THE VICTORIA CLIMBIE ENQUIRY

Report of the Director of Social Services and the Chief Executive

Recommendation(s):

I  That the Executive note the content and actions in the report.

II That Executive formally approve the immediate proposals for action within Devon.

III That Executive received regular reports on progress in responding to the recommendations made by Lord Laming.

1. Background

1.1. Victoria Climbie died on the 25th February 2000, aged 8 years, as a consequence of appalling ill-treatment at the hands of her Aunt, Marie-Therese Kouao and Carl John Manning. Both have since been convicted of Victoria’s murder and are now serving life sentences.

1.2 On the 20th April 2001 Lord Laming was appointed by the Secretary of State for Health and the Secretary of State for the Home Office to conduct three statutory inquiries into the circumstances surrounding Victoria’s death.

1.3 The Climbie report is a chastening catalogue of unrelenting institutional and individual incompetence in every agency with whom Victoria came into contact.

Prior to her death Victoria had been known to a number of statutory organisations including Social Services, Police, Health and the NSPCC because of concerns about her welfare. Despite at least a dozen opportunities over a 10 month period to take action to protect Victoria all agencies and organisations failed to do so.

1.4 The Government published Lord Laming’s Report on 20th January this year together with its initial response to the recommendations contained therein. The Government’s full response to the recommendations will be published in the Green Paper on Children at Risk, as part of its proposals for the fundamental reform of Children’s Services. This is expected in the Spring.

2. Summary of Findings - individual and organisational incompetence

2.1 The key message running through the report is that individual failings, poor standards and ineffective systems are the consequence of a failure in leadership. Senior managers in all agencies, and elected members, are responsible, and thus accountable for this failure. Lord Laming refers to the principle failure to protect Victoria was as a result of widespread organisational malaise.

“The effective safeguarding of children is a difficult and highly pressurised task. It is rendered virtually impossible if those who are charged with achieving it are not supported by proper systems and structures to work within.” (para 5.179)
Although the front-line staff who came to deal with Victoria’s case were not helped in their task by the structure in which they operated, they were, in many cases, guilty of inexcusable failures to carry out basic elements of their roles competently.” (para 5.180)

It is the job of senior officers and elected councillors to inform themselves about the quality of services being offered by their front-line staff, and to take appropriate action to remedy deficiencies as they are revealed.” (para 5.192)

2.2 The Report stresses that the protection of children is a multi-organisational responsibility and that statutory services must work in close association with community based groups. They must also be flexible in the way they work and use their resources. Eight principles are recommended on which the restructuring of services to children and families should be based. They are:

- Child and family centred
- Responsive to local needs and opportunities
- Adequately resourced
- Capable of delivering an agreed set of measurable, national outcomes for children
- Clear in its accountability from the top to the bottom of the organisation
- Transparent in its work and open to scrutiny
- Clear and straightforward to understand
- Placed on a statutory footing, with the powers to deliver the desired outcomes

2.3 The Report identified a failure of agencies to adhere to common standards in the care of children. This in part was attributable to confusion about the national guidance on child care and child protection. The result is repeated failures in basic professional practice that continued to place children at risk.

2.4 The Report highlights inadequacies in the training of front line professionals, particularly in relation to assessment, communication and joint working.

3. The Recommendations

3.1 Lord Laming’s Report makes a total of 108 recommendations covering a range of agencies and organisations. Each recommendation is required to be implemented within a timescale of either 3 or 6 months, or 2 years. The recommendations are summarised as follows:

Recommendations relating to leadership and structural change

3.2 Lord Laming has concluded that the structures within which services to children and families in need are organised are inefficient and need to change. Appendix 1 sets out the recommended new structure. A number of recommendations introduce requirements to improve the decision making and monitoring processes for the quality of service to children and families, they include:

- The establishment of a Children and Families Board chaired by a member of Cabinet rank with ministerial representation from all government departments concerned with the welfare of children and families
- The creation of a national agency for children and families reporting directly to the Children and Families Board. The post of Chief Executive of this agency should incorporate the responsibilities of the post of Children’s Commissioner for England
- The national agency will operate through a regional structure which will ensure that legislation and policy are being implemented at a local level
- Each Local Authority with Social Services responsibility must establish a Committee of Members for children and families with lay members drawn from
the Management Committees of each of the key services. The role of this Committee will be to ensure that services to children and families are properly co-ordinated and that the inter-agency dimension of this work is being managed effectively

- The Local Authority Chief Executive should establish and chair a Management Board for services to children and families which will report to the Member Committee. The Management Board should:
  - include senior officers from each of the key agencies
  - establish strong links with community based organisations
  - be responsible for the work currently undertaken by the Area Child Protection Committee
  - identify the budget contributed by each of the local agencies in support of vulnerable children and families
  - appoint a Director responsible for ensuring that inter-agency arrangements are appropriate and effective and advising on the development of services to meet local need
  - ensure that staff working in key agencies are appropriately trained and are able to demonstrate competence in their respective tasks

3.3 The majority of the recommendations concerning structural change are to be implemented within a 2 year timescale. In his initial response to the Report, the Secretary of State for Health has stated that these recommendations will be considered in the Green Paper on Children at Risk to be published in the Spring. In the meantime, the Government are pressing ahead with their proposals to establish the first generation of Children’s Trusts which mirror many of the responsibilities of the Management Board recommended by Lord Laming.

4. Professional Practice

4.1 More than half the recommendations made concern policies, procedures and practice aimed at improving the quality of performance on individual cases. Whilst these recommendations are directed towards particular agencies i.e. Social Services, Health and the Police they also impact upon the existing local multi-agency child protection system. It is important, therefore, that these recommendations are responded to in a corporate and collaborative way.

4.2 In his initial response to Lord Laming’s Report, the Secretary of State for Health has identified 46 of these recommendations which require immediate action. These are set out in Appendix 2. Social Services, Health and the Police are asked to carry out an audit, within the 3 month deadline demanded by Lord Laming, to guarantee that the basics elements of good professional practice are in place. To facilitate this process, the Social Services Inspectorate have now produced an audit tool that is required to be completed by the 30th April 2003. The SSI will then monitor performance in relation to these areas of services.

5. Initial Response in Devon

5.1 An immediate audit of the 46 critical recommendations identified by the Secretary of State for Health has been commenced in accordance with the audit tool supplied by the Social Services Inspectorate.

5.2 This audit will contribute to the requirements laid down in Recommendation 28 that the Chief Executive of the Local Authority should prepare a Position Statement on the true picture of the current strengths and weaknesses of their “front door” duty systems for children and families.

5.3 Chief officers from all the Agencies with an interest in safeguarding children in Devon have met and mandated the Devon Area Child Protection Committee to:
i) Co-ordinate the immediate requirements of the audit in order to identify the cross-cutting issues in relation to multi-agency child protection systems in Devon.

ii) Co-ordinate the response to all 108 recommendations contained within the report on behalf of all relevant agencies and organisations within Devon, as required.

iii) Feedback to a subsequent meeting of the Chief Officer Group.

5.4 A Seminar for Members and Senior Managers to be held to consider the findings and recommendations of Lord Laming’s Report and its implications.

5.5 A South West Peninsula Conference on Lord Laming’s Report to be held to which representatives of all relevant stakeholders and interested parties will be invited. This proposal is supported by all of the Directors of Social Services on the Peninsula and a Steering Group has now been formed to plan and organise the Conference.

DAVID JOHNSTONE AND PHILIP JENKINSON

Electoral Division: All

Executive Portfolio Holder (Children’s Service) Councillor John Smith
Executive Portfolio Holder (Adult Service) Councillor Lyn Gear
Recommended new structure

Ministerial Children and Families

National Agency for Children and Families (Children’s Commissioner for England)

Regional Office

Local Member Committee for Children and Families

Local Forum

Management Board for Services to Children and Families

Director of Children and Families’ Services

Social Services

Safeguarding Children

Police

Health Services

Others
Recommendation 12 Front-line staff in each of the agencies which regularly come into contact with families with children must ensure that in each new contact, basic information about the child is recorded. This must include the child’s name, address, age, the name of the child’s primary carer, the child’s GP, and the name of the child’s school if the child is of school age. Gaps in this information should be passed on to the relevant authority in accordance with local arrangements. (paragraph 17.97)

Recommendation 24 Where, during the course of an assessment, social services establish that a child of school age is not attending school, they must alert the education authorities and satisfy themselves that, in the interim, the child is subject to adequate daycare arrangements. (paragraph 4.43)

Recommendation 25 All social services assessments of children and families, and any action plans drawn up as a result, must be approved in writing by a manager. Before giving such approval, the manager must ensure that the child and the child’s carer have been seen and spoken to. (paragraph 4.52)

Recommendation 26 Directors of social services must ensure that no case involving a vulnerable child is closed until the child and the child’s carer have been seen and spoken to, and a plan for the ongoing promotion and safeguarding of the child’s welfare has been agreed. (paragraph 4.83)

Recommendation 28 The Department of Health should require chief executives of local authorities with social services responsibilities to prepare a position statement on the true picture of the current strengths and weaknesses of their ‘front door’ duty systems for children and families. This must be accompanied by an action plan setting out the timescales for remediying any weaknesses identified. (paragraph 5.9)

Recommendation 29 Directors of social services must devise and implement a system which provides them with the following information about the work of the duty teams for which they are responsible:

• number of children referred to the teams;
• number of those children who have been assessed as requiring a service;
• number of those children who have been provided with the service that they require;
• number of children referred who have identified needs which have yet to be met. (paragraph 5.24)

Recommendation 30 Directors of social services must ensure that senior managers inspect, at least once every three months, a random selection of case files and supervision notes. (paragraph 5.27)

Recommendation 31 Directors of social services must ensure that all staff who work with children have received appropriate vocational training, receive a thorough induction in local procedures and are obliged to participate in regular continuing training so as to ensure that their practice is kept up to date. (paragraph 5.30)

Recommendation 34 Social workers must not undertake home visits without being clear about the purpose of the visit, the information to be gathered during the course of it, and the steps to be taken if no one is at home. No visits should be undertaken without the social worker concerned checking the information known about the child by other child protection agencies. All visits must be written up on the case file. (paragraphs 5.108 and 6.606)

Recommendation 37 The training of social workers must equip them with the confidence to question the opinion of professionals in other agencies when conducting their own assessment of the needs of the child. (paragraph 5.138)
Recommendation 38 Directors of social services must ensure that the transfer of responsibility of a case between local authority social services departments is always recorded on the case file of each authority, and is confirmed in writing by the authority to which responsibility for the case has been transferred. (paragraph 5.52)

Recommendation 39 All front-line staff within local authorities must be trained to pass all calls about the safety of children through to the appropriate duty team without delay, having first recorded the name of the child, his or her address, and the nature of the concern. If the call cannot be put through immediately, further details from the referrer must be sought (including their name, address and contact number). The information must then be passed verbally and in writing to the duty team within the hour. (paragraph 5.69)

Recommendation 42 Directors of social services must ensure that where the procedures of a social services department stipulate requirements for the transfer of a case between teams within the department, systems are in place to detect when such a transfer does not take place as required. (paragraph 6.7)

Recommendation 43 No social worker shall undertake section 47 inquiries unless he or she has been trained to do so. Directors of social services must undertake an audit of staff currently carrying out section 47 inquiries to identify gaps in training and experience. These must be addressed immediately. (paragraph 6.1)

Recommendation 44 When staff are temporarily promoted to fill vacancies, directors of social services must subject such arrangements to six-monthly reviews and record the outcome. (paragraph 6.29)

Recommendation 45 Directors of social services must ensure that the work of staff working directly with children is regularly supervised. This must include the supervisor reading, reviewing and signing the case file at regular intervals. (paragraph 6.59)

Recommendation 46 Directors of social services must ensure that the roles and responsibilities of child protection advisers (and those employed in similar posts) are clearly understood by all those working within children's services. (paragraph 6.7)

Recommendation 49 When a professional from another agency expresses concern to social services about their handling of a particular case, the file must be read and reviewed, the professional concerned must be met and spoken to, and the outcome of this discussion must be recorded on the case file. (paragraph 6.289)

Recommendation 50 Directors of social services must ensure that when staff are absent from work, systems are in place to ensure that post, emails and telephone contacts are checked and actioned as necessary. (paragraph 6.318)

Recommendation 51 Directors of social services must ensure that all strategy meetings and discussions involve the following three basic steps:

- A list of action points must be drawn up, each with an agreed timescale and the identity of the person responsible for carrying it out.
- A clear record of the discussion or meeting must be circulated to all those present and all those with responsibility for an action point.
- A mechanism for reviewing completion of the agreed actions must be specified. The date upon which the first such review is to take place is to be agreed and documented. (paragraph 6.575)

Recommendation 52 Directors of social services must ensure that no case is allocated to a social worker unless and until his or her manager ensures that he or she has the necessary training, experience and time to deal with it properly. (paragraph 6.581)

Recommendation 53 When allocating a case to a social worker, the manager must ensure that the social worker is clear as to what has been allocated, what action is required and how
that action will be reviewed and supervised. (paragraph 6.586)

**Recommendation 54** Directors of social services must ensure that all cases of children assessed as needing a service have an allocated social worker. In cases where this proves to be impossible, arrangements must be made to maintain contact with the child. The number, nature and reasons for such unallocated cases must be reported to the social services committee on a monthly basis. (paragraph 6.589)

**Recommendation 55** Directors of social services must ensure that only those cases in which a social worker is actively engaged in work with a child and the child's family are deemed to be 'allocated'. (paragraph 6.590)

**Recommendation 56** Directors of social services must ensure that no child known to social services who is an inpatient in a hospital and about whom there are child protection concerns is allowed to be taken home until it has been established by social services that the home environment is safe, the concerns of the medical staff have been fully addressed, and there is a social work plan in place for the ongoing promotion and safeguarding of that child's welfare. (paragraph 6.594)

**Recommendation 57** Directors of social services must ensure that social work staff are made aware of how to access effectively information concerning vulnerable children which may be held in other countries. (paragraph 6.619)

**Recommendation 58** Directors of social services must ensure that every child's case file includes, on the inside of the front cover, a properly maintained chronology. (paragraph 6.629)

**Recommendation 59** Directors of social services must ensure that staff working with vulnerable children and families are provided with up-to-date procedures, protocols and guidance. Such practice guidance must be located in a single-source document. The work should be monitored so as to ensure procedures are followed. (paragraph 8.7)

**Recommendation 61** Directors of social services must ensure that hospital social workers participate in all hospital meetings concerned with the safeguarding of children. (paragraph 8.27)

**Recommendation 63** Hospital social workers must always respond promptly to any referral of suspected deliberate harm to a child. They must see and talk to the child, to the child's carer and to those responsible for the care of the child in hospital, while avoiding the risk of appearing to coach the child. (paragraph 8.100)

**Recommendation 64** When a child is admitted to hospital and deliberate harm is suspected, the nursing care plan must take full account of this diagnosis. (paragraph 9.35)

**Recommendation 66** When a child has been examined by a doctor, and concerns about deliberate harm have been raised, no subsequent appraisal of these concerns should be considered complete until each of the concerns has been fully addressed, accounted for and documented. (paragraph 9.60)

**Recommendation 68** When concerns about the deliberate harm of a child have been raised, doctors must ensure that comprehensive and contemporaneous notes are made of these concerns. If doctors are unable to make their own notes, they must be clear about what it is they wish to have recorded on their behalf. (paragraphs 9.72 and 10.30)

**Recommendation 69** When concerns about the deliberate harm of a child have been raised, a record must be kept in the case notes of all discussions about the child, including telephone conversations. When doctors and nurses are working in circumstances in which case notes are not available to them, a record of all discussions must be entered in the case notes at the earliest opportunity so that this becomes part of the child's permanent health record.
Recommendation 70 Hospital trust chief executives must introduce systems to ensure that no child about whom there are child protection concerns is discharged from hospital without the permission of either the consultant in charge of the child's care or of a paediatrician above the grade of senior house officer. Hospital chief executives must introduce systems to monitor compliance with this recommendation. (paragraphs 9.101 and 10.145)

Recommendation 71 Hospital trust chief executives must introduce systems to ensure that no child about whom there are child protection concerns is discharged from hospital without a documented plan for the future care of the child. The plan must include follow-up arrangements. Hospital chief executives must introduce systems to monitor compliance with this recommendation. (paragraphs 9.101 and 10.146)

Recommendation 73 When a child is admitted to hospital and deliberate harm is suspected, the doctor or nurse admitting the child must inquire about previous admissions to hospital. In the event of a positive response, information concerning the previous admissions must be obtained from the other hospitals. The consultant in charge of the case must review this information when making decisions about the child's future care and management. Hospital chief executives must introduce systems to ensure compliance with this recommendation. (paragraph 10.36)

Recommendation 74 Any child admitted to hospital about whom there are concerns about deliberate harm must receive a full and fully-documented physical examination within 24 hours of their admission, except when doing so would, in the opinion of the examining doctor, compromise the child's care or the child's physical and emotional well-being. (paragraph 10.41)

Recommendation 75 In a case of possible deliberate harm to a child in hospital, when permission is required from the child's carer for the investigation of such possible deliberate harm, or for the treatment of a child's injuries, the permission must be sought by a doctor above the grade of senior house officer. (paragraph 10.73)

Recommendation 76 When a child is admitted to hospital with concerns about deliberate harm, a clear decision must be taken as to which consultant is to be responsible for the child protection aspects of the child's care. The identity of that consultant must be clearly marked in the child's notes so that all those involved in the child's care are left in no doubt as to who is responsible for the case. (paragraph 10.105)

Recommendation 77 All doctors involved in the care of a child about whom there are concerns about possible deliberate harm must provide social services with a written statement of the nature and extent of their concerns. If misunderstandings of medical diagnosis occur, these must be corrected at the earliest opportunity in writing. It is the responsibility of the doctor to ensure that his or her concerns are properly understood. (paragraph 10.162)

Recommendation 79 During the course of a ward round, when assessing a child about whom there are concerns about deliberate harm, the doctor conducting the ward round should ensure that all available information is reviewed and taken account of before decisions on the future management of the child's case are taken. (paragraph 11.39)

Recommendation 81 Hospital chief executives must introduce systems to ensure that actions agreed in relation to the care of a child about whom there are concerns of deliberate harm are recorded, carried through and checked for completion. (paragraph 11.39)

Recommendation 89 All GPs must devise and maintain procedures to ensure that they, and all members of their practice staff, are aware of whom to contact in the local health agencies, social services and the police in the event of child protection concerns in relation to any of their patients. (paragraph 12.29)
Recommendation 91  Save in exceptional circumstances, no child is to be taken into police protection until he or she has been seen and an assessment of his or her circumstances has been undertaken. (paragraph 13.17)

Recommendation 92  Chief constables must ensure that crimes involving a child victim are dealt with promptly and efficiently, and to the same standard as equivalent crimes against adults. (paragraph 13.24)

Recommendation 94  In cases of serious crime against children, supervisory officers must, from the beginning, take an active role in ensuring that a proper investigation is carried out. (paragraph 13.55)

Recommendation 97  Chief constables must ensure that the investigation of crime against children is as important as the investigation of any other form of serious crime. Any suggestion that child protection policing is of a lower status than other forms of policing must be eradicated. (paragraph 14.15)

Recommendation 98  The guideline set out at paragraph 5.8 of Working Together must be strictly adhered to: whenever social services receive a referral which may constitute a criminal offence against a child, they must inform the police at the earliest opportunity. (paragraph 14.46)