assurances to the CSCB that the planned increases in health visiting capacity are on track to be in place within an agreed timescale.

### **Further Action identified:**

16.2 NHS England to provide a formal evidence report to next CSCB meeting to update partners on progress against this recommendation.

## **17. Recommendation 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.

17.1 A clear directive was issued to paediatricians and other medical staff from the Royal College of Paediatrics and Child Health following publication of the serious case review. Health partners have ensured that their staff are aware and adhere to the requirements to consider child abuse as a differential diagnosis in child health assessments.

17.2 The Acute Trust has adapted their safeguarding audit process to ensure that they check that clinical decisions adhere to this directive.

### **Further Action identified:**

Health partners to inform the CSCB of how they plan to provide clear evidence of compliance against this recommendation.

## **18. Recommendation 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.

- 18.1 The CSCB has devised and published its protocol on working with families with families who do not have English as a first language and the use of interpreters.
- 18.2 Partners have described how they utilise the services of interpreters in understanding the child's wishes and have stressed that this message has been disseminated to staff working with such families.

### **19. Recommendation 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.

- 19.1 Messages from the report were disseminated to staff across the partnership utilising a range of methods, both written and face-to-face.  
Key learning has been incorporated in training courses delivered at various levels by the CSCB.
- 19.2 Practitioners directly involved in the case were given the opportunity to read and digest the messages on practice in advance of publication of the report.
- 19.3 The CSCB has provided a newsletter outlining key learning from this and other recent reviews undertaken by Coventry.
- 19.4 The CSCB has been awaiting the messages arising from the deeper analysis on this case before setting briefing workshops on the review. Now that the deep analysis report has been received workshops will be planned for early In the New Year.

REPORT ENDS