House of Commons

Health Committee

The Victoria Climbié Inquiry Report

Sixth Report of Session 2002–03

HC 570

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Report, and formal minutes together with oral evidence

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Footnotes

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Introduction

"Her death has become one of those major modern occasions where there seems to have been a collective sense of empathy for a stranger's fate. She has become an embodiment of the betrayal, vulnerability and public abandonment of children. The inquiry must mark the end of child protection policy built on a hopeless process of child care tragedy, scandal, inquiry, findings, brief media interest and ad hoc political response. There is now a rare chance to take stock and rebuild"

Peter Beresford
Professor of Social Policy, Brunel University[1]

1. Victoria Climbié died in the intensive care unit of St Mary's Hospital Paddington on 25 February 2000, aged 8 years and 3 months. Her death was caused by multiple injuries arising from months of ill-treatment and abuse by her great-aunt, Marie-Therese Kouao and her great-aunt's partner, Carl John Manning. Following their conviction for her murder, Lord Laming was appointed in April 2001 to chair an independent statutory inquiry into the circumstances leading to and surrounding 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." The Report of the Inquiry was published on 28 January 2003.[2]

2. It is impossible to read the Report without being moved and appalled by the account of what happened to this little girl, who was sent to England by her family in the Ivory Coast, in the hope of a good education and a better life, but who ended her days the victim of almost unimaginable cruelty. We wish to place on the record our deepest sympathy for her parents, Francis and Berthe Climbié.

3. We held a single evidence session with Lord Laming on 27 March 2003. Our purpose was not to attempt to repeat the detail of the Inquiry, but rather to consider and assess the recommendations that Lord Laming made. We did not invite written evidence, nor did we take oral evidence from witnesses other than Lord Laming. This report is based solely on the evidence taken at that session, and does not pretend to be a comprehensive analysis of all the evidence presented to the original inquiry. We would like to express our gratitude to Lord Laming for agreeing to give us evidence.

4. We were most ably assisted in this inquiry by Melanie Henwood, an independent health and social care analyst. We are most grateful to her for her work for us on this emotive and complicated subject.

Report outline

5. Our report is divided into three chapters. We begin by exploring the background and context to any consideration of the particular recommendations. We then turn to examine

1 *Community Care*, 30 January, p 18

2 Department of Health and The Home Office, *The Victoria Climbié Inquiry, Report of an Inquiry by Lord Laming,* Cm 5730, January 2003

Lord Laming's analysis of what went wrong and why, before considering the detailed prescription for change.

1 Background and context

Non-accidental death and injury

6. The death of any child as the result of non-accidental injury is a tragedy. The fact that in England around 80 children die every year from abuse or neglect, and that this figure has remained relatively constant over more than 30 years, is shocking.[3] We wanted to understand what had happened to Victoria, and how the child protection system and medical care that should have protected her failed her so absolutely. More than this, we wanted to understand how the recommendations of the Laming Inquiry might improve things for the future.

7. Since 1948 there have been around 70 public inquiries into major cases of child abuse.[4] The names of many of the children who have died have become well known, simply because of the terrible nature of their deaths. From Maria Colwell in 1973, to Jasmine Beckford and Tyra Henry (both in 1984), Kimberley Carlile (1986), Leanne White (1992), and Chelsea Brown in 1999, the deaths of these children all share many points of similarity. The pattern does not even end with the death of Victoria; since that time there have been at least two more high profile cases (Lauren Wright in 2000, and Ainlee Walker in 2002). In many of these cases the child has been the target of abuse from an adult who is not the natural parent (typically a step-father). While the particular circumstances of each case are different, there are also areas of considerable similarity. In particular, the following features recur time after time:

- Failure of communication between different staff and agencies.
- Inexperience and lack of skill of individual social workers.
- Failure to follow established procedures.
- Inadequate resources to meet demands.

8. As various commentators have pointed out, the Laming Inquiry was by no means the first to attempt to grapple with a hugely complex issue, "and his predecessors' reports have ended up on shelves gathering dust." [5] We therefore asked Lord Laming what would be different this time, and what confidence we could have that his report would not join those many others that created an initial flurry of interest and then were soon forgotten. Lord Laming pointed out that his inquiry differed from previous ones; indeed, it was unique in being set up under three different Acts of Parliament.[6] This gave Lord Laming a very wide-ranging brief, and his concern was not with the way in which just one agency had discharged its duties, but the way in which *all the agencies involved* (four social services departments, three housing departments, two specialist child protection teams in the

3 HC Deb, 23 January 2003, col 738 (Alan Milburn MP, Secretary of State, Commons Statement on the Victoria Climbié Report)

4 Q6

5 Snell J (2003), 'Relief as prospect of child protection agency recedes—for the time being', *Community Care*, 30 January-5 February, pp. 16-17.

6 Q6

Metropolitan Police, two different hospitals, and the NSPCC) had done so. Accordingly, Lord Laming told us that his recommendations were "geared towards improving the system as a whole."[7] We turn later in this report to examine the recommendations in greater detail.

9. It was not entirely apparent to us that the findings from all the previous inquiries had informed the deliberations of the Laming Inquiry. However, Lord Laming assured us that he had indeed read every one of these inquiry reports "from cover to cover", not in the course of the Inquiry, but in relation to his earlier responsibilities (as Director of Social Services in Hertfordshire, and then as Chief Inspector for Social Services in the Department of Health). He also told us that he had re-visited the various reports as Chair of the Inquiry.

What happened to Victoria?

10. In order to understand the Inquiry conducted by Lord Laming, it is important to set out briefly Victoria's story.[8] Victoria was born near Abidjan in the Ivory Coast on 2 November 1991, the fifth of seven children. According to her parents, she had a happy and healthy childhood, and did well when she started at school aged six. In October 1998, Marie-Therese Kouao, the aunt of Victoria's father visited the family. She had been living for some time in France and told Francis and Berthe Climbié that she was prepared to take one of their children back to France with her and to arrange for their education, and Victoria was chosen. As Lord Laming commented in his report, entrusting children to relatives in Europe who can offer opportunities that would not be available to them in the Ivory Coast was "not uncommon in Victoria's parents' society."[9]

11. Victoria travelled with Kouao to France, and stayed there for some five months. Initially Victoria attended school, but by December 1998 Victoria's absenteeism was causing concern. When she was in school, Victoria tended to fall asleep and appeared unwell. By February 1999 the school in Villepinte was sufficiently concerned to issue a Child at Risk Emergency Notification. Some time in spring 1999 Kouao informed the school that she was removing Victoria in order to take her to London for treatment. Victoria and Kouao arrived in London on 24 April 1999. They travelled on Kouao's passport, which described Victoria as her daughter named Anna. Anna was the name of another child that Kouao had previously planned to bring from the Ivory Coast, and throughout her life with Kouao, Victoria was known as Anna.

12. The day after their arrival in London, Kouao and Victoria went to Ealing Homeless Persons' Unit seeking accommodation. They were also in contact with Ealing Social Services. Kouao made contact with Esther Ackah, a distant relative living in Hanwell, West London. It was Ms Ackah who was first concerned about Victoria and who made two anonymous telephone calls to Brent Social Services.

7 Q6

8 Information in this section is sourced from *The Victoria Climbié Inquiry, passim*.The Inquiry also produced a helpful Summary and Recommendations Document.

9 *The Victoria Climbié Inquiry,* Para 3.5

13. From June 1999 Victoria was spending much of her time with a childminder (Priscilla Cameron) while Kouao went to work. Victoria would arrive at around 7 am and often not be collected until 10 pm. Mrs Cameron did not like the way that Kouao treated and spoke to Victoria who was very subdued when ever Kouao was present. Kouao had met Manning (driving a bus) in June, and the following month she and Victoria moved in to his flat in Somerset Gardens, Tottenham. From this time on, the abuse of Victoria seemed to increase. Both Ms Ackah and Mrs Cameron had noticed marks on Victoria, and these became more evident.

14. On 13 July 1999 Kouao asked Mrs Cameron to keep Victoria permanently because Manning did not want her living with them. Mrs Cameron was unable to do so, but kept Victoria overnight. Victoria had many injuries on her face which Kouao claimed were self-inflicted. The following day Mrs Cameron's adult daughter took Victoria to the Accident and Emergency department of the Central Middlesex hospital. The doctor who examined her believed there was a "strong possibility" that this was a case of non-accidental injury, and referred Victoria to the paediatric registrar. The registrar examined Victoria and found a large number of injuries, at least some of which it was thought could be non-accidental. Victoria was admitted to the hospital and Brent Social Services and the police were informed. Another doctor conducted an evening ward round and concluded that Victoria was suffering from scabies.

15. The next morning Kouao went to the hospital and took Victoria away. Kouao visited the Camerons to collect Victoria's things, and Mrs Cameron did not see Victoria again other than on one occasion when she saw her walking down the road with Kouao.

16. On 24 July 1999, just over a week later, Victoria was back in hospital. This time she was admitted to the North Middlesex hospital and had been taken there by Kouao with a scald to her face, which Kouao claimed Victoria had inflicted on herself by putting her head under the hot tap. Her burns were so severe that she was admitted to the paediatric ward and stayed there for 13 nights.

17. The senior house officer contacted Haringey Social Services, and a referral was also made by an Enfield social worker based at the hospital. On 28 July a meeting was held at Haringey's offices, and Victoria's case was allocated to a social worker (Lisa Arthurworrey).

18. During her time in hospital Kouao and Manning visited Victoria whose behaviour changed in their presence; she appeared afraid of them. Ms Arthurworrey and a police constable visited Victoria on 6 August 1999 and decided it would be appropriate for her to be discharged back into Kouao's care. As Lord Laming's Report observed, "the brief interlude in her life in this country during which Victoria was safe, happy and well cared for ended."[10] She left the North Middlesex hospital on 6 August and returned to Manning's flat where she was to spend the remaining seven months of her life.

19. During these months Victoria had little contact with the outside world, and was seen by professionals on only four occasions, twice when she was visited by Arthurworrey, and twice when Kouao took her to Tottenham Social Services claiming that Victoria had been sexually abused by Manning (although she later withdrew this allegation). No one from the

10 *The Victoria Climbié Inquiry,* Para 3.48

Tottenham Child and Family Centre (to which she had been referred by Haringey Social Services on 5 August 1999) ever visited Victoria.

20. Since moving in with Manning, Victoria had become at times incontinent of urine, and often wet herself and her bed. In October 1999, the sofabed on which she had been sleeping was thrown out of the flat, and Victoria began to spend her nights in an unheated and unlit bathroom.

21. During Authurworrey's two pre-announced visits to the flat, little attention was paid to Victoria and Arthurworrey did not speak to her directly. She believed that the main issue was the poor housing that the family were in, and that the priority was to move them to better accommodation. Manning later indicated that preparations had been made for Authurworrey's planned visits. The flat had been cleaned and Victoria had been told how to behave during the visit. Aurthurworrey told Kouao that the council only accommodated children at risk of serious harm. On 1 November Kouao telephoned Arthurworrey and made allegations about Manning sexually abusing Victoria. When questioned alone, Victoria repeated what Kouao had said virtually word for word, and it was believed that she had been coached in what to say. Nonetheless, Arthurworrey told Kouao that Victoria should stay elsewhere while the allegations were investigated. A person identified by Kouao as a friend (Mrs Kimbidima) who might help was telephoned. It is not clear if the friend then changed her mind, but having set off for her home in a taxi, by the end of the day Victoria and Kouao had both returned to Manning's flat. The following day Kouao withdrew her allegations of sexual harm. She was told that Victoria would still have to live elsewhere until any allegations had been investigated. Kouao said that they would remain with the Kimbidimas, but in fact they returned to Manning's flat.

22. This was the last occasion that any of the professionals involved in Victoria's case saw her until her admission to hospital the night before she died. Very little is known about the last four months of Victoria's life.

23. It is believed that Victoria spent most of this time in the Somerset Gardens flat, although there is some evidence that she made two brief trips to France with Kouao, where they stayed with Kouao's son. Back at Somerset Gardens Victoria continued to be forced to sleep in the bath, and was tied up inside a black plastic sack. As a result Victoria spent long periods lying in her own urine and faeces. The sack ceased to be used when Victoria's skin condition became so damaged that Manning said they were concerned that "undue questions" would be asked. While no longer being kept in a bag, Victoria spent most of her days and nights confined in the bathroom.

24. By the beginning of 2000 Victoria was also being given her food on a piece of plastic in the bathroom. Her hands were tied with masking tape and she would be pushed towards the food to eat it like a dog.

25. Victoria was also beaten regularly by Manning and Kouao. Manning later reported that Kouao struck Victoria on a daily basis, using various implements including a shoe, a coat hanger, a wooden spoon and a hammer. Victoria's blood was found on the walls of the flat, on Manning's football boots and trainers. He also admitted to beating Victoria with a bicycle chain.

26. By 19 February 2000 Victoria had become very ill. Kouao took Victoria with her to the Universal Church of the Kingdom of God on Seven Sisters Road. Kouao spoke to the minister (Pastor Lima) and told him of the problems she was having with Victoria, particularly with her incontinence. Pastor Lima expressed the view that Victoria was possessed by an evil spirit and advised Kouao to bring Victoria back to the church a week later. During the week Kouao telephoned the Pastor and reported that Victoria's behaviour and incontinence was improving. However, later in the week Kouao returned to the church with Victoria where Pastor Lima advised them to go to hospital and called a minicab.

27. The minicab driver took Victoria and Kouao to the nearby Tottenham Ambulance Station. Victoria was then taken by ambulance to North Middlesex hospital and admitted to casualty. Her temperature on arrival was 27 degrees Celsius (compared with a normal temperature of 36-37C), and attempts to warm her were unsuccessful. The paediatric consultant believed that Victoria needed specialist care, and a place was found for her at St Mary's Hospital Paddington. Victoria was transferred to St Mary's with severe hypothermia and multi-system failure. Her respiratory, cardiac and renal systems all began to shut down and Victoria went into cardiac arrest. Attempts at cardio-pulmonary resuscitation failed and Victoria was declared dead at 3.15 pm on 25 February 2000. Ironically, this was the very day that Haringey Social Services formally closed her case.[11]

28. A post-mortem was conducted the following day. The cause of death was found to be hypothermia caused by malnourishment, a damp environment and restricted movement. The pathologist found 128 separate injuries on Victoria's body caused by both sharp and blunt instruments. No part of her body was spared injury. Marks on her wrists and ankles indicated that Victoria had been tied up. The pathologist reported that it was "the worst case of deliberate harm to a child he had ever seen."[12]

29. Later on 25 February 2000 Kouao was arrested on suspicion of neglect, Manning was arrested the following day. Both were subsequently charged with Victoria's murder. They were convicted on 12 January 2001 and are serving sentences of life imprisonment.[13]

30. Victoria's story highlights the system going badly wrong at every step. Lord Laming told us:

> Had this tragedy of Victoria Climbié been because one doctor, one social worker, one police officer, had failed to see one telling sign indicating deliberate harm, frankly there is no system in the world that can prevent that; any one of us can make mistakes ... However, when you get the whole system engaged, when the second day this child was in the country she was referred under the Children Act as a child in need, and the very day that she died the case was being closed as no further action was needed, that was the day she was in the third hospital when her life could not be saved, I am strongly of the view that nothing more was known about Victoria Climbié at the end of the process than was not in the first referral on the second day she was in this country. Never once was an assessment of need made; never once,

11 *The Victoria Climbié Inquiry*, Para 1.16

12 *The Victoria Climbié Inquiry*, Para 3.84

13 *The Victoria Climbié Inquiry*, Para 3.85

> whether by the hospital, social services or the police service. What happened to this little girl was shocking in the extreme.[14]

31. It is the reasons for this systematic failure that must be understood and addressed if further tragedies of this nature are to be avoided. It is to these issues that we now turn.

14 Q11

2 What went wrong and why

32. The previous chapter has provided a factual account of Victoria's final months spent in this country. While this describes the multiple opportunities when someone might have intervened and done something to help Victoria, it fails to indicate *why* this did not occur. Lord Laming told us that there were three key questions as far as he was concerned:

> First of all, in this day and age, in this country, how could this have happened? Secondly, how could such bad practice go on for so long, undetected and uncorrected? And thirdly, what can we do about it?[15]

33. In seeking to understand what had gone wrong in this case, Lord Laming observed that the inquiry could have lasted for many years, and it turned out to be much larger than anticipated. At the outset it was believed that because Victoria had spent a relatively short time in the country, the Inquiry would need to see in the region of 30 witnesses. In the event, 277 witness statements were taken.[16] Lord Laming had to find a balance between pursuing many issues in great detail, and getting a report produced as soon as possible in order to address issues of fundamental importance.

Gross failures of the system

34. The Inquiry Report identified an absence of basic good practice. There were at least 12 key occasions when the relevant services had opportunities successfully to intervene to help Victoria, but had failed to do so. The Report states that not one of these interventions would have required great skill or made heavy demands on staff:

> 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.[17]

35. As Lord Laming commented, not one of the agencies empowered by Parliament to protect children in positions such as Victoria's emerged from the Inquiry with much credit.[18] What happened to Victoria, and her ultimate death, resulted from an inexcusable "gross failure of the system."[19] Lord Laming's Report expressed his amazement that nobody in the 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."[20] We share Lord Laming's amazement that the system failed so comprehensively.

36. The Inquiry Report highlighted "widespread organisational malaise" as the principal reason for the lack of protection afforded to Victoria. In relation to the Health Service it

15 Q11
16 Q10
17 *The Victoria Climbié Inquiry*, Para 1.17
18 *The Victoria Climbié Inquiry*, Para 1.18
19 *Ibid*
20 *The Victoria Climbié Inquiry*, Para 1.1

was apparent that the basic discipline of medical evaluation—history taking, physical examination, differential diagnosis, note keeping, handover of care and monitoring of outcome—was simply not followed. Lord Laming speculated that medical staff felt especially uncomfortable about investigating evidence of deliberate harm to children. Their training in following the normal systematic approach to the diagnosis of illness appeared to have been entirely ignored in Victoria's case. When the possibility of non-accidental injury was raised by one doctor, it was not picked up by others because of poor or absent handover of responsibility of care, and then obscured by another diagnosis which was not confirmed. The organisational systems were not in place to ensure continuity of care or adequate consultant supervision. Lord Laming expressed this as follows:

> We cannot operate a system where the safety and well being of children depends upon the personal inclinations or ability or interests of individual staff. It is the organisations which must accept accountability.[21]

The paediatric units throughout the country should be instructed to review their arrangements for ensuring continuity of care, supervision of junior medical staff and medical audit.

37. Who should be held responsible for these failures? Lord Laming was clear that it is not the 'hapless' and sometimes inexperienced front-line staff to whom he directs most criticism, but to those in positions of management, including hospital consultants. He told us:

> I think that the performance of people in leadership positions should be judged on how well services are delivered at the front door. Too often in the Inquiry people justify their positions around bureaucratic activities rather than around outcomes for children. Frankly, I would be the very last person to say that good administration is not essential to good practice. Good administration—and we did not see a lot of it, I have to say—is a means to an end. I cannot imagine in any other walk of life if a senior manager was in charge of an organisation and that organisation was going down the pan—to put it crudely—in terms of sales and performance that someone would say 'My role is entirely strategic, do not hold me to account for what happens in the organisation.' … People who occupy senior positions have to stand or fall by what service is delivered at the front door.[22]

38. The Inquiry Report highlighted the apparent failure of those in senior positions to understand, or accept, that *they* were responsible for the quality, efficiency and effectiveness of local services. Indeed, Lord Laming pointed to the 'yawning gap' in the differing perceptions of the organisation held by front line staff and senior managers. Lord Laming was unequivocal that the failure was the fault of managers whose job it should have been to understand what was happening at their 'front door.' As the Report pointed out, some of those in the most senior positions used the defence "no one ever told me" to

21 Q33
22 Q22

distance themselves from responsibility, and to argue that there was nothing they could have done.[23] This was not a view shared by Lord Laming, nor is it our view.

39. Lord Laming went even further in evidence to us, telling us forcefully that, in his view, accountability of managers was paramount, and that the front line staff were generally doing their utmost:

> I do not believe that any one of the junior staff or the front line staff that came to the Inquiry were anything other than distressed at what happened to Victoria. I do not believe that any of them were not well motivated. I do not believe that any of them did not set out to do a reasonable job of work. The question is why are these well intentioned people put in a situation where they felt defeated by the task that they had?[24]

40. In addition to the fundamental problems of a lack of accountability and managerial control, it was also apparent in the course of the Inquiry that other failings existed in all aspects of practice. As with many previous inquiries into child protection failures, it was clear that the quality of information exchange was often poor, systems were crude and information failed to be passed between hospitals in close proximity to each other. As the Report commented, "information systems that depend on the random passing of slips of paper have no place in modern services."[25]

41. The question of adequate training and supervision for staff working in all the relevant agencies was also an issue identified in the Inquiry. In Haringey, for example, it was observed that the provision of supervision may have looked good on paper "but in practice it was woefully inadequate for many of the front line staff." Nowhere was this more evident than in the fact that in the final weeks of Victoria's life a social worker called several times at the flat where she had been living. There was no reply to her knocks and the social worker assumed, quite wrongly, that Victoria and Kouao had moved away, and took no further action. As the Laming Report commented, it was entirely 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."[26]

Adequacy of resources

42. In commenting on the adequacy or otherwise of resources, Lord Laming's analysis was more sophisticated than that of many commentators who have concluded that the issue is simply one of putting more money in the system. He argued to us, as he had also stated in his Report, that bad practice was extremely costly, and "had Ealing, in my view, done the job they should have done on the second day that Victoria was in this country, it is probable that all of the other agencies would not have needed to be involved."[27] He also pointed out that Ealing, Brent and Haringey were, at the time of Victoria's case, all spending significantly below their Standard Spending Assessment (SSA) on services for

23 *The Victoria Climbié Inquiry*, Para 1.26
24 Q26
25 Para 1.43
26 Para 1.11
27 Q16

children. This was in sharp contrast with the national picture, where most local authorities were overspending their SSA on services for children and families.[28]

43. An obvious question to ask was why authorities would underspend their SSA for children and families? The apparent low priority given to such services, Lord Laming told us, appeared to be a reflection of the pressures and demands from central policy:

> I think that too often in recent years the service has been deflected away from children and families into the adult agenda and the pressure which is on about getting people out of hospital, getting people discharged from hospital, about meeting the needs of adults, has led to children's services having too low a priority.[29]

44. This raises some very important issues. **We urge the Department of Health to examine whether current health service priorities have had deleterious effects on local priorities for children and families.**

45. Lord Laming cautioned against "believing that more and more money will produce better services." In his view, there had to be "an assurance that more and more money actually is about achieving outcomes for children."[30] In their response to the Laming Inquiry the Association of Directors of Social Services (ADSS) supported unreservedly the core principles of the Report, but challenged whether the recommendations could be delivered within existing resources, and argued the case for a thorough review of funding for social care similar to that undertaken for the NHS by Derek Wanless.[31] Indeed, Mr Wanless himself has called for such a review. While Lord Laming appeared to have limited patience with the argument that social care was under-resourced, he acknowledged that such a contention might carry more weight "if there was some intellectual rigour behind it that actually produced evidence to support such claims."[32]

46. **We agree with the arguments made by the ADSS, and in the past by the King's Fund, that there should be an independent review of funding for social care, along the lines of the Wanless review of the NHS. We recommend that the Government should commission an urgent review of the factors influencing demand for social care for children and adults, and consider the adequacy of resources currently allocated.**

Failure fully to implement the Children Act

47. Lord Laming told us that he continued to believe that the Children Act 1989 was "basically sound legislation". His recommendations do not argue for a major new legislative framework. However, he did not believe that the Act was being implemented in the way that had been envisaged for it, and, in his view, there was "a yawning gap at the present time between the aspirations and expectations of Parliament and the certainty of what is delivered at the front door."

28 *Ibid*
29 Q16
30 Q16
31 Derek Wanless, *Securing our future health: taking a long term view*, April 2002.
32 Q54

48. In the absence of adequate managerial accountability, front line workers were obliged to make crucial strategic decisions, for example about the use of the Children Act, and between using sections 17 and 47 (relating respectively to a child in need, and a child in need of protection). The sections of the Act had been developed with the intention of recognising the different needs of children. How the sections were being applied on the ground, Lord Laming told us, was quite different. Far from employing the section of the Act that would best meet the needs of the particular child and their circumstances, "what they were actually doing was using these sections to restrict access to services and to limit the availability of services to people."[33] The Children Act, Lord Laming argued to us, "should be about promoting the well-being of children, not about putting labels around people's neck." He went on to suggest that front line workers were being forced into making decisions that should properly have rested with management and policy decisions. This raised major questions about the role of public services and the basic principles that should underpin them, as Lord Laming observed:

> We heard evidence that made me think that we need to stand back and say that we need to discover the basic principle that the public services are there to serve the public, not just some of the public and not just some people who can get through eligibility criteria, who can go over hurdles or who are sufficiently persistent. Therefore services must be more accessible and they must be more in tune with their local communities.[34]

49. **If, as Lord Laming believes, the Victoria Climbié case was not unique, but highlighted widespread and major deficiencies in the implementation of the Children Act, this raises issues that Government should address. We believe that the Children Act 1989 remains essentially sound legislation. However, we are concerned that the provisions of the Act which sought to ensure an appropriate response to the differing needs of children are being applied inappropriately, used as a means of rationing access to services, and have led to section 17 cases being regarded as having low priority. The Laming Inquiry recommended that consideration should be given to unifying the Working Together guidance and the National Assessment Framework guidance into a single document, setting out clearly how the sections of the Act should be applied, and giving clear direction on action to be taken under sections 17 and 47.[35] We strongly support this recommendation.**

Moving Forward

50. The Inquiry into Victoria Climbié's case was charged not only with investigating what happened to Victoria, but also with making recommendations as to how such an event may, as far as possible, be avoided in the future. We turn now to consider those recommendations.

33 Q15

34 Q20

35 *Working Together*, Department of Health and the then Department for Education and Employment, 1999. "This document sets out how all agencies and professionals should work together to promote children's welfare and protect them from abuse and neglect. It is addressed to those who work in the health and education services, the police, social services, the probation service, and others whose work brings them into contact with children and families. It is relevant to those working in the statutory, voluntary and independent sectors" (Introduction).

3 A new management and accountability structure

51. The Inquiry offered a total of 108 recommendations for change, 89 of which Lord Laming believed should be implemented within six months, as they "should be part of the lifeblood of organisations to behave in that way." We do not propose to scrutinise these individually, but to consider the totality of the recommendations and the overall model that they set out.

Development of recommendations

52. Lord Laming told us that he believed it was very important that the recommendations should not be based upon what happened to one child, or what happened in one part of North London. In his view, hard cases could make bad law. The Inquiry team decided to find a method that would enable them to test out the matters that had arisen during the first phase of the Inquiry with a much wider range of people. Five key themes were identified from Phase One (Discovery and inclusion; Identification; Determining requirements; Service provision and delivery; and Monitoring performance), and a series of five seminars was arranged around each of these. The participants for the seminars were invited to ensure a geographical spread, a range of political interests and varied experience. The seminars provided confirmation that many of the issues that had arisen in Victoria's case were indicative of issues causing general concern across the country.

53. **We were somewhat surprised by the methodology adopted for the second phase of the Inquiry, which appeared to us to be a particularly selective model. It seems to us that a more broadly based investigative approach might have been of greater value. Lord Laming defended his choice of method on the basis of the need to "strike a balance between a reasonable examination of the issues and the amount of time and effort and expense that would be necessary to go down other routes."[36] In view of the arguably selective methodology used in developing the full recommendations from the Climbié Inquiry, we recommend that the Government should ensure the forthcoming Green Paper allows full consultation with the widest possible audience and stakeholders.**

54. We recognise the difficult balance that needed to be maintained between further analysis and producing a timely and relevant report. However, we were especially struck by the absence of analysis of experience in other countries, which might have proved worthwhile. Lord Laming accepted that there could be arguments for looking at such experience, but contended that it was not possible to simply "pick up a system from one country and replicate it in another."[37] Moreover, because the Inquiry was already convinced from the first phase of its work that existing legislation provides a basically sound framework, but that the problems arose through the legislation being incorrectly interpreted and applied at local level, the essential challenge was to make the existing system work. As Lord Laming put it: "and because of that I thought, let's get on and do it."

36 Q10
37 Q14

55. However, not all other countries seem to have the same problems with child abuse as Britain does. The experience in Sweden, for example, which has long outlawed the physical punishment of children, is one in which child deaths from deliberate harm by adults are now unknown. What happened to Victoria involved the apparent escalation of discipline and punishment. Carl Manning told the Inquiry that the abuse had begun with little smacks. This raises the question of 'reasonable chastisement', and we are aware that this can be used as a defence in cases of child abuse, and often leads to the collapse of cases where real harm has taken place. Lord Laming's predecessor as Chief Inspector of Social Services (Sir William Utting) had argued that the reasonable chastisement defence should be removed in order to protect children from injury by parents or carers. Lord Laming did not address this particular issue in his Inquiry, although the implication of the recommendations and much of what he told us is that he recognises that a physical assault on a child must be treated with the same seriousness as an assault on an adult. Physical punishment of children is no longer permitted in schools, and the Government recently announced that new standards from September 2003 will outlaw childminders smacking children in their care. **We urge the Government to use the opportunity of its forthcoming Green Paper on children at risk to remove the increasingly anomalous reasonable chastisement defence from parents and carers in order fully to protect children from injury and death.**

The recommended new structure

56. While leaving the legislative framework intact, the Laming Inquiry recommended major structural changes, which are summarised in Figure 1 below. Lord Laming argued that the structures need to reflect new arrangements. For example, the proliferation of new organisational forms and boundaries creates major challenges to old structures such as the Area Child Protection Committee system established at a time when circumstances were different, and structures were less complex. As Lord Laming pointed out, there are now 30 Strategic Health Authorities, 43 police forces, 150 social services departments, 300 Primary Care Trusts and 355 housing authorities, which—he argued—constitute "a bureaucratic nightmare."[38] The system he was proposing was intended to create "less bureaucracy, greater focus and more certainty that things actually happen that can achieve outcomes for children."[39]

57. Lord Laming's Inquiry's recommendations were intended to ensure managerial accountability throughout the system. Lord Laming told us that there were three main weaknesses in the current system. First, there was no way of ensuring "that the will of Parliament is implemented." Second, there was no accountability through the system and Area Child Protection Committees have no statutory basis, but rather "depend solely on good will and best endeavours of local people." Third, there was no clear focus on ensuring a dedication to good outcomes for children.

58. The key changes proposed by the Laming Inquiry comprise the introduction of:

38 Q17
39 Q27

- **A Children and Families Board** which should be established within government, chaired by a Minister of Cabinet rank, and having representation at ministerial level from each of the relevant government departments. The Board should be charged with ensuring that the impact of all initiatives with a bearing on the well-being of children and families is considered within the forum.

- **A National Agency for Children and Families** where the Chief Executive will report to the Ministerial Children and Families Board. The Chief Executive should incorporate the responsibilities of a Children's Commissioner for England. The national agency should:

    - *Assess and advise the ministerial Children and Families Board about the impact on children and families of proposed changes in policy*

    - *Scrutinise the 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 legislation and policy are implemented at 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*

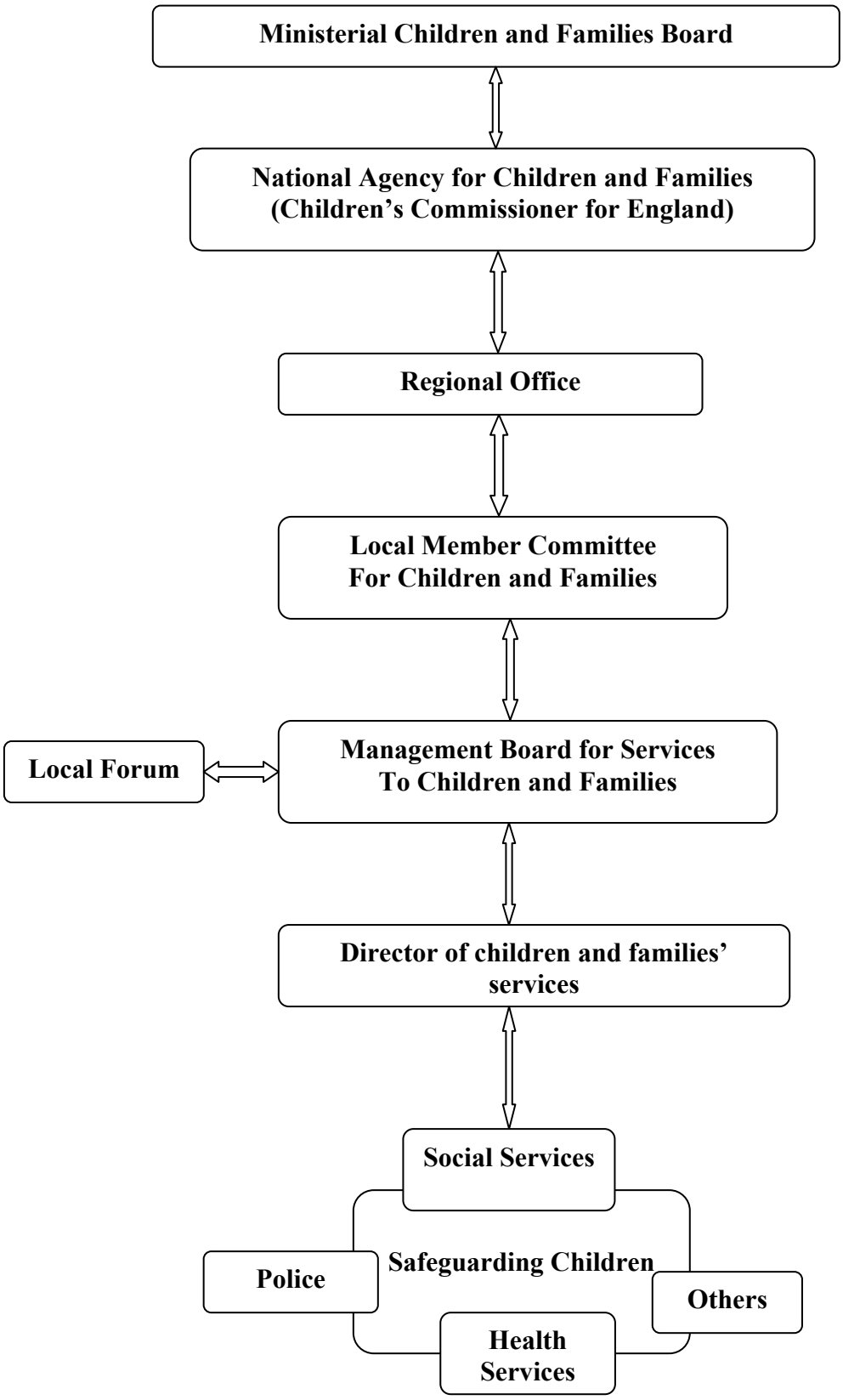
- **Local Committees for Children and Families**: each local authority with social services responsibilities should establish a Committee for Children and Families with lay members drawn from the management committees of each of the key services (local authority, police authority and health service boards and trusts). This Committee must ensure that services to children and families are properly co-ordinated and that the inter-agency dimension of this work is being managed effectively.

- **Management Boards for Services to Children and Families**: the local authority Chief Executive should chair a Management Board for Services to Children and Families which will report to the Member Committee referred to above. The Management Board must include senior officers from each of the key agencies, and must also establish strong links with community-based organisations that make significant contributions to local services for children and families. The Board must ensure staff working in the key agencies are appropriately trained and are able to demonstrate competence in their respective tasks. It will be responsible for the work currently undertaken by the Area Child Protection Committee. The Management Board must appoint a Director responsible for ensuring that inter-agency arrangements are appropriate and effective, and for advising the Board on the development of services to meet local need.

59. The proposals are intended to "secure a clear line of accountability for the protection of children and for the well-being of families." It should ensure, the Report argued, that people in a senior position were no longer able to claim ignorance of what is happening on

the ground, and to argue that this is not their responsibility. Instead, the arrangements would 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."

Figure 1: Recommended New Structure



Local accountability and new local government structures

60. While response to the Laming Report has generally (and in our view entirely deservedly) been very favourable, particularly for its clarity of forensic analysis over the nature and circumstances of Victoria's death, there has been considerable debate about many of the recommendations and their appropriateness to current structures of local governance. The ADSS, for example, fully supported Lord Laming's wish to embed within local government structures the accountability of elected members for the delivery of services to children. However, in its position statement in response to the Report it said it considered:

> that this can be best achieved by working through the arrangements already in place following the implementation of the Local Government Act. The arrangements for Cabinets, Scrutiny and Executive Members with specific portfolios of responsibilities already focus accountability in a clearer way than previous arrangements within Councils. Consequently, the national and local accountability arrangements proposed within Lord Laming's Report do not sit easily with the structures that will be in place in most local authorities.[40]

61. We recognise the considerable experience that Lord Laming has acquired both in managing services at local level, and in having a wider national inspection responsibility. However, we do not believe that his Inquiry's recommendations take full account of recent developments in local government structures. **We believe it is essential that further structural change and upheaval is not imposed unnecessarily on local government. We therefore recommend that the Government should consider carefully whether the new structure proposed by Lord Laming offers the best fit with arrangements that have emerged following the Local Government Act 2000, and whether revisions are required to ensure new national and local accountability arrangements are properly located within local government structures and mechanisms.**

62. There may be opportunities to develop local approaches to multi-agency working through the piloting of Children's Trusts. On the day that the Laming Report was published, the statement by the Secretary of State for Health noted the failure of services to work together in Victoria's case, as in many others before:

> Down the years, inquiry after inquiry has called for better communication and better co-ordination, but neither exhortation nor legislation has proven adequate. The only sure-fire way to break down the barriers between those services is to remove them altogether. Fundamental reform is needed to pool knowledge, skills and resources to provide more seamless local services for children.[41]

63. The Secretary of State went on to invite health and social services, and other local services such as education, to apply to become the first generation of Children's Trusts that would allow local services for children to be run through a single organisation. Some 45 local authorities have subsequently submitted bids. We asked Lord Laming whether he believed that Children's Trusts could offer a way forward, and we were disappointed that

40 ADSS Position statement in response to *The Victoria Climbie Inquiry Report*.

41 HC Deb, 28 January 2003, Col 740

he was unable to address this issue. He commented that the Inquiry had taken no evidence on Children's Trusts,

> and it would be quite wrong of me to comment on them other than to say that I do not know what is in the Secretary of State's mind about Children's Trusts. What I hope is that the principles that are set out in this Report will be achieved, whatever the structural arrangements that are ultimately settled.[42]

64. **If a child protection system has different structures, systems and functioning in different areas, this has the potential to cause serious difficulties. Any arrangement that has the potential to tackle the boundaries between health and social care, and other local services, has much to commend it, and we are interested in the role that might be played by Children's Trusts. However, the model is at present extremely vague. The guidance issued in January 2003 made it clear that there was no single approach to Children's Trusts and that a variety of models might be developed. While we recognise that this could encourage diversity and locally responsive services, we are concerned that the model is currently too vague and there is a danger of new structures and mechanisms running ahead of any coherent strategy. We recommend that the forthcoming Green Paper should provide further clarification on the contribution that might be expected of Children's Trusts, and the nature of the preferred model.**

A National Child Protection Agency?

65. There is a view held by many of those who worked in health and social care prior to 1974 that the new system introduced at that time (which among other things separated health visiting from social services) was a regressive step for the child protection system. Lord Laming remarked to us that health and social care appeared to have suffered from long term ad hoc piecemeal change, and the cumulative impact of these changes on children and families had not been addressed adequately.[43] One benefit of a *National* Agency dedicated to children and families, Lord Laming argued, would be the opportunity it provided to see the wider system and its impact much more clearly.

66. Despite the various structural changes proposed at both national and local levels, Lord Laming rejected the idea of establishing a National Child Protection Agency. The idea for such an agency is a superficially attractive one. However, Lord Laming told us that he believed it to be "fundamentally misguided", and that this was an issue on which his views had changed very considerably in the course of the Inquiry.[44] In particular, he regarded it as total nonsense to think that child protection could be separated from wider family support. There would be real risks, he believed, with a child protection agency that referrals would not be made sufficiently early, but only when child protection concerns were at an advanced stage.

42 Q48
43 Q49
44 Q46

A Children's Commissioner

67. We queried with Lord Laming why it was that he had adopted an inclusive 'children and families' category, rather than pursuing an approach that would signal the importance of addressing children in their own right. Lord Laming emphasised that most children continue to live in families, and that the Children Act was quite clear that the focus should be on the well-being of the child. A new National Agency would be required to demonstrate that the system was working in the best interests of children. The National Agency chief executive would incorporate the responsibilities of a Children's Commissioner for England. We put it to Lord Laming that this fundamentally misunderstands the role of a Children's Rights Commissioner, which we believe should be a wholly independent role. Lord Laming robustly defended his position and argued:

> Straightforwardly I do not believe the Children's Commissioner would actually achieve what I want it to achieve on its own, however well intentioned ... The fact is that what I want to see is not more people who are able to comment on the system and advocate change. I want to see a system of accountability that delivers and has the responsibility to deliver.[45]

A national children's database?

68. Lord Laming recommended that Child Protection Registers should be abolished and replaced with a more effective system. He told us that he would support the registers "if I thought they did any good, but I think they have the potential to do harm. People who place a child's name on the register have the right to assume that that child is receiving services and I think there is no guarantee that a child will receive services."[46] The ADSS suggested that Child Protection Registers should remain until there were strong and workable proposals in place for their replacement. Lord Laming also recommended the establishment of a new national children's database for *all* children under the age of 16. He acknowledged the need for a feasibility study and a pilot exercise in establishing such a database. These appear to us to be two completely different things. **The establishment of a national database for all children under the age of 16 would not necessarily in itself provide an alternative to the existing Child Protection Register, and the arguments around both of these elements need to be separated.**

69. The idea of a national database for children reflects the importance of ensuring that children do not 'slip through the net' or disappear without services knowing where they have gone. Lord Laming told us that because we now lived in a highly mobile society, with very fluid family structures, children were more likely to move around and there was no system that allowed them to be tracked. Lord Laming contended that establishing such a database would be entirely feasible technologically, and that "it is not a huge database compared with many databases in this country." Even leaving aside the arguments which some people would have about the potential infringement of civil liberties, we believe that the scale of the challenge (both technically and practically) may be considerably greater than has been assumed. The database that Lord Laming envisages would not merely be a

45 Q39
46 Q61

static register, but a highly sophisticated system that recorded the contacts of each child with health, social care, social security and education services.

70. **We believe that establishing a national database for children along the lines envisaged by the Laming Report would represent a major practical and technical challenge that should not be underestimated. However, this is not an argument for not establishing it, and we endorse Lord Laming's recommendation that there should be a feasibility study to explore the value and practicality of setting up a national database for children, and to compare the respective merits of such a system with the Government's own initiative on developing an effective Identification, Referral and Tracking system.**

'Common sense' recommendations?

71. Many of the Report's specific recommendations are extraordinarily basic. Lord Laming acknowledged that this was the case, and that he was almost embarrassed to offer some of these. However, the fact that such 'common sense' recommendations had to be made "just shows how far we are from acceptable practice at the present time", a point of view which we share. As Lord Laming pointed out, basic things such as adequate case recording are "not rocket science", but if they are *not* done, and cases are not properly monitored, there are enormous implications for the quality of practice, and the potential for harm to children at risk.

72. Other criticisms that have been made by some commentators concern the level of micro-management envisaged for directors of social services. Lord Laming rejected this interpretation and told us he was:

> absolutely staggered with people I have read saying that directors of social services cannot know every case in their area no more than a chief executive can. Where in the Report does it say the director of social services should know every case? It is impossible ... There is no question that I expect directors of social services or elected members or chief executives to know about every case. What I do expect—and this is what the Report is aiming to achieve—is that people in leadership positions should make sure that they have systems in place where, if things are going wrong, they are identified very early and they are corrected quickly.[47]

73. Lord Laming argued that the current structure and system for child protection was " far too precarious", and he was seeking to replace it with a system that would ensure things worked well at the local level.

74. Lord Laming told us that the structure he was proposing was essentially "a means to an end and I am not wedded to any particular approach." The model was, he believed, a realistic one which offered the means of providing better outcomes for children. Any alternative reforms proposed by the Government—or any one else—would, Lord Laming suggested, need to be considered in terms of their capacity to deliver a "child-centred

47 Q41

approach, accountability from top to bottom, transparency and something that has teeth to actually make things happen." [48]

75. Of all the recommendations that were made by the Inquiry, Lord Laming told us that he believed the most important to be the development of a National Agency for Children and Families "with powers not to do other people's job but to make sure other people did their job."[49]

76. **We accept, as Lord Laming has argued, that the precise structures that need to be put in place are to some extent a matter of opinion. However, we believe that the experience in Wales points to the value in pursuing the role of a Children's Rights Commissioner, and we do not believe that this role could be fulfilled by the Chief Executive of a new national agency. We also believe that it is important to recognise the primacy of addressing children's well-being, and there are risks of this becoming diluted within a general responsibility for children and families. We recommend that the Government consider, as a matter of priority, the case for establishing a Children's Rights Commissioner as part of any fundamental review of structural arrangements for child protection arising from the Laming Inquiry.**

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49 Q83

Conclusion

77. The Report of the Inquiry by Lord Laming into the death of Victoria Climbié makes for harrowing and disturbing reading. It adds to the already considerable volumes of previous inquiries into similar cases of children who have died at the hands of their parents or carers. Society can never guarantee that a child will not be harmed in this way. Victoria was murdered by deeply wicked individuals consciously acting so as to evade detection by the authorities. But society *should* be aiming to ensure that there are systems in place which detect what is happening at an early stage so as to be able to intervene successfully to protect the child. That did not happen in Victoria's case; she was failed comprehensively by all the services that should have protected her. Despite repeated contacts with different services, no proper assessment was ever undertaken, and as Lord Laming told us, no more was known about Victoria when she died than was known on her second day in the country. The fact that her case was closed by Haringey Social Services on the very day that she died points to the scale of failure. So too does the fact that the authorities charged with her care almost without exception failed to talk to Victoria directly but addressed their concerns to those responsible ultimately for killing her.

78. It is easy to be pessimistic about the problem of child protection. There is a huge amount of good practice in social work, carried out by social workers who are highly professional and devoted to their roles. Unfortunately, most of this goes unnoticed and unrewarded in the face of headline-grabbing scandals, which, although tragic, are not common and do not represent the day to day reality of the good service that the majority of social services departments deliver, often in very difficult circumstances. We are only too familiar with the legacy of past inquiries into failures, and while recognising the scale of the challenge that must be addressed if these are not to continue to recur, we nonetheless believe that the establishment of new regulatory bodies for social care—the National Care Standards Commission (and its successor body the Commission for Social Care Inspection), and the General Social Care Council, for the first time create the infrastructure for ensuring that staff are properly trained, supervised and managed. The introduction of the new three year social work degree from September 2003 is another important step towards raising standards. There is a huge amount of very good practice in social work, carried out by social workers who are highly professional and devoted to their roles, most of which goes unnoticed and unrewarded.

79. In his statement on the day of the Report's publication, the Secretary of State for Health indicated the immediate steps that the Government would take to address some of the shortcomings. We welcome the Government's readiness to modify and simplify the guidance on the Children Act. We believe that the Children Act remains relevant and would not wish to see a rush to new legislation. However, it was apparent in the evidence to the Climbié Inquiry that the Act was failing in its implementation and this must be addressed as a priority.

80. Victoria was a black child, and many of the staff who had contact with her were also black. To what extent racism may have been a contributory factor in what happened to Victoria is a centrally important question. Lord Laming told us that he found no evidence of overt racism, but what the Inquiry *did* find "was staff making assumptions that because

people originated from a particular culture that behaviour could be described as being culturally determined, when in fact they knew nothing about that culture and had never visited the country."[50] For example, the way in which Victoria 'jumped to attention' when Kouao was present was assumed by some to be a reflection of her upbringing on the Ivory Coast. In fact, the reality was quite different and Victoria had not been expected to behave in this way with her own parents.

81. In the ten years since the murder of Stephen Lawrence, and the subsequent Macpherson Inquiry,[51] the notion of 'institutionalised racism' reflected in organisational policies, practices and procedures has become familiar. The extent to which this may have contributed to a lack of recognition of what was happening to Victoria is disturbing, and is an indication of the scale of change that still needs to take place.

82. Following the death of Victoria there was considerable debate about issues of private fostering, and it was estimated that there are currently more than 10,000 West African children in this country in private fostering arrangements *who are unknown to social services*, and therefore potentially highly vulnerable. We recognise that it was assumed in Victoria's case that Kouao was her natural mother, and the issue of private fostering did not arise. As Lord Laming told us, if any one had actually made even basic enquiries "they might have discovered something quite different." **We endorse the recommendation made by the Social Care Institute for Excellence in their position paper on private fostering, that those who provide private fostering services should be subject to a registration process that, as a minimum safeguard, ensures they meet certain basic standards of care.**[52]

83. The Climbié Inquiry offers a unique opportunity to tackle the underlying issues, and a chance to ensure that we do not continue to see repeated inquiries of this nature, all identifying very similar shortcomings that need to be tackled. While very basic improvements to practice and communication continue to be necessary, we are persuaded by the Laming Inquiry that the essential deficit through the system is that of adequate management accountability. **We agree with the Inquiry Report that in future there must be 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 children." We urge the Government to put in place the necessary structural reforms to ensure this unbroken and explicit line of accountability is established as a matter of the utmost priority.**

84. **We are aware that the Government has already taken steps to implement some of Lord Laming's recommendations. However, given the gravity of the situation, we call for the Department to submit to us by the end of 2003 a memorandum indicating progress made to date in implementing each of the recommendations made in the Report.**

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51 *The Stephen Lawrence Inquiry: Report of an Inquiry by Sir William Macpherson of Cluny*, Cm 4262, London: The Stationery Office, 1999.

52 *Effectiveness of childminding registration and implications for private fostering*, Social Care Institute for Excellence, January 2003.

Conclusions and recommendations

1. The paediatric units throughout the country should be instructed to review their arrangements for ensuring continuity of care, supervision of junior medical staff and medical audit. (Paragraph 36)

2. We urge the Department of Health to examine whether current health service priorities have had deleterious effects on local priorities for children and families. (Paragraph 44)

3. We agree with the arguments made by the ADSS, and in the past by the King's Fund, that there should be an independent review of funding for social care, along the lines of the Wanless review of the NHS. We recommend that the Government should commission an urgent review of the factors influencing demand for social care for children and adults, and consider the adequacy of resources currently allocated. (Paragraph 46)

4. If, as Lord Laming believes, the Victoria Climbié case was not unique, but highlighted widespread and major deficiencies in the implementation of the Children Act, this raises issues that Government should address. We believe that the Children Act 1989 remains essentially sound legislation. However, we are concerned that the provisions of the Act which sought to ensure an appropriate response to the differing needs of children are being applied inappropriately, used as a means of rationing access to services, and have led to section 17 cases being regarded as having low priority. The Laming Inquiry recommended that consideration should be given to unifying the Working Together guidance and the National Assessment Framework guidance into a single document, setting out clearly how the sections of the Act should be applied, and giving clear direction on action to be taken under sections 17 and 47. We strongly support this recommendation. (Paragraph 49)

5. We were somewhat surprised by the methodology adopted for the second phase of the Inquiry, which appeared to us to be a particularly selective model. It seems to us that a more broadly based investigative approach might have been of greater value. Lord Laming defended his choice of method on the basis of the need to "strike a balance between a reasonable examination of the issues and the amount of time and effort and expense that would be necessary to go down other routes." In view of the arguably selective methodology used in developing the full recommendations from the Climbié Inquiry, we recommend that the Government should ensure the forthcoming Green Paper allows full consultation with the widest possible audience and stakeholders. (Paragraph 53)

6. We urge the Government to use the opportunity of its forthcoming Green Paper on children at risk to remove the increasingly anomalous reasonable chastisement defence from parents and carers in order fully to protect children from injury and death. (Paragraph 55)

7. We believe it is essential that further structural change and upheaval is not imposed unnecessarily on local government. We therefore recommend that the Government should consider carefully whether the new structure proposed by Lord Laming offers the best fit with arrangements that have emerged following the Local Government Act 2000, and whether revisions are required to ensure new national and local accountability arrangements are properly located within local government structures and mechanisms. (Paragraph 61)

8. If a child protection system has different structures, systems and functioning in different areas, this has the potential to cause serious difficulties. Any arrangement that has the potential to tackle the boundaries between health and social care, and other local services, has much to commend it, and we are interested in the role that might be played by Children's Trusts. However, the model is at present extremely vague. The guidance issued in January 2003 made it clear that there was no single approach to Children's Trusts and that a variety of models might be developed. While we recognise that this could encourage diversity and locally responsive services, we are concerned that the model is currently too vague and there is a danger of new structures and mechanisms running ahead of any coherent strategy. We recommend that the forthcoming Green Paper should provide further clarification on the contribution that might be expected of Children's Trusts, and the nature of the preferred model. (Paragraph 64)

9. The establishment of a national database for all children under the age of 16 would not necessarily in itself provide an alternative to the existing Child Protection Register, and the arguments around both of these elements need to be separated. (Paragraph 68)

10. We believe that establishing a national database for children along the lines envisaged by the Laming Report would represent a major practical and technical challenge that should not be underestimated. However, this is not an argument for not establishing it, and we endorse Lord Laming's recommendation that there should be a feasibility study to explore the value and practicality of setting up a national database for children, and to compare the respective merits of such a system with the Government's own initiative on developing an effective Identification, Referral and Tracking system. (Paragraph 70)

11. We accept, as Lord Laming has argued, that the precise structures that need to be put in place are to some extent a matter of opinion. However, we believe that the experience in Wales points to the value in pursuing the role of a Children's Rights Commissioner, and we do not believe that this role could be fulfilled by the Chief Executive of a new national agency. We also believe that it is important to recognise the primacy of addressing children's well-being, and there are risks of this becoming diluted within a general responsibility for children and families. We recommend that the Government consider, as a matter of priority, the case for establishing a Children's Rights Commissioner as part of any fundamental review of structural arrangements for child protection arising from the Laming Inquiry. (Paragraph 76)

12. We endorse the recommendation made by the Social Care Institute for Excellence in their position paper on private fostering, that those who provide private fostering services should be subject to a registration process that, as a minimum safeguard, ensures they meet certain basic standards of care. (Paragraph 82)

13. We agree with the Inquiry Report that in future there must be 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 children." We urge the Government to put in place the necessary structural reforms to ensure this unbroken and explicit line of accountability is established as a matter of the utmost priority. (Paragraph 83)

14. We are aware that the Government has already taken steps to implement some of Lord Laming's recommendations. However, given the gravity of the situation, we call for the Department to submit to us by the end of 2003 a memorandum indicating progress made to date in implementing each of the recommendations made in the Report. (Paragraph 84)

Formal minutes

Thursday 5 June 2003

Members present:

Mr David Hinchliffe, in the Chair

Mr John Austin	Dr Doug Naysmith
Sandra Gidley	Dr Richard Taylor

The Committee deliberated.

Draft Report (*The Victoria Climbié Inquiry Report*), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 84 read and agreed to.

Resolved, That the Report be the Sixth Report of the Committee to the House.

Ordered, That the provisions of Standing Order No. 134 (select committees (reports)) be added to the Report.

[Adjourned till Thursday 12 June at 10 am.

Witnesses

Thursday 27 March 2003

Reports from the Health Committee since 2001

The following reports have been produced by the Committee since the start of the 2001 Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395
Third Report	Sexual Health	HC 69
Fourth Report	Provision of Maternity Services	HC 464
Fifth Report	The Control of Entry Regulations and Retail Pharmacy Services in the UK	HC 571

Session 2001–02

First Report	The Role of the Private Sector in the NHS	HC 308
Second Report	National Institute for Clinical Excellence	HC 515
Third Report	Delayed Discharges	HC 617