Handout 1

Daniel Pelka died tragically on 3rd March, 2012. He was just 4 years and 8 months old.
He lived with his mother, Magdelena Luczak, an older sister, Anna, 7 years old, a younger brother, Adam, 6 months old and mother's partner, Mariusz Krezolek (Adam's father).
The cause of his death was subsequently found to be a head injury, "almost certainly the result of a direct blow to the head" and, on 31st July, 2013, Ms Luczak and Mr Krezoleck were found guilty of his murder and both sentenced to 30 years imprisonment.

In **September 2011**, Daniel started at the same school where his sister, Anna, had attended since September 2010. Although the school had received information from Anna's previous school, no-one had looked at it. However, Anna had settled well, spoke good English and made friends and the only concerns recorded were about her occasionally poor attendance. Daniel, on the other hand, spoke very little English and school staff appeared to have relied on his gesticulations as the main form of communication and, when possible, upon Anna and Ms Luczak to provide insights into what Daniel was saying or experiencing. He was generally seen as isolated though he was well dressed, well behaved and joined in activities.
During **October and November 2011** there were several occasions when both children arrived late for school and were absent because of illness.

During **November 2011,** the school spoke to Ms Luczak about Daniel's obsession with food and that he was taking food from other children's lunch boxes. Ms Luczak presented as concerned but said that he must not eat more than what was in his lunchbox as he had a medical problem and so the school locked the food away. Ms Luczak was generally viewed as a caring mother although one teaching assistant recalled that she always seemed cross with Daniel and that he always walked home twenty paces behind her.

The education welfare officer (EWO), accompanied by a translator, made a home visit in **mid-December 2011** when Ms Luczak said that the children were not well enough to go to school although the EWO considered that they were. Ms Luczak however refused to send them to school. At this time, a letter was sent to Ms Luczak by the school head teacher and the learning mentor regarding Daniel's attendance which was below 64%.

After Christmas 2011, the deputy head teacher became concerned that Daniel was not growing despite his obsession with food. School staff spoke of how Daniel "looked for food everywhere" and that he "would eat whatever he could get his hands on". On one occasion he found and ate half of a large cake meant to be given to all the children as it was the teacher's birthday. Despite his poor engagement with peers, he was nevertheless said to take or persuade other children to give him food and eat it in the toilets. On some occasions he had taken food from bins and had tried to eat discarded food. He also tried to eat beans being planted in soil and raw jelly taken from a sandpit. Daniel had a lunch box everyday which school staff said contained the bare minimum and that he would always eat this. School staff believed that his medical problems were being investigated.
On two occasions the Deputy Headteacher spoke with Ms Luczak who reminded the deputy head that Daniel had a medical problem and reported that he was taking food at home and getting up in the night to raid the fridge. She said that Daniel got diarrhoea as a result.

Between December 2011 and February 2012 there were occasions when Daniel was seen at school with facial injuries.
The injuries on Daniel were stated as follows:

- **around Christmas 2011** "a bruise to the centre of the forehead" – seen by a teaching assistant (**not recorded**).
- **16th January 2012** "approximately four spot bruises down the neck from the ear to the shoulder" - seen by the class teacher and recorded in the concerns' book (for the reception class)
- **sometime before the 10th February 2012** "fresh blue/black bruises on the eyes and a scratch across the nose" – seen by the class teacher and she stated that she told the head teacher (**not recorded**).
- **January or February 2012** - "severe mark on his nose,(almost like a dent), a black eye and blood spots on his face" seen by one of the teaching assistants and that the head teacher had been told (**not recorded**).
- Another teaching assistant referred to "a large bump on the left hand side of his forehead about the size of a 2p piece" and that she told the class teacher of this (**not recorded**).

- **mid February 2012** "a graze to the top/front of his forehead" – seen by the head teacher who ascertained what had happened from Anna who said that her brother had been pushed over by another child outside of school (**not recorded**).

Daniel was asked by one of the teaching assistants about how two of the injuries were caused. He was reported not to give any explanation but just looked down and would not say anything.
None of these injuries was referred to Children's Social Care or the Police.

During January 2012 the learning mentor discussed the possibility with the new EWO of completing a Common Assessment although it was noted that the deputy head teacher was working closely with Ms Luczak in respect of Daniel and that this would be sufficient. Also, because of improved school attendance for both Daniel and Anna, a letter of congratulations was sent to Ms Luczak on the **9th February 2012.**

However, the concerns about Daniel increased. He was described as looking normal when he first started school but that his appearance had changed, with one teaching assistant saying that she was "very, very concerned" and that he had become a "bag of bones" (not recorded).
Because of these concerns the deputy head contacted the GP by telephone on the **25th January 2012** and the GP advised that she should ask Ms Luczak to bring Daniel into the surgery. The deputy head told Ms Luczak the next day that she needed to make an appointment and believed that Ms Luczak understood the need to do this. The detail of the conversation was not recorded by the Deputy Head and, when the mother did not make an appointment, the GP did not inform the school. The school then wrote a "to whom it may concern letter" which included concerns about Daniel's continual consumption of food and that the school had to manage this by locking food away. Concern was also expressed that he nevertheless appeared to be losing weight. The letter was given to Ms Luczak who took it to her appointment with the community paediatrician.

This appointment took place on the **10th February 2012**, and the paediatrician was given the letter written by the school. The outcome of the appointment was that the paediatrician requested further investigations because of Daniel's excessive appetite and poor weight gain. Medication was prescribed because of the possibility of thread worms.

Daniel attended school for the week **27th February to 1st March 2012** during which time the deputy head explained to the head teacher that Daniel had been prescribed treatment for worms. The school sought the help of a teacher from a neighbouring school who could speak Polish, and asked her to speak with Daniel. This teacher spoke to Daniel about him taking food, but later reported that he was not communicative and she was unsure how much Daniel understood what was being said to him.
On the **1st March 2012**, Daniel was seen to take a piece of half eaten fruit from a bin in school although he was prevented from eating it.
On Friday the **2nd March 2012** Daniel was logged as having an unauthorised absence from school. The school made a telephone call to the home but there was no reply.

On **Saturday the 3rd March 2012** Daniel was admitted to hospital after having suffered a cardiac arrest and he could not be resuscitated. The cause of death was found to be a head injury but Daniel was also found to be grossly malnourished and dehydrated with bruising over his body for which no natural cause could be identified. (A total of forty injuries were noted). Daniel also had a very high sodium level. The forensic pathologist concluded that these findings reflected longstanding neglect. It was considered that, for a period of at least six months prior to his death, he had been starved, assaulted, neglected and abused.

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Children and Young People's Service

Handout 2
Issues

The school had received information from Anna's previous school but no-one had looked at it

Daniel spoke very little English and school staff appeared to have relied on his gesticulations

School staff appeared to have relied …. upon Anna and Ms Luczak to provide insights into what Daniel was saying or experiencing.

Ms Luczak said he had a medical problem

She always seemed cross with Daniel

Daniel's attendance was below 64%.

School staff believed that his medical problems were being investigated.

Between December 2011 and February 2012 there were occasions when Daniel was seen at school with facial injuries.

He was reported not to give any explanation but just looked down and would not say anything.

Deputy head teacher was working closely with Ms Luczak

The deputy head contacted the GP by telephone on the **25th January 2012** and the GP advised that she should ask Ms Luczak to bring Daniel into the surgery.
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School wrote a "to whom it may concern letter" The letter was given to Ms Luczak
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Deputy head explained to the head teacher that Daniel had been prescribed treatment for worms

He was not communicative and the Polish teacher was unsure how much Daniel understood what was being said to him.

The school made a telephone call to the home but there was no reply

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Handout 3 What the school did not know / may not have known

Daniel's father, Mr Pelka, brought the family to the UK from Poland, their native country, at the end of 2005 and he remained with the family until the end of 2008, by which time Anna was approximately 3 ½ years old and Daniel was just over a year old. A second male, Mr A, then lived in the home from late 2008 until mid-2010, when Ms Luczak's third male partner (Mr Krezolek) moved into the family home. He became the father of Adam who was born just over a year later, in August 2011. All of the adult family members were of Polish nationality.

All of these relationships involved excessive alcohol use by Ms Luczak and her partners and domestic abuse and violence. Between 2007 and 2010 the family moved five times within Coventry and once into Warwickshire. Between November 2006 and December 2010 the Police were called to the family home on many occasions and in total there were 27 reported incidents of domestic abuse. There were no reports to the police after December 2010 but in July 2011 Ms Luczak reported to the midwife that Mr Kresolek had tried to strangle her and pulled her hair.

Four multi-agency domestic abuse Joint Screening Meetings were called in Coventry between September 2008 and August 2009 and a MARAC called in Warwickshire in March 2010.

Children's Social Care completed 4 Assessments:

Initial Assessment commenced April 2008: The finding was that the parents (Ms Luczak and Mr. Pelka) had acknowledged the domestic violence and had implemented strategies to address this (case closed).

Initial Assessment commenced January 2009: The finding was no further action as Ms Luczak said she could protect the children (Mr. A in the home) (case closed)

Core Assessment commenced November 2009: The finding was that the male partner (Mr A) had left the home and the children were safe in Ms Luczak's care (case closed).

Core Assessment commenced January 2011: The finding was that, as alcohol misuse was no longer thought to be an issue, the domestic abuse would also cease and that there was a positive interaction between mother and children (Mr Kresolek in the home) (case closed).

In January 2011 Daniel was taken to hospital and was diagnosed with a spiral fracture to his arm. There was also multiple bruising to the arm as well as a small bruise on his left shoulder and a bruise on his lower stomach which Ms Luczak said was probably caused by a fall from his bicycle, which he was said to frequently do. A referral was made to CSC and Anna confirmed the account of Daniel's injury given by her mother to the police. A core assessment (noted above) was completed in February 2011 and the case was closed in May.

In September 2011 Daniel started at the school which Anna had attended since September 2010. She had already attended 2 previous schools. In October the School Nurse made a referral to the Community Paediatrician after a review of the school health records. During a joint home visit with the school nursing support worker, Ms Luczak explained that Daniel had aggressive behaviour towards her and had an excessive appetite and was a secretive eater, with speech and language delay and possibly learning difficulty. Daniel was not seen during this visit. Three appointments made during November and December 2011 with the community paediatrician were cancelled by Ms Luczak or missed and she did not see the paediatrician until 10th February 2012.

The paediatrician was given the letter from the school but this did not include the injuries seen by school staff. The paediatrician took a detailed history from Ms Luczak that Daniel had an excessive appetite and non-stop hunger leading him to steal from lunch boxes and eat from roadside bins. He was also drinking lots of water/fluids and soiling almost every day. He had also smeared faeces over his bedroom. His relationship with his siblings and his peers was, according to his mother, poor with limited interaction and aggression towards his siblings. The paediatrician did not hear Daniel speak any recognisable words.

Following the post mortem on the **6th March 2012** it was found that the cause of death was a head injury, "almost certainly the result of a direct blow to the head". Daniel was also considered to be grossly malnourished and dehydrated with bruising over his body for which no natural cause could be identified. (A total of forty injuries were noted). He also had a very high sodium level. The forensic pathologist concluded that these findings reflected longstanding neglect. For a period of at least six months he had been starved, assaulted, neglected and abused.

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Handout 4 What no professional knew

Birmingham Crown Court 2 August 2013

Extracts from Sentencing remarks of Mrs Justice Cox to Ms Luczak and Mr Kresolek

While the evidence demonstrates that systematic cruelty probably began when Daniel started school in September 2011, your complicity in his ill treatment was first evidenced by the displaced fracture to his arm, sustained 14 months before his death on 5 January 2011, when he was just 3½. This serious injury would have resulted immediately in excruciating pain and loss of function, yet you did not take him to hospital until the following day, clearly increasing his mental and physical suffering. I have no doubt that you, Mariusz Krezolek, deliberately used considerable force to inflict that injury, and that you Magdalena Luczak, discovering what had happened, joined with him in waiting to see if you could keep it secret, and then in lying to the doctors about how it had happened. This determination to lie and to protect yourselves at all costs was to become the hallmark of your subsequent conduct.

The scale of Daniel's suffering was truly horrific.

He was subjected to acts described by you as punishments but which, in reality, were acts designed to cause pain, to humiliate and to intimidate. He was required to kneel on the floor for long periods of time, to run continuously around the living room, or to perform squats repeatedly and slowly.

He was repeatedly forced to swallow salt, which you admit was poured neat into his mouth from the salt container and which caused him to vomit.

He was subjected to a form of cold water punishment, being held under cold water until the point of unconsciousness, something his sister, then aged 6, saw and had to describe to this court. He must have been absolutely terrified.

He was subjected to regular beatings, as the teachers' observations of bruising and the multiple bruises seen on his body after death testify. There were nine separate bruises to his head.

He was confined for regular and prolonged periods of time in the small, bare box room upstairs. The inner door handle was removed and the metal panel so arranged that he could not even see out of the keyhole. The small hand and finger marks on the inside of that door provided a poignant image of his desperate attempts to escape. The urine stains to the mattress on which he was made to sleep and the damp state of the carpet testify to his inability to go to the toilet when he needed. There is evidence of him soiling himself.

It is a particularly grave aggravating feature in this case that, before the fatal blows to his head, Daniel was the victim of chronic and systematic starvation. Both of you deliberately deprived him of food over a prolonged period of time. He was literally wasting away.

Both of you constructed a careful and wholly untruthful account that Daniel had a serious eating disorder and learning difficulties, which he may have inherited and for which he was receiving medical treatment. This account was deliberately designed to prevent interference by school, medical and welfare personnel, and to perpetuate the brutality being meted out to him. You instructed and encouraged Daniel's older sister to tell lies to the authorities if she were asked any questions about what was happening at home.

At some time in the evening of Thursday 1 March 2012, by which time Daniel's weakened physical condition made him particularly vulnerable, I am satisfied on all the evidence that in the minutes preceding the fatal blow or blows to his head, he was subjected to a brutal assault, in which he was given salt and subjected to a form of cold water punishment in the bath. I am satisfied, Mariusz Krezolek, that this head injury was inflicted by you and that you applied considerable force. By their verdict, Magdalena Luczak, the jury clearly rejected your account that you tried to intervene and were sure that you were jointly liable for Daniel's death. Daniel then lay alone in the box room, as his life slipped away, from that Thursday evening until just before 3 a.m. on Saturday morning,

Your internet searches on the family's computer at home on the 2nd March 2012 to seek information on salt poisoning and of a child not responding reveal the scale of the cruelty you had inflicted on him. Still you did not take him to hospital, until you discovered in the early hours of 3rd March that he was not breathing and eventually called the emergency services.

Daniel was admitted to hospital after having suffered a cardiac arrest and he could not be resuscitated. He was pronounced dead at 3.50 a.m.

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Handout 5 Recommendations for Education from Overview report

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.

Recommendations for Education from Individual Management Report

Coventry City Council Children Learning & Young People's Directorate
Schools and Academies
1. Head teachers should ensure that school staff including attendance officer, learning mentor, SENCo and senior management within school should meet twice per term to discuss children with a number of different concerns, particularly those children who are not the subject of an open common assessment framework intervention, have difficulties with attendance, where English is a second language or where there are special educational needs.

Children and Families First Service
2. The head of the education welfare service should ensure that there are supervision arrangements for staff include checking records for, and the discussion of, previous attendance history or family difficulties such as domestic violence.

Schools and Academies
3. Head teachers should ensure that school records are checked and all information is passed to children's social care when the school is contacted in relation to a child or family assessment.

4. Head teachers should ensure that, within the context of existing procedures, the views and feelings of all children are always ascertained and where English is an additional language, particularly for very young children, using the translation service if necessary.
North Yorkshire Community interpreting and translating service: TALK TO US! available at:
http://www.northyorks.gov.uk/index.aspx?articleid=21328

5. Head teachers should put in place procedures to log formally all contact with parents and external agencies and any logs should be kept on the child's confidential file. This should include written logs of any meeting arranged with parents and any follow work needed as a result or if the meeting is rearranged

6. Head teachers should put in place procedures to ensure Contact with external services such as health services are always formally logged by the school and letters of concern sent directly to the appropriate professionals and not via the parent.

North Yorkshire additional recommendations for Education

Headteacher/DSP should ensure that:

1. all files including the child protection/welfare file received from a previous school or setting are requested and read and that appropriate staff are informed of relevant information in order to safeguard the child.
2. where a parent/carer provides an explanation for a child's presentation/ behaviour as medical, consent to seek medical advice should be sought from the parent. Where consent is not given, HT/DSP should refer to the child protection procedures.
3. all staff follow the process for addressing concerns about a child's non-attendance at school including all contacts with home.
4. all staff follow the process when they are not satisfied that a concern they have raised has been dealt with appropriately and they need to escalate that concern.

Recording

What?

- Information about the child : name(aka),address, d.o.b., those with parental responsibility, primary carers, emergency contacts, names of persons authorised to collect from school, any court orders, if a child is or has been subject to a CP Plan (been on the CP Register)
- Key contacts in other agencies including GP details
- Any disclosures/accounts from child or others including all questions asked (Do not destroy original notes)
- All concerns, discussions, decisions, actions taken (dated timed and signed) and arrangements for monitoring/review

How?

Should be objective and evidence based:

- Statements, facts and observable things (what was seen/heard, not an individual's interpretation)
- Distinguish between fact, observation, allegation and opinion
- Diagram indicating position, size and colour of any bruising (not photograph)
- Words child uses, (don't translate into 'proper' words)
- Non-verbal behaviours

Where?

- Separate from the main pupil file, in a locked cabinet, accessible only to the Headteacher and Designated Senior Person

Information Sharing

- There may be a requirement for the school to provide its records
- Information from third parties can only be shared with their consent

Monitoring

What? Any cause for concern including:

- Injuries/marks
- Attendance
- Changes e.g. mood/ academic functioning
- Relationships
- Language
- Behaviour
- Demeanour and appearance
- Statements, comments
- Medicals
- Stories, 'news', drawings
- Response to P.E./Sport
- Family circumstances
- Parental behaviour/ care of child

When?

In any circumstances where there could be serious child welfare concerns

How?

Individual review, timescale and manner determined by circumstances, recorded and clearly understood by all concerned