THE VICTORIA CLIMBIÉ INQUIRY

Chairman: Lord Laming

REPORT

THE VICTORIA CLIMBIÉ INQUIRY

REPORT OF AN INQUIRY
BY LORD LAMING

Presented to Parliament by the
Secretary of State for Health and
the Secretary of State for the Home Department
by Command of Her Majesty
January 2003

CM 5730

THE
VICTORIA CLIMBIÉ
INQUIRY

Rt Hon Alan Milburn MP
Secretary of State for Health

Rt Hon David Blunkett MP
Home Secretary

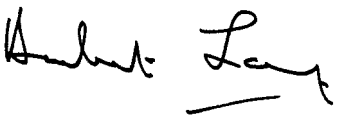
Dear Secretaries of State,

In April 2001, you asked me to chair an Independent Statutory Inquiry following the death of Victoria Climbié, and to make recommendations as to how such an event may, as far as possible, be avoided in the future. I am pleased to submit my report to you.

I appointed four expert assessors to assist me in my task. They were Dr Nellie Adjaye, Mr John Fox, Mrs Donna Kinnair and Mr Nigel Richardson.

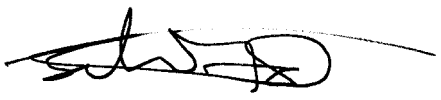
I take responsibility for this report and I am pleased that my four colleagues who sat with me fully endorse its findings and its recommendations.

Yours sincerely,

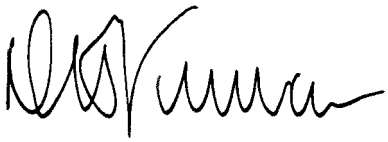


LORD LAMING

DR NELLIE ADJAYE



MR JOHN FOX



MRS DONNA KINNAIR

MR NIGEL RICHARDSON

"I have suffered too much grief in setting down these heartrending memories. If I try to describe him, it is to make sure that I shall not forget him."

Jiro Hirabayashi from Yasunori Kawahara's
translation of *The Little Prince* by Antoine de Saint-Exupéry.

This sentiment applies also to Victoria Climbié.
This Report is dedicated to her memory.

Contents

Phase Two

Part one: Background

1 Introduction

"Victoria had the most beautiful smile that lit up the room." Patrick Cameron

1.1 This Report begins and ends with Victoria Climbié. It is right that it should do so. The purpose of this Inquiry has been to find out why this once happy, smiling, enthusiastic little girl – brought to this country by a relative for 'a better life' – ended her days the victim of almost unimaginable cruelty. The horror of what happened to her during her last months was captured by Counsel to the Inquiry, Neil Garnham QC, who told the Inquiry:

> "The food would be cold and would be given to her on a piece of plastic while she was tied up in the bath. She would eat it like a dog, pushing her face to the plate. Except, of course that a dog is not usually tied up in a plastic bag full of its excrement. To say that Kouao and Manning treated Victoria like a dog would be wholly unfair; she was treated worse than a dog."

1.2 On 12 January 2001, Victoria's great-aunt, Marie-Therese Kouao, and Carl John Manning were convicted of her murder.

Abuse and neglect

1.3 At his trial, Manning said that Kouao would strike Victoria on a daily basis with a shoe, a coat hanger and a wooden cooking spoon and would strike her on her toes with a hammer. Victoria's blood was found on Manning's football boots. Manning admitted that at times he would hit Victoria with a bicycle chain. Chillingly, he said, "You could beat her and she wouldn't cry ... she could take the beatings and the pain like anything."

1.4 Victoria spent much of her last days, in the winter of 1999–2000, living and sleeping in a bath in an unheated bathroom, bound hand and foot inside a bin bag, lying in her own urine and faeces. It is not surprising then that towards the end of her short life, Victoria was stooped like an old lady and could walk only with great difficulty.

1.5 When Victoria was admitted to the North Middlesex Hospital on the evening of 24 February 2000, she was desperately ill. She was bruised, deformed and malnourished. Her temperature was so low it could not be recorded on the hospital's standard thermometer. Dr Lesley Alsford, the consultant responsible for Victoria's care on that occasion, said, "I had never seen a case like it before. It is the worst case of child abuse and neglect that I have ever seen."

1.6 Despite the valiant efforts of Dr Alsford and her team, Victoria's condition continued to deteriorate. In a desperate attempt to save her life, Victoria was transferred to the paediatric intensive care unit at St Mary's Hospital Paddington. It was there that, tragically, she died a few hours later, on the afternoon of 25 February 2000.

1.7 Seven months earlier, Victoria had been a patient in the North Middlesex Hospital. Nurse Sue Jennings recalled:

> "Victoria did not have any possessions – she only had the clothes that she arrived in. Some of the staff had brought in dresses and presents for Victoria. One of the nurses had given her a white dress and Victoria found some pink wellingtons which she used to wear with it. I remember Victoria dressed like this, twirling up and down the ward. She was a very friendly and happy child."

Victoria's injuries

1.8 At the end, Victoria's lungs, heart and kidneys all failed. Dr Nathaniel Carey, a Home Office pathologist with many years' experience, carried out the post-mortem examination. What stood out from Dr Carey's evidence was the extent of Victoria's injuries and the deliberate way they were inflicted on her. He said:

> "All non-accidental injuries to children are awful and difficult for everybody to deal with, but in terms of the nature and extent of the injury, and the almost systematic nature of the inflicted injury, I certainly regard this as the worst I have ever dealt with, and it is just about the worst I have ever heard of."

1.9 At the post-mortem examination, Dr Carey recorded evidence of no fewer than 128 separate injuries to Victoria's body, saying, "There really is not anywhere that is spared – there is scarring all over the body."

1.10 Therefore, in the space of just a few months, Victoria had been transformed from a healthy, lively, and happy little girl, into a wretched and broken wreck of a human being.

Abandoned, unheard and unnoticed

1.11 Perhaps the most painful of all the distressing events of Victoria's short life in this country is that even towards the end, she might have been saved. In the last few weeks before she died, a social worker called at her home several times. She got no reply when she knocked at the door and assumed that Victoria and Kouao had moved away. It is possible that at the time, Victoria was in fact lying just a few yards away, in the prison of the bath, desperately hoping someone might find her and come to her rescue before her life ebbed away.

1.12 At no time during the weeks and months of this gruelling Inquiry did familiarity with the suffering experienced by Victoria diminish the anguish of hearing it, or make it easier to endure. It was clear from the evidence heard by the Inquiry that Victoria's intelligence, and the warmth of her engaging smile, shone through, despite the ghastly facts of what she experienced during the 11 months she lived in England. The more my colleagues and I heard about Victoria, the more we came to know her as a lovable child, and our hearts went out to her. However, neither Victoria's intelligence nor her lovable nature could save her. In the end she died a slow, lonely death – abandoned, unheard and unnoticed.

Victoria's parents

1.13 Before moving on to the introductory part of this Report, I wish to pay a warm tribute to Victoria's parents, Francis and Berthe Climbié. They were present for the whole of Phase One of this Inquiry. Their love for Victoria was clear, as were their hopes that she would receive a better education in Europe. In the face of the most disturbing evidence about the treatment of their daughter, they displayed both courage and dignity.

What went wrong?

1.14 I recognise that those who take on the work of protecting children at risk of deliberate harm face a tough and challenging task. Staff doing this work need a combination of professional skills and personal qualities, not least of which are persistence and courage. Adults who deliberately exploit the vulnerability of children can behave in devious and menacing ways. They will often go to great lengths to hide their activities from those concerned for the well-being of a child. Staff often have to cope with the unpredictable behaviour of people in the parental role. A child can appear safe one minute and be injured the next. A peaceful scene can be transformed in seconds because of a sudden outburst of uncontrollable anger.

1.15 Whenever a child is deliberately injured or killed, there is inevitably great concern in case some important tell-tale sign has been missed. Those who sit in judgement often do so with the great benefit of hindsight. So I readily acknowledge that staff who undertake the work of protecting children and supporting families on behalf of us all deserve both our understanding and our support. It is a job which carries risks, because in every judgement they make, those staff have to balance the rights of a parent with that of the protection of the child.

A lack of good practice

1.16 But Victoria's case was altogether different. Victoria was not hidden away. It is deeply disturbing that during the days and months following her initial contact with Ealing Housing Department's Homeless Persons' Unit, Victoria was known to no less than two further housing authorities, four social services departments, two child protection teams of the Metropolitan Police Service (MPS), a specialist centre managed by the NSPCC, and she was admitted to two different hospitals because of suspected deliberate harm. The dreadful reality was that these services knew little or nothing more about Victoria at the end of the process than they did when she was first referred to Ealing Social Services by the Homeless Persons' Unit in April 1999. The final irony was that Haringey Social Services formally closed Victoria's case on the very day she died. The extent of the failure to protect Victoria was lamentable. Tragically, it required nothing more than basic good practice being put into operation. This never happened.

1.17 In his opening statement to the Inquiry, Neil Garnham QC listed no fewer than 12 key occasions when the relevant services had the opportunity to successfully intervene in the life of Victoria. As evidence to the Inquiry unfolded, several other opportunities emerged. Not one of these required great skill or would have made heavy demands on time to take some form of action. Sometimes it needed nothing more than a manager doing their job by asking pertinent questions or taking the trouble to look in a case file. There can be no excuse for such sloppy and unprofessional performance.

A gross failure of the system

1.18 Not one of the agencies empowered by Parliament to protect children in positions similar to Victoria's – funded from the public purse – emerge from this Inquiry with much credit. The suffering and death of Victoria was a gross failure of the system and was inexcusable. It is clear to me that the agencies with responsibility for Victoria gave a low priority to the task of protecting children. They were under-funded, inadequately staffed and poorly led. Even so, there was plenty of evidence to show that scarce resources were not being put to good use. Bad practice can be expensive. For example, had there been a proper response to the needs of Victoria when she was first referred to Ealing Social Services, it may well be that the danger to her would have been recognised and action taken which may have avoided the need for the later involvement of the other agencies.

1.19 Even after listening to all the evidence, I remain amazed that nobody in any of the key agencies had the presence of mind to follow what are relatively straightforward procedures on how to respond to a child about whom there is concern of deliberate harm. The most senior police officer to give evidence from the MPS was Deputy Assistant Commissioner William Griffiths. He said of the investigation carried out by Haringey Child Protection Team, "In the A to Z of an investigation, that investigation did not get to B." Therefore, I conclude that, despite the Children Act 1989 having been in force for just under a decade, the standard of investigation into criminal offences against children may not be as rigorous as the investigation of similar crimes against adults.

Widespread organisational malaise

1.20 It seems that the basic discipline of medical evaluation, covering history-taking, examination, arriving at a differential diagnosis, and monitoring the outcome, was not put into practice in Victoria's case. I accept the evidence of Dr Peter Lachman, clinical director for Women and Children Services Directorate of North West London Hospitals NHS Trust, that paediatric doctors and nurses are highly trained in helping sick children get well. However, as he said, "child abuse is one of the most complex areas of paediatrics and child health". That being so, I found it hard to understand why established good medical practice, that would have undoubtedly helped clarify the complexities in Victoria's case, was not followed on the paediatric wards at the Central Middlesex Hospital and North Middlesex Hospital.

1.21 Having considered the response to Victoria from each of the agencies, I am forced to conclude that the principal failure to protect her was the result of widespread organisational malaise.

1.22 It is, however, instructive to contrast the inadequate response to safeguarding Victoria with the work of the health service in attempting to save her life at the end, and the professionalism of the police investigation after her death that led to the prosecution of Kouao and Manning. Alas, it was then too late for Victoria.

Management issues

1.23 It is not to the handful of hapless, if sometimes inexperienced, front-line staff that I direct most criticism for the events leading up to Victoria's death. While the standard of work done by those with direct contact with her was generally of very poor quality, the greatest failure rests with the managers and senior members of the authorities whose task it was to ensure that services for children, like Victoria, were properly financed, staffed, and able to deliver good quality support to children and families. It is significant that while a number of junior staff in Haringey Social Services were suspended and faced disciplinary action after Victoria's death, some of their most senior officers were being appointed to other, presumably better paid, jobs. This is not an example of managerial accountability that impresses me much.

1.24 Following Victoria's death, the response of the various agencies involved was variable. One example of the approach taken by senior management to the tragedy was provided by Dr John Riordan, medical director at the Central Middlesex Hospital, who told me:

> "If I am totally frank I was being advised by other partners in the health economy 'get an external inquiry done because it will protect your position' and I thought that was a good idea initially, but I later came to the view that, given the difficulty we had in getting it, as time had moved on it was not going to be worth pursuing."

Credit should be given to both UNISON and the Police Federation for the support they gave to some front-line staff who gave evidence to this Inquiry.

1.25 The front-line staff of the key public services were all employees. They acted on behalf of the organisations which employed them. Those in senior positions in such organisations carry, on behalf of society, responsibility for the quality, efficiency and effectiveness of local services. I believe that several of those in such positions who gave evidence to this Inquiry, either did not understand this, or did not accept it. Front-line staff may well have a different perception of the organisation they work in from that of their senior managers. Based on the evidence to this Inquiry, the differences could only be described as a yawning gap. The failure to grasp this was undoubtedly the fault of the managers because it was their job to understand what was happening at their 'front door'.

1.26 Some used the defence "no one ever told me". The chief executive of Brent council, Gareth Daniel, chose to describe his role as "strategic" and to distance himself from the day-to-day realities. Gina Adamou, a Haringey councillor, said, "If I ask questions she [Mary Richardson, the director of social services] would say 'everything is okay, do not worry, if there is a problem I will let you know'." I find this an unacceptable state of affairs. Elected councillors and senior officers must ensure that they are kept fully informed about the delivery of services to the populations they serve, and they must not accept at face value what they are told. There was also a reluctance among senior officers to accept there was anything they could have done for Victoria. The former chief executive of Haringey council, Gurbux Singh, said, "There is the issue of resources ... but beyond that I cannot honestly think of what else I could have actually done to ensure that the tragedy which happened did not happen." This is not a view I share.

The future

1.27 I strongly believe that in future, those who occupy senior positions in the public sector must be required to account for any failure to protect vulnerable children from deliberate harm or exploitation. The single most important change in the future must be the drawing of a clear line of accountability, from top to bottom, without doubt or ambiguity about who is responsible at every level for the well-being of vulnerable children. Time and again it was dispiriting to listen to the 'buck passing' from those who attempted to justify their positions. For the proper safeguarding of children this must end. If ever such a tragedy happens again, I hope those in leadership posts will examine their responsibilities before looking more widely.

1.28 The most lasting tribute to the memory of Victoria would be if her suffering and death resulted in an improvement in the quality of the management and leadership in these key services. What is needed are managers with a clear set of values about the role of public services, particularly in addressing the needs of vulnerable people, combined with the ability to 'lead from the front'. Good administrative procedures are essential to facilitate efficient work, but they are not sufficient on their own and cannot replace effective management. This Inquiry saw too many examples of those in senior positions attempting to justify their work in terms of bureaucratic activity, rather than in outcomes for people.

Moving forward

1.29 It is important to understand what went wrong in the way individual social workers, police officers, doctors and nurses responded to Victoria's needs, and how deficiencies in their organisations contributed to this. This is dealt with in detail in sections 4 to 16. However, this Inquiry has been more than just a forensic exercise. It has been charged with looking forward and to make recommendations for "how such an event may, as far as possible, be avoided in the future".

1.30 The gross failings that I heard about during the Inquiry caused me to consider a number of ways in which current arrangements for the safeguarding of children might be strengthened. For example, I have given careful thought as to whether or not this might be achieved by the development of a National Child Protection Agency. While at first this seemed to be a worthwhile proposition, on reflection, I believe the following points are factors which rule against this:

- It is not possible to separate the protection of children from wider support to families. Indeed, often the best protection for a child is achieved by the timely intervention of family support services. The wholly unsatisfactory practice, demonstrated so often in this Inquiry, of determining the needs of a child before an assessment has been completed, reinforces in me the belief that 'referrals' should not be labelled 'child protection' without good reason. The needs of the child and his or her family are often inseparable.

- I am in no doubt that effective support for children and families cannot be achieved by a single agency acting alone. It depends on a number of agencies working well together. It is a multi-disciplinary task.

- Evidence to this Inquiry demonstrated very clearly the dangers to children if staff from different agencies do not fulfil their separate and distinctive responsibilities. No set of responsibilities is subordinate to another, and each must be carried out efficiently and effectively. Gathering together staff in a dedicated team might well run the risk of blurring their responsibilities.

- I am not persuaded there is an untapped source of talent standing ready to operate a national child protection service. It is likely that staff would simply transfer from their current employment into the new organisation.

- I recognise the fact that over the years, successive governments have refined both legislation and policy, no doubt informed in part by earlier Inquiries of this kind, so that in general, the legislative framework for protecting children is basically sound. I conclude that the gap is not a matter of law but in its implementation.

- I am convinced that it is not just 'structures' that are the problem, but the skills of the staff that work in them. For example, at the time of the joint review of Haringey, they were convinced of the merit of integrating the management of housing and social services. They have since separated these two departments at the very time that Ealing was combining them into a single organisation. Therefore, I am satisfied that organisational structure is unlikely to be an impediment to effective working. What is critical is the effectiveness of the management and leadership.

1.31 From the evidence I heard I conclude that it is neither practical nor desirable to try to separate the support services for children and families from that of the service designed to investigate and protect children from deliberate harm. Therefore, an alternative solution must be found. To address this, I set out elsewhere in this Report a number of changes which I recommend should be introduced to the organisation and management of services designed to protect children and support families. These changes are intended to build on the best in the current arrangements, and to respond to the changes since the Children Act 1989. The recommendations that flow from these changes are intended to secure a clear line of accountability for the safety of children and the support of families – a factor sadly lacking in the current arrangements.

Changes in services to support children

What is wrong with current arrangements?

1.32 Current inter-agency arrangements for protecting children depend very heavily on the key agencies in health, the police and social services working within closely related geographical boundaries. This is no longer the case. Local authorities with responsibility for social services have been reorganised so they are now smaller and more numerous. Indeed, there are now 150 of them in England. In contrast, health authorities are now larger and fewer, numbering only 30. Front-line health services are provided by a growing number of Primary Care Trusts, currently over 300, while 43 police authorities cover England and Wales.

1.33 As a result, Area Child Protection Committees (ACPCs), the organisations with responsibility for co-ordinating child protection services at a local level, have generally become unwieldy, bureaucratic and with limited impact on front-line services. I was told that in the London Metropolitan Police area, there are 33 local authorities with social services responsibilities and 27 Area Child Protection Committees. In Liverpool, there are five ACPCs, while in Essex (with a population of over one million) there is one. Such wide variations in geographical areas and populations served by the ACPCs must inevitably lead to equally wide variations in the co-ordination and quality of services offered to vulnerable children. A new arrangement is needed.

Improvements at a national level

A Children and Families Board

1.34 Therefore, I recommend a fundamental change in the way that services to support children and families are organised and managed. With the support of the Prime Minister, a Children and Families Board should be established at the heart of government. The Board should be chaired by a minister of Cabinet rank and have representatives at ministerial level from each of the relevant government departments. This Inquiry was told that well-intentioned ministerial initiatives are introduced piecemeal, and either do not fulfil their potential or divert staff from other essential front-line work. This Board should be charged with ensuring that the impact of all such initiatives that have a bearing on the well-being of children and families is considered within this forum.

A National Agency for Children and Families

1.35 In addition, a National Agency for Children and Families should be created. The chief executive of this agency – who may have the functions of a Children's Commissioner for England – would be responsible for servicing the Government's Children and Families Board. The National Agency for Children and Families should:

- assess, and advise the Children and Families Board about, the impact on children and families of proposed changes in policy;
- scrutinise new legislation and guidance issued for this purpose;
- advise on the implementation of the UN Convention on the Rights of the Child;
- advise on setting nationally agreed outcomes for children and how they might best be achieved and monitored;
- ensure that policy and legislation are implemented at a local level and are monitored through its regional office network;
- report annually to Parliament on the quality and effectiveness of services to children and families, in particular on the safety of children;
- at its discretion, conduct serious case reviews or oversee the process if this task is carried out by other agencies.

At a local level

1.36 Clearly, it is for central government to make key decisions on overall policy, legislation and the funding of services. However, it is unrealistic for service delivery to be managed centrally. The managers of local services must be given the responsibility to assess local need and to respond accordingly. However, where the care and protection of children and the support of children and families is concerned, this independence must not be pursued to the detriment of effective joint working. I recognise that committee structures and job descriptions vary between local authorities.

1.37 The future lies with those managers who can demonstrate the capacity to work effectively across organisational boundaries. Such boundaries will always exist. Those able to operate flexibly need encouragement, in contrast to those who persist in working in isolation and making decisions alone. Such people must either change or be replaced. The safeguarding of children must not be placed in jeopardy by individual preference. The joint training of staff and the sharing of budgets are likely to ensure an equality of desire and effort to make them work effectively.

Committees for Children and Families

1.38 In order to secure strong local working relationships so that collaboration on the scale of that which I envisage takes place, I propose that each local authority with social services responsibilities should establish a Committee for Children and Families, with members drawn from the relevant committees of the local authority, the police authority and relevant boards and trusts of health services. This committee will oversee the work of a Management Board for Services to Children and Families.

Management Board for Services to Children and Families

1.39 In each local authority, the chief executive should chair a Management Board for Services to Children and Families, made up of chief officers (or very senior officers) from the police, social services, relevant health services, education, housing and the probation service. The Management Board for Services to Children and Families will be required to appoint a director of children and family services at local level. This person will be responsible for ensuring service delivery, including the effectiveness of local inter-agency working, which must also include working with voluntary and private agencies. Each board must also establish a local forum to secure the involvement of voluntary and private agencies, service users, including children, and other contributors as appropriate. Special arrangements will have to be made in London, to take account of the fact there are 33 London authorities.

Accountability

1.40 The relevant government inspectorates should be jointly required to inspect the effectiveness of these arrangements.

1.41 In order to ensure coherence within this proposed structure, it should be a requirement that each Management Board for Services to Children and Families reports to its parent Committee for Children and Families. In turn, the Committee for Children and Families will report through the regional structure to the National Agency for Children and Families. The Children and Families Board should report annually to Parliament on the state of services to children and families.

1.42 The purpose of these proposals is to secure a clear line of accountability for the protection of children and for the well-being of families. Never again should people in senior positions be free to claim – as they did in this Inquiry – ignorance of what was happening to children. These proposals are designed to ensure that those who manage services for children and families are held personally accountable for the

effectiveness of these services, and for the arrangements their organisations put in place to ensure that all children are offered the best protection possible.

Improvements to the exchange of information

1.43 Improvements to the way information is exchanged within and between agencies are imperative if children are to be adequately safeguarded. Staff must be held accountable for the quality of the information they provide. Information systems that depend on the random passing of slips of paper have no place in modern services. Each agency must accept responsibility for making sure that information passed to another agency is clear, and the recipients should query any points of uncertainty. In the words of the two hospital consultants who had care of Victoria:

> "I cannot account for the way other people interpreted what I said. It was not the way I would have liked it to have been interpreted."
>
> (Dr Ruby Schwartz)

> "I do not think it was until I have read and re-read this letter that I appreciated quite the depth of misunderstanding."
>
> (Dr Mary Rossiter)

The fact that an elementary point like this has to be made reflects the dreadful state of communications which exposed Victoria to danger.

1.44 There can be no justification for hospitals in close proximity to each other failing to access information about earlier patient contact. In this day and age, it must be reasonable to expect the free exchange of information within the National Health Service. The need for this is all the more critical because experience shows that 'shopping around' the health service is one of the favourite ploys of carers wishing to evade suspicion about their treatment of their children.

1.45 Effective action designed to safeguard the well-being of children and families depends upon sharing relevant information on an inter-agency basis. The following contribution to one of the Phase Two seminars was compelling in this respect:

> "Whenever we do a Part 8 case review ... we have this huge chronology of information made available to the Panel and it is very frustrating to read that ... a long way before that happened, a pattern of things emerging, but knowing that at the time ... separate agencies held those bits of information. So GPs will be seeing things, accident and emergency will be seeing things, the police may be dealing with other aspects of what is going on in that child's life, and nobody is bringing it together."

1.46 However, I was told that the free exchange of information about children and families about whom there are concerns is inhibited by the legislation on data protection and human rights. It appears that, unless a child is deemed to be in need of protection, information cannot be shared between agencies without staff running the risk of contravening this legislation. This has two consequences: either it deters information sharing, or it artificially increases concerns in order that they can be expressed as the need for protection. This is a matter that the Government must address. It is not a matter that can be tackled satisfactorily at local level.

A national children's database

1.47 Those who deliberately harm children have a tendency to cover their tracks. Poor record-keeping, doubts about the exchange of information between services, and inadequate client information systems make that easy. We live in a highly mobile society. Ninety million people pass through our ports of entry each year. Many

children experience several moves. I have considered the benefits of establishing a national database on children. In the circumstances set out above, there is much to be said in favour of a database covering all children. I was told that such a database is technically feasible and that there are many much larger systems. The benefit of such a database would be that every new contact with a child by a member of staff from any of the key services would initiate an entry that would build up a picture of the child's health, developmental and educational needs. I have recommended that the Government commission work to look into the feasibility of such a national database, and this may result in pilot studies being carried out.

Action now

1.48 While the introduction of the proposals set out above will require changing the law, the vast majority of recommendations in this Report can be implemented immediately. Some 82 of the 108 recommendations should be implemented within six months. The Inquiry website received around three million hits in the period 30 September 2001 to 30 September 2002, and already a number of the key agencies have reviewed their practices. In this respect, the Inquiry has already had a considerable impact on service delivery. This momentum must be maintained and, where necessary, speeded up, if the unacceptable practice I heard about is to be eliminated. This Report is intended to have an impact on practice **now** – not just some time in the future. Its recommendations cannot be deferred to some bright tomorrow. Robust leadership must replace bureaucratic administration. The adherence to inward-looking processes must give way to more flexible deployment of staff and resources in the search for better results for children and families.

Service funding

1.49 Some elected councillors from Haringey and Brent insisted that the amount of money allocated by central government to their authorities for children's services under the Standard Spending Assessment (SSA) was a result of the distribution formula and did not reflect the needs of the local area. They claimed that because 80 per cent of the funding comes from central government, and because they were being pressed to address central government priorities, they had little scope to influence spending at a local level.

1.50 In this respect, local authorities portrayed themselves as being little more than the agents of central government, rather than being independently elected corporate bodies. If this is correct, it has potentially serious implications for the future of local government in this country. Significantly, at the time that Ealing, Brent and Haringey were spending well below their SSA on services for children, the national picture was quite different, with most local authorities overspending the SSA on services for children and families.

1.51 Nobody from these authorities could give a convincing explanation as to why services for children and families were so significantly underfunded. For example, in 1998/1999 the Brent SSA for children and families was £28 million, whereas the amount spent was just £14.5 million. Since the death of Victoria, Ealing, Brent and Haringey have increased their budgetary provision for children and families. It is my opinion that elected councillors and senior managers in these authorities allowed the services for children and families to become seriously under-funded, and they did not properly consider the impact this would have upon their front-line services.

Eligibility criteria

1.52 The management of the social care of children and families represents one of the most difficult challenges for local government. The variety and range of referrals, together with the degree of risk and urgency, needs strong leadership, effective decision-making, reliable record-keeping, and a regular review of performance.

Sadly, many of those from social services who gave evidence seemed to spend a lot of time and energy devising ways of limiting access to services, and adopting mechanisms designed to reduce service demand.

1.53 The use of eligibility criteria to restrict access to services is not found either in legislation or in guidance, and its ill-founded application is not something I support. Only after a child and his or her home circumstances have been assessed can such criteria be justified in determining the suitability of a referral, the degree of risk, and the urgency of the response.

1.54 Local government in this country should be at the forefront of organisations serving the public. Sadly, little I heard persuades me that this is so. Many of the procedures that I heard about seemed to me to be self-serving – supporting the needs of the organisation, rather than the public they are set up to serve. Local authorities should take the lead in promoting social regeneration and combating social exclusion. In this regard, I have recommended that local authorities become more closely engaged with their local communities in defining local needs and the ways to meet them. Little I heard in this Inquiry convinced me that local authorities accept that in public service, the needs of the public must come first. This must change.

Availability of services

1.55 The availability of services provided by social services departments emerged as a very important matter. The 'out-of-office-hours' teams in Ealing, Brent and Haringey were involved with Victoria to varying degrees. Office hours cover, at best, 40 hours of the working week. During the remaining 128 hours, a single member of staff, possibly with little or no experience of services for children, is frequently expected to cover all social care needs within an authority. Inevitably, the intervention can only be limited until the full service is again available. As families often experience problems during the times when they are most likely to be together – during the evening and at weekends – it is clearly unsatisfactory to provide services in this restricted way. In future, local authorities should be funded to provide specialist services for children and families on a 24-hour basis, as do the other 'emergency' services, such as the police and the health service.

The use of agency and locum staff

1.56 The practice of using a front-line 'duty team' with agency staff is totally unacceptable. This was particularly apparent in the way Brent Social Services managed its duty commitments. Furthermore, even the most able members of staff working on duty should at all times have access to someone dedicated to the task of managing the duty arrangements and supervising the work of the staff.

1.57 I was also concerned to learn that a locum junior hospital doctor, with little knowledge of local child protection procedures, was left unsupported at the Central Middlesex Hospital and allowed to handle alone Victoria's discharge from hospital. This is also totally unacceptable. No member of staff, from any of the agencies, should be put in a position that places both them and their client, or patient, in such a vulnerable position.

Training and supervision

1.58 In addition to promoting better practice immediately, I hope that this Report will be used for the training of future generations of social workers, police officers and doctors and nurses. There is a huge task to be undertaken to ensure that in each of the services, staff are trained adequately to carry out their duties in the care and protection of children and support to families. A balance between theoretical teaching and practical training should be guaranteed on all training courses. All staff appointed to any of the services where they will be working with children and families must have adequate training for the positions they will fill. However,

along with this general requirement of competence to do the job, it is vital that all staff have the benefit of a period of induction that covers, specifically, their roles in protecting children and supporting families.

1.59 Supervision is the cornerstone of good social work practice and should be seen to operate effectively at all levels of the organisation. In Haringey, the provision of supervision may have looked good on paper, but in practice it was woefully inadequate for many of the front-line staff. This must change. The same is true for the police and the health services.

Practice guidance and documentation

1.60 I also heard much about front-line staff working with numerous volumes of guidance, some of which was seriously out of date. In Ealing, the field work manual was so out of date it did not include reference to the Children Act 1989. In Haringey, there were no fewer than 13 documents containing policies, procedures and guidance to staff in relation to children's services. It was the belief of two senior staff managers from Haringey that some staff had difficulty in reading practice guidance because of problems with literacy.

1.61 Judging by the material put before the Inquiry, the problem is less about the ability of staff to read and understand guidelines, and more about the huge and dense nature of the material provided for them. Therefore, the challenge is to provide busy staff in each of the agencies with something of real practical help and of manageable length. The test is simply one of ensuring the material actually helps staff do their job.

The issue of race in relation to Victoria

1.62 Understandably, the agencies with whom Victoria came into contact have asked the question: "If Victoria had been a white child, would she have been treated any differently?" Having listened to the evidence before me, it is, even at this stage, impossible to answer this question with any confidence. Much has been made outside this Inquiry of the fact that two black people murdered Victoria, and a high proportion of the staff who had contact with her were also black. But to dismiss the possibility of racism on the basis of this superficial analysis of the circumstances is to misunderstand the destructive effect that racism has on our society and its institutions.

1.63 As Neil Garnham QC put it so perceptively in his opening statement:

> "Assumption based on race can be just as corrosive in its effect as blatant racism ... racism can affect the way people conduct themselves in other ways. Fear of being accused of racism can stop people acting when otherwise they would. Assumptions that people of the same colour, but from different backgrounds, behave in similar ways can distort judgments."

He urged the Inquiry to "keep its antennae finely tuned" to the possible effects of racial assumptions. This I have sought to do, and return to the subject in section 16.

Conclusion

1.64 Throughout this Inquiry, it has been my firm intention to produce a report that is unambiguous, and has a set of recommendations that will strengthen the safeguards for children. It is my hope that this Report will be read in its entirety. It is only by doing this that readers will understand the full impact of the events

surrounding Victoria's life and death, the inter-relationships between them, and the similarities of the issues emerging from the analysis of practice and organisational factors in the three agencies charged with Victoria's care.

1.65 Sadly, the Report is a vivid demonstration of poor practice within and between social services, the police and the health agencies. It is also a stark reminder of the consequences of ineffective and inept management. Too often it seemed that too much time was spent deferring to the needs of Kouao and Manning, and not enough time was spent on protecting a vulnerable and defenceless child. This must change. However, this Report is no more than a summary of what was heard and can neither rehearse nor condense the vast amount of the evidence that was put before me. That material will remain available on the Inquiry's website for at least a year. (**www.victoria-climbie-inquiry.org.uk**)

1.66 It has felt as if Victoria has attended every step of this Inquiry, and it has been my good fortune to have had the assistance of colleagues whose abilities have been matched by their commitment to the task of doing justice to Victoria's memory and her enduring spirit, and to creating something positive from her suffering and ultimate death. These colleagues have shared with me a determination that the Inquiry should be open, fair and rigorous. Throughout, we have all kept a clear focus on the facts and on finding out what happened to Victoria, why things happened the way they did, and how such terrible events may be prevented in the future. I am convinced that the answer lies in doing relatively straightforward things well. Adhering to this principle will have a significant impact on the lives of vulnerable children. It is the duty of those in authority to see that this happens. Unfortunately, none of us can bring Victoria back, but we can all try to ensure that some lasting benefit comes from her death, and that other children do not suffer a similar fate.

1.67 This Inquiry was established under three Acts of Parliament. In this respect it is probably unique. I am solely responsible for the content of this Report and any weaknesses it may have. However, I am delighted that the four expert assessors, Dr Nellie Adjaye, Donna Kinnair, John Fox and Nigel Richardson, endorse this Report. The names of the whole Inquiry team are recorded in Annex 3. Each has played their part to the full, and richly deserves the warm tribute which I gladly pay them. They have been unfailing in the help and support which they have given me. I am indebted to them. It is invidious to make mention of individuals, because this has been a real team effort. But some of my colleagues have carried an exceptionally heavy workload and done so cheerfully. They are Mandy Jacklin, Secretary to the Inquiry; Neil Garnham QC, Counsel to the Inquiry; and Michael Fitzgerald, Solicitor to the Inquiry. I am grateful to Neil Sheldon, Barrister, for assisting me in marshalling evidential material, to Dr Valerie Brasse and Dr Susan Shepherd for their assistance in drafting this Report, and to Paul Rees, the Director of Communications.

1.68 It is the hope of the full Inquiry team that the horror of what happened to Victoria will endure as a reproach to bad practice and be a beacon pointing the way to securing the safety and well-being of all children in our society.