THE VICTORIA CLIMBIÉ INQUIRY

Chairman: Lord Laming

SUMMARY AND RECOMMENDATIONS

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SUMMARY REPORT OF AN INQUIRY
BY LORD LAMING

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

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

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

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This Summary Report contains sections 1, 3 and 18 from the Main Report

1 Introduction

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

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

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

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

Abuse and neglect

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

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

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

Despite the valiant efforts of Dr Alsford and her team, Victoria's condition continued to deteriorate. In a desperate attempt to save her life, Victoria was transferred to the

paediatric intensive care unit at St Mary's Hospital Paddington. It was there that, tragically, she died a few hours later, on the afternoon of 25 February 2000.

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

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

Victoria's injuries

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

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

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

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

Abandoned, unheard and unnoticed

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

At no time during the weeks and months of this gruelling Inquiry did familiarity with the suffering experienced by Victoria diminish the anguish of hearing it, or make it easier to endure. It was clear from the evidence heard by the Inquiry that Victoria's intelligence, and the warmth of her engaging smile, shone through, despite the

ghastly facts of what she experienced during the 11 months she lived in England. The more my colleagues and I heard about Victoria, the more we came to know her as a lovable child, and our hearts went out to her. However, neither Victoria's intelligence nor her lovable nature could save her. In the end she died a slow, lonely death – abandoned, unheard and unnoticed.

Victoria's parents

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

What went wrong?

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

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

A lack of good practice

But Victoria's case was altogether different. Victoria was not hidden away. It is deeply disturbing that during the days and months following her initial contact with Ealing Housing Department's Homeless Persons' Unit, Victoria was known to no less than two further housing authorities, four social services departments, two child protection teams of the Metropolitan Police Service (MPS), a specialist centre managed by the NSPCC, and she was admitted to two different hospitals because of suspected deliberate harm. The dreadful reality was that these services knew little or nothing more about Victoria at the end of the process than they did when she was first referred to Ealing Social Services by the Homeless Persons' Unit in April 1999. The final irony was that Haringey Social Services formally closed Victoria's case on the very day she died. The extent of the failure to protect Victoria was lamentable. Tragically,

it required nothing more than basic good practice being put into operation. This never happened.

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

A gross failure of the system

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

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

Widespread organisational malaise

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

the complexities in Victoria's case, was not followed on the paediatric wards at the Central Middlesex Hospital and North Middlesex Hospital.

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

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

Management issues

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

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

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

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

The front-line staff of the key public services were all employees. They acted on behalf of the organisations which employed them. Those in senior positions in such organisations carry, on behalf of society, responsibility for the quality, efficiency and effectiveness of local services. I believe that several of those in such positions who gave evidence to this Inquiry, either did not understand this, or did not accept it. Front-line staff may well have a different perception of the organisation they work in from that of their senior managers. Based on the evidence to this Inquiry, the

differences could only be described as a yawning gap. The failure to grasp this was undoubtedly the fault of the managers because it was their job to understand what was happening at their 'front door'.

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

The future

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

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

Moving forward

It is important to understand what went wrong in the way individual social workers, police officers, doctors and nurses responded to Victoria's needs, and how deficiencies in their organisations contributed to this. However, this Inquiry has been more

than just a forensic exercise. It has been charged with looking forward and to make recommendations for "how such an event may, as far as possible, be avoided in the future".

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

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

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

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

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

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

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

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

Changes in services to support children

What is wrong with current arrangements?

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

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

Improvements at a national level

A Children and Families Board

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

A National Agency for Children and Families

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

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

At a local level

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

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

Committees for Children and Families

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

Management Board for Services to Children and Families

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

Accountability

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

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

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

Improvements to the exchange of information

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

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

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

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

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

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

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

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

A national children's database

Those who deliberately harm children have a tendency to cover their tracks. Poor record-keeping, doubts about the exchange of information between services, and inadequate client information systems make that easy. We live in a highly mobile society. Ninety million people pass through our ports of entry each year. Many children experience several moves. I have considered the benefits of establishing a national database on children. In the circumstances set out above, there is much to be said in favour of a database covering all children. I was told that such a database is technically feasible and that there are many much larger systems. The benefit of such

a database would be that every new contact with a child by a member of staff from any of the key services would initiate an entry that would build up a picture of the child's health, developmental and educational needs. I have recommended that the Government commission work to look into the feasibility of such a national database, and this may result in pilot studies being carried out.

Action now

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

Service funding

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

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

Nobody from these authorities could give a convincing explanation as to why services for children and families were so significantly underfunded. For example, in 1998/1999 the Brent SSA for children and families was £28 million, whereas the amount spent was just £14.5 million. Since the death of Victoria, Ealing, Brent and Haringey have increased their budgetary provision for children and families. It is my opinion that elected councillors and senior managers in these authorities allowed the services

for children and families to become seriously under-funded, and they did not properly consider the impact this would have upon their front-line services.

Eligibility criteria

The management of the social care of children and families represents one of the most difficult challenges for local government. The variety and range of referrals, together with the degree of risk and urgency, needs strong leadership, effective decision-making, reliable record-keeping, and a regular review of performance. Sadly, many of those from social services who gave evidence seemed to spend a lot of time and energy devising ways of limiting access to services, and adopting mechanisms designed to reduce service demand.

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

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

Availability of services

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

The use of agency and locum staff

The practice of using a front-line 'duty team' with agency staff is totally unacceptable. This was particularly apparent in the way Brent Social Services managed its duty

commitments. Furthermore, even the most able members of staff working on duty should at all times have access to someone dedicated to the task of managing the duty arrangements and supervising the work of the staff.

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

Training and supervision

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

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

Practice guidance and documentation

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

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

The issue of race in relation to Victoria

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

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

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

He urged the Inquiry to "keep its antennae finely tuned" to the possible effects of racial assumptions. This I have sought to do.

Conclusion

Throughout this Inquiry, it has been my firm intention to produce a report that is unambiguous, and has a set of recommendations that will strengthen the safeguards for children. It is my hope that the Report will be read in its entirety. It is only by doing this that readers will understand the full impact of the events surrounding Victoria's life and death, the inter-relationships between them, and the similarities of the issues emerging from the analysis of practice and organisational factors in the three agencies charged with Victoria's care.

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

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

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

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

2 Victoria's story

This section looks in detail at the interaction between Victoria, Kouao and Manning, and the various professionals they came into contact with during the course of Victoria's life in this country. It gives a brief account of the evidence received by the Inquiry about Victoria's background. It also looks at the way she was treated by people who were supposed to have assumed responsibility for her welfare while she was in this country.

Victoria meets Kouao

Victoria Adjo Climbié was born near Abidjan in the Ivory Coast on 2 November 1991. She was the fifth of seven children and, according to her parents, she had a healthy and happy early childhood. She started school at the age of six and showed herself to be intelligent and articulate. She seems to have been a child who stood out.

Perhaps this was why Victoria came to the attention of her father's aunt, Marie-Therese Kouao, when she turned up at the Climbié house in October 1998. Kouao had lived in France for some years but was visiting the Ivory Coast to attend the funeral of her brother. She told Mr and Mrs Climbié that she wished to take a child back to France with her and arrange for his or her education. Apparently, Victoria was happy to be chosen.

In fact, Victoria was a late substitute for another young girl called Anna whom Kouao had originally intended to take. However, Anna's parents appear to have had second thoughts. This would explain why the 'daughter' named on the French passport used by Kouao and Victoria to gain entry into the UK was called 'Anna'. This was also the name by which Victoria was known throughout her life in this country.

Victoria's parents' reasons for allowing her to travel to Europe with Kouao fall outside the Terms of Reference of this Inquiry. It is not a matter I will be dealing with, except to observe that I have seen evidence which shows that entrusting children to relatives living in Europe who can offer financial and educational opportunities unavailable in the Ivory Coast is not uncommon in Victoria's parents' society.

After leaving her parents' house, Victoria travelled first to another part of the Ivory Coast, where she stayed with Kouao's brother. Shortly afterwards, probably some time in November 1998, she and Kouao flew to Paris.

Victoria in France

Victoria spent approximately five months in France. It is possible that she lived in Rue George Meliés, Villepinte, which was the address given by Kouao to Ealing Social Services shortly after they arrived in the UK. However, on other occasions she gave a different address, in Tremblay-en-France. There is little credible evidence available concerning Kouao's background, but it appears from documents the Inquiry has seen that her husband, whom she divorced, died in 1995. Before Victoria arrived, according to French social services, Kouao lived with her three sons, claiming welfare benefits.

In the beginning, Kouao seemed prepared to honour her promise to make sure Victoria received a proper education. Shortly after her arrival in France, Victoria was enrolled at the Jean Moulin primary school in Villepinte. However, by December 1998, Kouao began to receive formal warnings from the school about Victoria's absenteeism. The situation became serious enough by February 1999 for the school to issue a Child at Risk Emergency Notification. A social worker became involved and she reported a difficult 'mother and child relationship' between Victoria and Kouao.

Some of Victoria's absences from school were justified by medical certificates, all of which said she needed to rest. When she was at school, staff worried about Victoria's tendency to fall asleep in class. As a result, the school formed the view that Victoria was clinically unwell and being monitored and treated by doctors. The head teacher, Monsieur Donnet, also recalled Kouao mentioning that Victoria was suffering from some form of dermatological condition.

Some time in the spring of 1999, Kouao gave the school notice that she was removing Victoria so she could receive "treatment" in London. The home address of Esther Ackah was given as a forwarding address. Ms Ackah was a distant relative of Kouao's and the two had been in intermittent contact for the previous two years. When Victoria went to say goodbye to her classmates on 25 March 1999, Monsieur Donnet noticed that Victoria had a shaven head and was wearing a wig.

Why Kouao decided to leave France for the UK is unclear. For a long while before leaving, she had been claiming benefits that she was not entitled to. The French benefits agency was trying to recover money for these benefits, and this could have influenced her decision.

Victoria arrives in the UK

Kouao and Victoria boarded a flight from Paris to London on 24 April 1999. They travelled on Kouao's French passport, in which Victoria was described as her daughter. The picture in the passport was not of Victoria but 'Anna', the child she had

replaced. The two children did not look particularly similar so it is likely that Victoria was made to wear a wig so she looked more like the child in the photograph.

Kouao and Victoria travelled as EU citizens, so no immigration record of their arrival exists. However, the date they travelled can be established by the airline ticket that was later shown to Ealing Social Services by Kouao as proof of her identity. Kouao also presented documentation from the French travel company that arranged the trip.

When they arrived in the UK, Kouao and Victoria went to Acton and moved into a double room in a bed and breakfast in Twyford Crescent. The reservation had been made in France and lasted until 1 May 1999.

At about 4.30pm on 25 April 1999, Victoria and Kouao paid an unannounced visit to Ms Ackah. Ms Ackah had just come home from work when she heard the doorbell ring at her house in Hanwell, west London. Victoria was introduced to her as 'Anna'. Despite being somewhat taken aback by their presence, Ms Ackah invited Kouao and Victoria inside.

The first thing Ms Ackah noticed about Victoria was that she was wearing a wig. This was also remarked upon by Ms Ackah's daughter, Grace Quansah, who joined her in a visit to see Victoria and Kouao later that day. Ms Quansah removed the wig from Victoria's head to discover that she had no hair and her scalp was covered with patchy marks. She also thought Victoria looked rather small and frail, but neither she nor her mother noticed anything inappropriate or disturbing about Victoria's behaviour or her interaction with Kouao at this stage.

The following day, Kouao and Victoria visited Ealing's Homeless Persons' Unit because they needed somewhere to live when their week in Twyford Crescent ran out. The unit agreed to provide them with accommodation in a hostel situated at Nicoll Road, Harlesden, and they moved in around 1 May 1999.

The first warning signs

Over the next few weeks, Victoria and Kouao attended Ealing Social Services several times to collect subsistence payments and, on one occasion, to complain about the standard of their accommodation. During this period, concerns first started to emerge. A number of Ealing staff who saw Kouao and Victoria together during May 1999 noticed a marked difference between Kouao's appearance (she was always well dressed) and that of Victoria (who was far scruffier). Deborah Gaunt, who saw the two of them together on 24 May 1999, went as far as to say that she thought Victoria looked like an "advertisement for Action Aid".

It is unclear how Victoria passed her days during the first month she spent in the Nicoll Road hostel. No effort was made, either by Kouao or by Ealing Social Services,

to enrol her in any form of educational or daycare activity, and there is no evidence to indicate she had any friends or playmates.

On 8 June 1999, Kouao took Victoria to a GP surgery on Acton Lane, Harlesden. Here she was seen by the practice nurse, Grace Moore. Nurse Moore did not carry out a physical examination of Victoria because she was reported not to have any current health problems or complaints. She felt there were "no child protection concerns that required follow up or reporting to other agencies".

Shortly afterwards, Victoria began to show what may have been early signs of deliberate physical harm. Ms Ackah, who had not seen Victoria since her visit six weeks earlier, bumped into her and Kouao on the street on or around 14 June 1999. Victoria was wearing a dress with long sleeves, leaving only her face and hands exposed. Ms Ackah noticed a fresh scar on Victoria's right cheek, which Kouao told her had been caused when Victoria fell on an escalator.

Victoria meets Manning

Later that same day, Victoria met Manning for the first time. He had been driving a bus boarded by Kouao four days before and the two had fallen into conversation. According to Manning, he gave Kouao his telephone number and she called him a few days later inviting him to visit her at Nicoll Road. This appears to have been the start of their relationship. It lasted until their arrest just over eight months later.

Anonymous telephone call

Ms Ackah was sufficiently concerned by what she had seen of Victoria in the street to visit Nicoll Road on 17 June 1999. She thought the accommodation was unsuitable for a child because it was dirty, cramped and ill-equipped. She also thought Victoria had lost weight since she had last seen her. A Ghanaian man was present and he told Ms Ackah he was concerned about the way Kouao treated Victoria. The following day, Ms Ackah made the first of her two anonymous telephone calls to Brent Social Services.

Victoria and the childminder

By the middle of June, Victoria was spending the majority of her days being looked after by Priscilla Cameron, an experienced, but unregistered, childminder. Kouao approached Mrs Cameron when she (Kouao) got a job at the Northwick Park Hospital on 8 June 1999. Victoria's history was taken by Dr Rhys Beynon at the Central Middlesex Hospital on 14 July 1999 from Mrs Cameron's daughter, Avril. His notes record that Mrs Cameron had been caring for Victoria for the previous five weeks. Typically, Victoria would arrive around 7am and not be picked up until the evening, sometimes as late as 10pm.

There is nothing to indicate that Victoria was treated with anything other than kindness and generosity by Mrs Cameron during the days she spent at her house. She would watch television, draw, play and often took a nap after lunch. Her English

improved and she appears to have struck up a good relationship with Mrs Cameron's adult son, Patrick, whom she showed how to dance. Mrs Cameron provided all her meals on the days Victoria came to stay.

Mrs Cameron was not greatly impressed by the way Victoria was treated by Kouao. She noticed that Kouao would often speak very harshly to Victoria. On one occasion, when Mrs Cameron mentioned to Kouao that Victoria would sometimes move household objects around when she should not, she was shocked to hear Kouao shout at Victoria that she was a "wicked girl", something she repeated on numerous occasions. Her unease was increased by a conversation she had with a woman she referred to as "Nigerian Mary", who asked Mrs Cameron what it was she said to Kouao that made her beat Victoria every night. Both Mrs Cameron and her son, Mr Cameron, recalled that Victoria would become very quiet and reserved when Kouao arrived at the house to take her home. Victoria tended to look down at the floor, rubbing her hands together, whenever Kouao was present.

On several occasions, Victoria turned up at Mrs Cameron's house with a number of small cuts to her fingers. When questioned about them, Kouao said they had been caused by Victoria playing with razor blades. Mr Cameron also noticed marks to Victoria's face, although these were not serious and he thought they could have been caused by ordinary childish rough and tumble.

Kouao and Victoria move in with Manning

Kouao's relationship with Manning developed quickly. On 6 July 1999, Victoria and Kouao moved into his flat at 267 Somerset Gardens. The flat was really no more than a small bedsit. There was a separate bathroom and kitchen area, but only one room for all three people to sleep in. The bedsit contained two sofa beds. Manning said Victoria slept on one of them, and he and Kouao slept on the other. This arrangement continued until October, when Victoria's sofa bed was thrown out and she began to spend her nights in the bathroom.

There is some evidence to suggest that Victoria's physical abuse increased considerably soon after she moved into Manning's flat. Both Ms Ackah and Mrs Cameron had seen marks on Victoria's face and fingers before July, but the injuries she was suffering from when she turned up at Mrs Cameron's house on the evening of 13 July 1999 seem to have been of a different order.

According to Mrs Cameron, Kouao was in an agitated state when she turned up on her doorstep that evening. She asked Mrs Cameron to take Victoria "for good" because apparently Manning was not prepared to tolerate Victoria living with him. Mrs Cameron refused but agreed to take Victoria in for one night because "the poor child was looking so ill". Kouao then presented Mrs Cameron with two large bags full of Victoria's clothes.

When she arrived, Victoria was wearing a baseball cap pulled down over her brow. When Mrs Cameron removed it, she saw what she took to be a burn the size of a 50 pence piece on Victoria's face. Mr Cameron also noticed three circular marks on Victoria's lower right jaw which looked to him "like injuries that had been healing for a little while". Both he and Mrs Cameron noticed Victoria's eyes were bloodshot, and Mrs Cameron also observed a loose piece of skin hanging from her right eyelid. Mrs Cameron's opinion as to the likely cause of these injuries is shown by the fact she asked Kouao who had burned and beaten Victoria. Kouao replied that all the injuries were self-inflicted.

Manning's account offers a different explanation. He said Victoria began to suffer from urinary incontinence very soon after she came to live in his flat. He told the police that this prompted him to hit Victoria. He recalled that he began by slapping her, but by the end of July he had started using his fist. It is highly likely that at least some of the injuries observed by the Camerons on the night of 13 July 1999 were the result of deliberate physical harm.

Mrs Cameron gave Victoria a clean pair of pyjamas and put her to bed. Later that evening, she heard groaning coming from the room and went in to see what was the matter. Victoria was asleep but Mrs Cameron saw that her face was swollen and her fingers were oozing pus. Mrs Cameron called her daughter Avril to come and look. They agreed that Victoria had to be taken to hospital.

The next morning, Avril Cameron took Victoria to see Marie Cader, a French teacher at her sons' school. She wanted to discover the cause of the injuries as well as get them treated. Ms Cader noticed injuries to Victoria's face and fingers, but Victoria was reluctant to talk about how she got them. She advised Ms Cameron to take Victoria to hospital.

Victoria's first visit to hospital

Ms Cameron took Victoria to the accident and emergency department of the Central Middlesex Hospital around 11am on 14 July. Victoria was seen by Dr Beynon within an hour of her arrival. Dr Beynon took a history from Ms Cameron which, together with the results of a basic examination of Victoria, concerned him enough to refer the matter to a paediatric registrar. In his view there was a "strong possibility" that this was a case of non-accidental injury.

The paediatric registrar who saw her next was Dr Ekundayo Ajayi-Obe. She performed a more extensive physical examination than Dr Beynon and discovered a large number of injuries to Victoria's body, which she recorded on a set of body maps. She formed the view that at least some of Victoria's injuries might be non-accidental. Dr Ajayi-Obe arranged for Victoria to be admitted overnight and called Brent Social Services to inform them. The police were told and Victoria was placed under police protection at 5.20pm. The medical notes record the instruction that there were to be no unsupervised visits by Victoria's mother.

That evening, a very agitated and displeased Kouao discovered from the Camerons that Victoria had been admitted to the Central Middlesex Hospital. She went to the hospital and was there when Dr Ruby Schwartz saw Victoria as part of her evening ward round. As a result of her examination that evening, Dr Schwartz concluded Victoria was suffering from scabies.

Due to the infectious nature of scabies, Victoria was nursed in isolation for the rest of her stay on the ward. Victoria was extremely distressed to see Ms Cameron leave earlier that evening, but then seemed to settle down and, apart from wetting the bed, she passed a fairly uneventful night. The next morning, after the police had withdrawn their protection, Kouao returned to the hospital and left with Victoria.

The first agency they visited on leaving hospital was Ealing Social Services' Acton Area Office. Kouao left Victoria in the waiting room on her own for over an hour, much to the annoyance of a social worker named Pamela Fortune. They spent that night in a hotel in Wembley before returning to Somerset Gardens the next day.

On the way, they stopped off at the Camerons' house to collect Victoria's clothes. Mrs Cameron tried to speak to Victoria but she would not answer her. Mr Cameron was also there and recalled that Victoria seemed "totally different" from other times he had seen her. She would not smile at him and she did not respond when he said hello to her in French. The clothes were retrieved and Kouao and Victoria left. Apart from one occasion when Mrs Cameron saw Kouao and Victoria walking together down the street, the Camerons never saw either of them again.

Victoria's second visit to hospital

Just over a week later on 24 July 1999, Victoria was back in hospital. This time it was the North Middlesex Hospital and Kouao who brought her in. Her most urgent injury was a serious scald to the face, which Kouao said was caused by Victoria placing her head under the hot tap in the bathroom to try and relieve the itching caused by scabies. According to one of the versions of events put forward by Kouao, she had been asleep in bed at around midday when a scream from the bathroom woke her up. Victoria's burns were so serious she was admitted to the paediatric ward – known as Rainbow ward – where she stayed for the next 13 nights.

At about 11pm on 24 July 1999, Dr Simone Forlee, the senior house officer who first examined her, explained the position to Haringey Social Services. A more detailed referral was made three days later by Karen Johns, an Enfield social worker based at the hospital. As a result, a strategy meeting was held at Haringey's offices on 28 July 1999 and Victoria's case was allocated to a social worker – Lisa Arthurworrey.

A number of medical staff who cared for Victoria during her stay on Rainbow ward noticed marks on her body which they considered were signs of serious deliberate physical harm. Nurse Beatrice Norman saw what she thought was a belt buckle mark

on Victoria's shoulder, and Nurse Millicent Graham noticed a mark which made her suspect Victoria had been deliberately burned. Nurse Grace Pereira, who bathed Victoria the following day, saw marks which led her to believe Victoria had been hit with a belt and bitten.

It seems Victoria had started to suffer serious deliberate harm by late July 1999. This is also indicated by her behaviour when Kouao and Manning came to visit her on the ward. She gave the impression of being frightened of them. When Kouao came onto the ward, Victoria changed from being lively and vivacious to withdrawn and timid, and the relationship between her and Kouao was recorded in the ward's critical incident log as being like that of "master and servant". On one occasion she was seen to wet herself while standing to attention in front of a seated Kouao, who was apparently telling her off.

Her reaction to Manning when he came to visit seems to have been similar. He said Victoria seemed "wary of his presence" and was anxious to keep her distance from him. Neither he nor Kouao ever brought Victoria anything in the way of clothes, food, toys or treats throughout the fortnight she spent in hospital.

When Kouao was not around, Victoria seems to have enjoyed her time on Rainbow ward. She certainly became something of a favourite of several of the nurses, including Nurse Lucienne Taub, a French speaker whom Dr Mary Rossiter, the hospital's named doctor for child protection, had asked to befriend Victoria. She liked to dress up and was given clothes to dress up in by the nursing staff. Nurse Taub would take her to see the babies in the neo-natal ward and bought her sweets and treats. According to Dr Rossiter, she was a "little ray of sunshine".

Apart from Kouao and Manning, the only other visitors Victoria received while in the North Middlesex Hospital were Ms Arthurworrey and PC Karen Jones. They visited on 6 August 1999 and, after speaking briefly to Victoria, decided it would be appropriate for her to be discharged back into Kouao's care.

The brief interlude in her life in this country during which Victoria was safe, happy and well cared for ended. She left the North Middlesex Hospital with Kouao at approximately 8pm on 6 August 1999. They went straight back to Manning's flat in Somerset Gardens where Victoria was to spend the remaining seven months of her life.

The first social worker visit

During the course of those seven months, Victoria's contact with the outside world was limited and sporadic. Professionals saw her on only four separate occasions during this period. The first two times were home visits made by Ms Arthurworrey to Somerset Gardens. The other two occasions were at the beginning of November when Kouao took Victoria to Haringey Social Services' North Tottenham District

Office. Here Kouao made, then later retracted, allegations that Victoria had been sexually harmed by Manning.

No representative from the Tottenham Child and Family Centre, to which she had been referred by Haringey Social Services on 5 August 1999, ever visited Victoria at Manning's flat. She was registered in November at the health centre that stands approximately 100 yards from Manning's flat, but she never attended it and none of the medical staff who worked there ever saw her.

The first of Ms Arthurworrey's two visits to Somerset Gardens took place on 16 August 1999, shortly after Victoria was discharged from the North Middlesex Hospital. She found her to be smartly dressed and well cared for. Victoria spent most of the visit playing with a doll – one of a number of toys seen by Ms Arthurworrey. Although Ms Arthurworrey did not talk to Victoria during the course of this visit, she formed the impression that Victoria was happy and seemed like the "little ray of sunshine" described by the nurses. As far as Ms Arthurworrey was concerned, the priority was to move Kouao and Victoria to alternative accommodation, because she did not think their current living arrangements were satisfactory.

Ms Arthurworrey did not ask Kouao how Victoria was spending her days at this stage. She was not enrolled in a school and there is no indication she participated in any form of daycare activity. Kouao no longer worked at the Northwick Park Hospital (her employment had been terminated due to prolonged absences) and so Manning's assumption that Kouao and Victoria spent most of their time in his bedsit seems correct.

Mr and Mrs Kimbidima

Some time in July, probably just before Victoria was admitted to the Central Middlesex Hospital, Kouao approached a man on the street and engaged him in conversation. They discovered that they both spoke French and the man, Julien Kimbidima, invited Kouao back to his house so that she could meet his wife, Chantal. Kouao visited the Kimbidimas again on 2 August 1999 (to celebrate their daughter's birthday) and appears to have struck up a friendship with Mr Kimbidima in particular.

Shortly after Victoria's discharge from the North Middlesex Hospital, Kouao took her to meet Mr and Mrs Kimbidima for the first time. Victoria appeared quiet and withdrawn, although she started to cry when Kouao told Mrs Kimbidima that Victoria was not her real daughter. Judging by the strength with which Kouao complained to the Kimbidimas, Victoria's incontinence had become serious by this stage.

The Kimbidimas saw Victoria several times over the following months, and Mrs Kimbidima sometimes looked after Victoria when Kouao was otherwise engaged. When at the Kimbidimas' house, Victoria would, on Kouao's instruction, sit quietly in the corner unless instructed to do otherwise. Once or twice she wet herself while at their house but she was never incontinent of faeces. According to Mrs Kimbidima,

Kouao would shout at Victoria all the time and never showed her much affection. At one stage, Kouao told her that Victoria was possessed by an evil spirit.

Victoria and the church

Kouao visited church towards the end of August and this helps explain why she began to believe Victoria was possessed. Since her arrival in the UK, Kouao had shown an interest in attending church. According to Pat Mensah, a Baptist pastor based at a church in north west London, Kouao started visiting her church on a fairly regular basis from the middle of May 1999. The move to Manning's flat in early July may have prompted her to look elsewhere. On 29 August 1999, Kouao and Victoria attended the Mission Ensemble pour Christ, a church which meets in a hall close to Borough High Street.

The pastor here was Pascal Orome. He had a detailed recollection of Victoria's appearance at this stage. Despite the season, Victoria was dressed in heavy clothing that covered all of her body apart from her head and hands. He noticed wounds on both and advised Kouao to cut Victoria's hair shorter so that the injuries to her scalp could "breathe". Kouao told him about Victoria's incontinence and he formed the view that she was possessed by an evil spirit. He advised that the problem could be solved by prayer.

Two weeks after her first visit to his church, Kouao phoned Pastor Orome and told him that, following a brief improvement, Victoria's incontinence had returned. He claims he reproached her for being insufficiently vigilant and allowing the evil spirit to return. Whatever its cause, the incontinence appears to have continued throughout the rest of September because it was in October, according to Manning, that the sofa bed Victoria had been sleeping on was thrown out and she began to spend her nights in the bathroom.

The second social worker visit

The bathroom in Manning's flat was small and the door opened out onto the living room. There was no window and, although there was a heater, it was either broken or unused. When Victoria was inside, the door was kept closed and the light was switched off. She began to spend her nights alone, cold and in pitch darkness.

However, Ms Arthurworrey noticed nothing untoward when she made the second of her two pre-announced home visits to Somerset Gardens on 28 October 1999. The purpose of her visit was to explain to Kouao that the housing application, made after the previous visit in August, had been turned down and to discuss the remaining options. Victoria seems to have been all but ignored during this visit as she sat on the floor playing with a doll. The fact that she was still not attending school was raised during the conversation, but no questions seem to have been asked about how Victoria was spending her days.

At his trial, Manning described this second visit of Ms Arthurworrey's as "a put up job". It seems that the flat had been made especially clean and tidy in preparation for the visit. This seems to be consistent with Ms Arthurworrey's evidence: she said she neither saw nor smelt any evidence of Victoria's incontinence. According to Manning, Victoria was told how to behave in front of Ms Arthurworrey. Victoria was said to be sleeping on the remaining sofa bed, with Manning and Kouao sharing a newly-purchased bed on the other side of the room. At the end of the visit, Victoria suddenly jumped up and shouted at Ms Arthurworrey. She said words to the effect that she did not respect her or her mother, and that they should be given a house. This behaviour surprised Ms Arthurworrey at the time.

During the course of their conversation, Ms Arthurworrey told Kouao that the council only accommodated children who were "at risk of serious harm" and that, in the council's view, Victoria was not at such risk. It may be no coincidence that within three days of this conversation, Kouao contacted Ms Arthurworrey to make allegations which, if true, would have placed Victoria squarely within that category.

On 1 November 1999, Kouao telephoned Ms Arthurworrey and told her that Manning had been sexually harming Victoria. Ms Arthurworrey told Kouao to come to her office. Kouao arrived with Victoria and Manning later that morning. Understandably, Ms Arthurworrey thought it would be better if Manning left. Kouao then cited three separate instances of sexual abuse. Victoria was then spoken to alone and repeated what Kouao had said, almost word for word. She appeared very anxious to be believed and both Ms Arthurworrey and the other social worker present, Valerie Robertson, thought she had been coached. However, in Ms Arthurworrey's view, Victoria did not seem to be "a particularly nervous, frightened or fearful child" on this occasion.

The short-term solution devised by Ms Arthurworrey to deal with the sexual harm allegations was to arrange for somewhere else for Victoria to stay while the allegations were investigated. A call was made to Mrs Kimbidima whom Kouao had identified as a friend who might be willing to help. It is unclear what precisely was agreed to by the Kimbidimas as a result of this telephone call. Mrs Kimbidima, whose English is far from perfect, may have initially agreed but later changed her mind having spoken about the matter to her husband. In any event, the result was that Victoria and Kouao left the office in a taxi bound for the Kimbidimas' house, but by the end of the day they were both back at Somerset Gardens.

The next day, Victoria and Kouao returned to north Tottenham to withdraw the allegations of sexual harm. They spoke to Rosemarie Kozinos who told Kouao that, despite the retraction, she and Victoria would have to live elsewhere while the matter was investigated. Kouao told Ms Kozinos that she and Victoria could continue to stay with the Kimbidimas. In fact, they simply returned to Somerset Gardens.

This was the last time any of the professionals involved in Victoria's case saw her before her admission to hospital on the night before her death. This fact, together

with the incoherence of much of Kouao's evidence – both at her trial and before the Inquiry – means that any account of the last four months of Victoria's life must partly be guesswork.

Victoria's last four months alive

It is likely that Victoria spent most of this four-month period in the Somerset Gardens flat. However, there is some evidence to suggest she made two trips to France towards the end of 1999. Manning recalled that he, Kouao and Victoria all went to Paris on or about 11 November. They stayed for a long weekend at Kouao's son's house where Victoria was allowed to sleep in a bed. Manning recalled no particular problems concerning Victoria's incontinence during the visit.

A second visit to France seems to have been made at the end of November. Following her arrest, a Eurostar ticket in Kouao's name was found at Manning's flat showing that she had travelled to Paris on 29 November 1999 and returned on 12 December 1999. No ticket was found for Victoria, but Manning was clear that she had accompanied Kouao on the trip. As he understood it, they had again stayed with Kouao's son.

Whatever the nature or purpose of these two visits to France, they appear to have made little difference to the pattern of Victoria's life when she returned to Somerset Gardens. She continued to be forced to sleep in the bath and, from November onwards, she was tied up inside a black plastic sack in an effort to stop her from soiling the bath. We know that these were her circumstances on New Year's Eve due to the disturbing entry in Manning's diary. In it he describes an argument with Kouao which ended by her returning to his flat in order to "release satan from her bag".

This refinement of the torture meant that Victoria spent extended periods lying in her own urine and faeces. The obviously corrosive effect this was having on her skin may have prompted Kouao and Manning to abandon this policy in January 2000. In his interview with the police, Manning suggested he and Kouao became worried that the condition of Victoria's skin might cause social workers to ask "undue questions". However, in his evidence to the Inquiry he was unable to remember the thinking behind the change.

Despite no longer being kept in a bag, Victoria began to spend more and more of her time in the bathroom in January 2000. Not only did she continue to sleep in the bath, but she also began to spend some of her days in it as well. This could explain why she was not with Kouao and Manning when they met Mr Kimbidima at a tube station around 16 January 2000. They told him they had left Victoria at home because her incontinence made it difficult to get things done.

At the start of the new year, Kouao and Manning began to serve Victoria her meals in the bath. This was done by placing the food on a piece of plastic, or a plastic bag, and placing it in the bath next to Victoria. She would generally be given whatever

Manning and Kouao had cooked for themselves, but by the time it reached her it was usually cold. Given that her hands were kept bound with masking tape, she was forced to eat by pushing her face towards the food, like a dog.

As well as being forced to spend much of her time in inhuman conditions, Victoria was also beaten on a regular basis by both Kouao and Manning. According to Manning, Kouao used to strike Victoria on a daily basis, sometimes using a variety of weapons. These included a shoe, a hammer, a coat hanger and a wooden cooking spoon. The forensic examination of the flat after Manning's arrest revealed traces of Victoria's blood on the walls, on his football boots and on the undersole of one of his trainers. He also admitted to sometimes using a bicycle chain.

It is unclear what Kouao's intentions were at this stage. During the course of Ms Arthurworrey's home visit on 28 October 1999, they discussed the option of returning to France. However, despite the two visits to Paris, Kouao seems to have had little inclination to return permanently. Manning was under the impression that Kouao's intention was to send Victoria back to her parents in the Ivory Coast, but despite his obvious distaste for Victoria, he said he did not push the issue.

If this was Kouao's plan, she did little to advance it and Victoria's parents were not approached to see if they would be willing to have their daughter back. Instead, Kouao kept them in complete ignorance of Victoria's condition. In early 2000, they received a Christmas card from Kouao containing several photographs of a smiling Victoria. On the back of one photograph was written in French, "She's growing up well and she finds herself … well".

Given the very limited contact Victoria had with the outside world in the weeks leading up to her death, it is difficult to identify with any accuracy the speed with which her condition deteriorated to the state she was in when admitted to the North Middlesex Hospital on 24 February 2000. The pastor from north west London, Pat Mensah, recalled that Victoria seemed "a bit poorly" when she visited Somerset Gardens on 12 February. Although she neglected to mention it in her statement, during the course of her oral evidence Ms Mensah indicated that she was sufficiently concerned about Victoria's health at this point to advise Kouao to take her to a hospital. She also advised her to take her to a church.

Victoria returns to church

There is evidence to suggest that by 19 February 2000, Victoria was very ill. On this day, which was a Saturday, Kouao took her to the Universal Church of the Kingdom of God housed in the old Rainbow Theatre on Seven Sisters Road. This was the church recommended to her by Ms Mensah during the course of her visit earlier that month. Audrey Hartley-Martin, who was assisting Pastor Alvaro Lima in the administration of the 3pm service, noticed the two of them coming up the stairs. They were shouting at each other and Victoria seemed to be having difficulty walking.

Kouao and Victoria were disturbing the service, so Ms Hartley-Martin took Victoria downstairs to the crèche. She noticed Victoria was shivering and she asked her if she was cold. Victoria replied that she was not cold but she was hungry. Ms Hartley-Martin obtained some biscuits for her and Victoria hid them in her pocket when Kouao came down to collect her. Ms Hartley-Martin said in evidence that she did not seek to ensure Victoria received any medical attention because she "was not aware that the child was ill".

At the end of the service, Pastor Lima spoke to Kouao about the difficulties she said she was having with Victoria, particularly her incontinence. He expressed the view that Victoria's problems were due to her possession by an evil spirit and said he would spend the week fasting on Victoria's behalf. He believes he made it clear that Victoria was not expected to fast herself. Kouao was advised to bring Victoria back to church on the following Friday morning. According to Pastor Lima, Friday was the day on which prayers are said for deliverance from "witchcraft, bad luck and everything bad or evil".

The events of the next week unfolded as follows. On the Sunday, Kouao and Victoria returned to the church where they were seen by Pastor Celso Junior. Apparently, Victoria was quiet and well-behaved during the visit. On Wednesday, Kouao phoned Pastor Lima in the evening and told him Victoria's behaviour had improved in that she had ceased to cover the flat in excrement. On Thursday, Kouao phoned Ms Hartley-Martin and told her that Victoria had been asleep for two days and had not eaten or drunk anything. By the evening of the same day, Kouao was sufficiently concerned to bring Victoria to the church and ask for help. Pastor Lima advised them to go to the hospital and a mini-cab was called.

Victoria's final visit to hospital

Mr Salman Pinarbasi, the mini-cab driver, was sufficiently concerned about the condition Victoria was in to take her instead to the nearby Tottenham Ambulance Station. She was then taken by ambulance to the North Middlesex Hospital and admitted to the casualty unit. On arrival, Victoria was unconscious and very cold. Her temperature was 27 degrees Celsius. Initial attempts to warm her up were unsuccessful and a paediatric consultant, Dr Lesley Alsford, was called in to take responsibility for Victoria's treatment.

Dr Alsford arrived around midnight. Her examination of Victoria was limited because her first wish was to increase Victoria's temperature, which at this point was 28.7 degrees Celsius. In any event, she could not have recorded all the injuries she saw because they were "too numerous". She formed the view that Victoria needed the type of intensive care facilities unavailable at the North Middlesex Hospital. She tried to find space in another hospital and was eventually successful. A team from the paediatric intensive care unit at St Mary's Hospital Paddington arrived at 2.30am.

Victoria was transferred to St Mary's Hospital Paddington where she remained in a critical condition with severe hypothermia and multi-system failure. The medical staff were unable to straighten her legs. Over the hours that followed, Victoria suffered a number of episodes of respiratory and cardiac arrest. Her respiratory, cardiac and renal systems began to fail. At about 3pm, Victoria went into cardiac arrest for the last time. Cardio-pulmonary resuscitation was attempted but Victoria did not respond. She was declared dead at 3.15pm on 25 February 2000. She was eight years and three months old.

The post-mortem examination

A post-mortem examination was carried out the following day by Dr Nathaniel Carey, a Home Office-accredited pathologist. He found the cause of death to be hypothermia, which had arisen in the context of malnourishment, a damp environment and restricted movement. He also found 128 separate injuries on Victoria's body, showing she had been beaten with a range of sharp and blunt instruments. No part of her body had been spared. Marks on her wrists and ankles indicated that her arms and legs had been tied together. It was the worst case of deliberate harm to a child he had ever seen.

The arrest

Kouao was arrested on suspicion of neglect at the hospital around 11.35pm on 25 February 2000. She told the police, "It is terrible, I have just lost my child." Manning was arrested the following afternoon as he returned to his flat. Both were subsequently charged with Victoria's murder and were convicted at the Central Criminal Court on 12 January 2001. Kouao and Manning are currently serving sentences of life imprisonment.

3 Recommendations

This section brings together the recommendations that are to be found in the Main Report. The way in which local authorities name committees and officers can vary. For ease of reference, the recommendations are expressed in the terms of the Local Authorities Personal Social Services Act 1970. To the left of each recommendation is an indication of the timescale for action:

1 means the recommendation should be implemented within three months.

2 means the recommendation should be implemented within six months.

3 means the recommendation should be implemented within two years.

Of the 108 recommendations in the Main Report, 46 are under '1' and a further 36 are under '2'. This means that some 82 of the recommendations could be acted upon within six months.

The paragraph numbers that follow the recommendations are cross-references to the paragraphs in the Main Report in which they can be found.

General recommendations

3 **Recommendation 1** With the support of the Prime Minister, a ministerial Children and Families Board should be established at the heart of government. The Board should be chaired by a minister of Cabinet rank and should have ministerial representation from government departments concerned with the welfare of children and families. (paragraph 17.97)

3 **Recommendation 2** The chief executive of a newly established National Agency for Children and Families will report to the ministerial Children and Families Board. The post of chief executive should incorporate the responsibilities of the post of a Children's Commissioner for England. (paragraph 17.97)

3 **Recommendation 3** The newly established National Agency for Children and Families should have the following responsibilities:

- to assess, and advise the ministerial Children and Families Board about, the impact on children and families of proposed changes in policy;
- to scrutinise new legislation and guidance issued for this purpose;
- to advise on the implementation of the UN Convention on the Rights of the Child;

- to advise on setting nationally agreed outcomes for children and how they might best be achieved and monitored;
- to ensure that legislation and policy are implemented at a local level and are monitored through its regional office network;
- to report annually to Parliament on the quality and effectiveness of services to children and families, in particular on the safety of children. (paragraph 17.97)

3 **Recommendation 4** The National Agency for Children and Families will operate through a regional structure which will ensure that legislation and policy are being implemented at a local level, as well as providing central government with up-to-date and reliable information about the quality and effectiveness of local services. (paragraph 17.97)

3 **Recommendation 5** The National Agency for Children and Families should, at their discretion, conduct serious case reviews (Part 8 reviews) or oversee the process if they decide to delegate this task to other agencies following the death or serious deliberate injury to a child known to the services. This task will be undertaken through the regional offices of the Agency with the authority vested in the National Agency for Children and Families to secure, scrutinise and analyse documents and to interview witnesses. I consider it advisable that these case reviews are published, and that additionally, on an annual basis, a report is produced collating the Part 8 review findings for that year. (paragraph 17.97)

2 **Recommendation 6** Each local authority with social services responsibilities must establish a Committee of Members for Children and Families with lay members drawn from the management committees of each of the key services. This Committee must ensure the services to children and families are properly co-ordinated and that the inter-agency dimension of this work is being managed effectively. (paragraph 17.97)

2 **Recommendation 7** 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 for Services to Children and Families must include senior officers from each of the key agencies. The Management Board 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. (paragraph 17.97)

3 **Recommendation 8** The Management Board for Services to Children and Families must appoint a director responsible for ensuring that inter-agency arrangements are appropriate and effective, and for advising the Management Board for Services to Children and Families on the development of services to meet local need. Furthermore, each Management Board for Services to Children and Families should:

- establish reliable ways of assessing the needs and circumstances of children in their area, with particular reference to the needs of children who may be at risk of deliberate harm;
- identify ways of establishing consultation groups of both children and adult users of services. (paragraph 17.97)

2 **Recommendation 9** The budget contributed by each of the local agencies in support of vulnerable children and families should be identified by the Management Board for Services to Children and Families so that staff and resources can be used in the most flexible and effective way. (paragraph 17.97)

2 **Recommendation 10** As part of their work, the government inspectorates should inspect both the quality of the services delivered, and also the effectiveness of the inter-agency arrangements for the provision of services to children and families. (paragraph 17.97)

3 **Recommendation 11** The Government should review the law regarding the registration of private foster carers. (paragraph 17.97)

1 **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)

3 **Recommendation 13** The Department of Health should amalgamate the current *Working Together* and the National Assessment Framework documents into one simplified document. The document should tackle the following six aspects in a clear and practical way:

- It must establish a 'common language' for use across all agencies to help those agencies to identify who they are concerned about, why they are concerned, who is best placed to respond to those concerns, and what outcome is being sought from any planned response.
- It must disseminate a best practice approach by social services to receiving and managing information about children at the 'front door'.

- It must make clear in cases that fall short of an immediately identifiable section 47 label that the seeking or refusal of parental permission must not restrict the initial information gathering and sharing. This should, if necessary, include talking to the child.
- It must prescribe a clear step-by-step guide on how to manage a case through either a section 17 or a section 47 track, with built-in systems for case monitoring and review.
- It must replace the child protection register with a more effective system. Case conferences should remain, but the focus must no longer be on whether to register or not. Instead, the focus should be on establishing an agreed plan to safeguard and promote the welfare of the particular child.
- The new guidance should include some consistency in the application of both section 17 and section 47. (paragraph 17.111)

3 **Recommendation 14** The National Agency for Children and Families should require each of the training bodies covering the services provided by doctors, nurses, teachers, police officers, officers working in housing departments, and social workers to demonstrate that effective joint working between each of these professional groups features in their national training programmes. (paragraph 17.114)

2 **Recommendation 15** The newly created local Management Boards for Services to Children and Families should be required to ensure training on an inter-agency basis is provided. The effectiveness of this should be evaluated by the government inspectorates. Staff working in the relevant agencies should be required to demonstrate that their practice with respect to inter-agency working is up to date by successfully completing appropriate training courses. (paragraph 17.114)

3 **Recommendation 16** The Government should issue guidance on the Data Protection Act 1998, the Human Rights Act 1998, and common law rules on confidentiality. The Government should issue guidance as and when these impact on the sharing of information between professional groups in circumstances where there are concerns about the welfare of children and families. (paragraph 17.116)

3 **Recommendation 17** The Government should actively explore the benefit to children of setting up and operating a national children's database on all children under the age of 16. A feasibility study should be a prelude to a pilot study to explore its usefulness in strengthening the safeguards for children. (paragraph 17.121)

Social care recommendations

1 **Recommendation 18** When communication with a child is necessary for the purposes of safeguarding and promoting that child's welfare, and the first language of that child is not English, an interpreter must be used. In cases where the use of an interpreter is dispensed with, the reasons for so doing must be recorded in the child's notes/case file. (paragraph 6.251)

1 **Recommendation 19** Managers of duty teams must devise and operate a system which enables them immediately to establish how many children have been referred to their team, what action is required to be taken for each child, who is responsible for taking that action, and when that action must be completed. (paragraph 4.14)

2 **Recommendation 20** Directors of social services must ensure that staff in their children and families' intake teams are experienced in working with children and families, and that they have received appropriate training. (paragraph 4.16)

1 **Recommendation 21** When a professional makes a referral to social services concerning the well-being of a child, the fact of that referral must be confirmed in writing by the referrer within 48 hours. (paragraph 4.59)

1 **Recommendation 22** If social services place a child in temporary accommodation, an assessment must be made of the suitability of that accommodation and the results of that assessment must be recorded on the child's case file. If the accommodation is unsuitable, this should be reported to a senior officer. (paragraph 4.77)

1 **Recommendation 23** If social services place a child in accommodation in another local authority area, they must notify that local authority's social services department of the placement. Unless specifically agreed in writing at team manager level by both authorities or above, the placing authority must retain responsibility for the child concerned. (paragraph 4.82)

1 **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 4.143)

1 **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 4.152)

1 **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 4.183)

2 **Recommendation 27** Chief executives and lead members of local authorities with social services responsibilities must ensure that children's services are explicitly included in their authority's list of priorities and operational plans. (paragraph 5.4)

2 **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 remedying any weaknesses identified. (paragraph 5.9)

2 **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)

1 **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)

2 **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)

3 **Recommendation 32** Local authority chief executives must ensure that only one electronic database system is used by all those working in children and families' services for the recording of information. This should be the same system in use across the council, or at least compatible with it, so as to facilitate the sharing of information, as appropriate. (paragraph 5.46)

3 **Recommendation 33** Local authorities with responsibility for safeguarding children should establish and advertise a 24-hour free telephone referral number for use by members of the public who wish to report concerns about a child. A pilot study should be undertaken to evaluate the feasibility of electronically recording calls to such a number. (paragraph 5.71)

2 **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)

1 **Recommendation 35** Directors of social services must ensure that children who are the subject of allegations of deliberate harm are seen and spoken to within 24 hours of the allegation being communicated to social services. If this timescale is not met, the reason for the failure must be recorded on the case file. (paragraph 5.127)

1 **Recommendation 36** No emergency action on a case concerning an allegation of deliberate harm to a child should be taken without first obtaining legal advice. Local authorities must ensure that such legal advice is available 24 hours a day. (paragraph 5.128)

2 **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)

1 **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 5.152)

1 **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 5.169)

1 **Recommendation 40** Directors of social services must ensure that no case that has been opened in response to allegations of deliberate harm to a child is closed until the following steps have been taken:

- The child has been spoken to alone.
- The child's carers have been seen and spoken to.
- The accommodation in which the child is to live has been visited.
- The views of all the professionals involved have been sought and considered.
- A plan for the promotion and safeguarding of the child's welfare has been agreed. (paragraph 5.187)

2 **Recommendation 41** Chief executives of local authorities with social services responsibilities must make arrangements for senior managers and councillors to regularly visit intake teams in their children's services department, and to report their findings to the chief executive and social services committee. (paragraph 5.193)

1 **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)

2 **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 6.12)

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)

1 **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)

1 **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 6.71)

3 **Recommendation 47** The chief executive of each local authority with social services responsibilities must ensure that specialist services are available to respond to the needs of children and families 24 hours a day, seven days a week. The safeguarding of children should not be part of the responsibilities of general out-of-office-hours teams. (paragraph 6.181)

1 **Recommendation 48** Directors of social services must ensure that when children and families are referred to other agencies for additional services, that referral is only made with the agreement of the allocated social worker and/or their manager. The purpose of the referral must be recorded contemporaneously on the case file. (paragraph 6.263)

1 **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)

1 **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)

1 **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)

2 **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)

1 **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)

2 **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)

1 **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)

1 **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)

2 **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)

1 **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)

2 **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)

2 **Recommendation 60** Directors of social services must ensure that hospital social workers working with children and families are line managed by the children and families' section of their social services department. (paragraph 8.19)

1 **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)

2 **Recommendation 62** Where hospital-based social work staff come into contact with children from other local authority areas, the directors of social services of their employing authorities must ensure that they work to a single set of guidance agreed by all the authorities concerned. (paragraph 8.53)

1 **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)

Healthcare recommendations

1 **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)

2 **Recommendation 65** When the deliberate harm of a child is identified as a possibility, the examining doctor should consider whether taking a history directly from the child is in that child's best interests. When that is so, the history should be taken even when the consent of the carer has not been obtained, with the reason for dispensing with consent recorded by the examining doctor. *Working Together* guidance should be amended accordingly. In those cases in which English is not the first language of the child concerned, the use of an interpreter should be considered. (paragraph 9.39)

1 **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)

2 **Recommendation 67** When differences of medical opinion occur in relation to the diagnosis of possible deliberate harm to a child, a recorded discussion must take place between the persons holding the different views. When the deliberate harm of a child has been raised as an alternative diagnosis to a purely medical one, the diagnosis of deliberate harm must not be rejected without full discussion and, if necessary, obtaining a further opinion. (paragraph 9.65)

1 **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)

1 **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. (paragraph 9.95)

2 **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)

2 **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)

1 **Recommendation 72** No child about whom there are concerns about deliberate harm should be discharged from hospital back into the community without an identified GP. Responsibility for ensuring this happens rests with the hospital consultant under whose care the child has been admitted. (paragraph 9.105)

2 **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)

1 **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)

1 **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)

1 **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)

1 **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)

1 **Recommendation 78** Within a given location, health professionals should work from a single set of records for each child. (paragraph 11.39)

1 **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)

1 **Recommendation 80** When a child for whom there are concerns about deliberate harm is admitted to hospital, a record must be made in the hospital notes of all face-to-face discussions (including medical and nursing 'handover') and telephone conversations relating to the care of the child, and of all decisions made during such conversations. In addition, a record must be made of who is responsible for carrying out any actions agreed during such conversations. (paragraph 11.39)

2 **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)

2 **Recommendation 82** The Department of Health should examine the feasibility of bringing the care of children about whom there are concerns about deliberate harm within the framework of clinical governance. (paragraph 11.39)

2 **Recommendation 83** The investigation and management of a case of possible deliberate harm to a child must be approached in the same systematic and rigorous manner as would be appropriate to the investigation and management of any other potentially fatal disease. (paragraph 11.53)

3 **Recommendation 84** All designated and named doctors in child protection and all consultant paediatricians must be revalidated in the diagnosis and treatment of deliberate harm and in the multi-disciplinary aspects of a child protection investigation. (paragraph 11.53)

3 **Recommendation 85** The Department of Health should invite the Royal College of Paediatrics and Child Health to develop models of continuing education in the diagnosis and treatment of the deliberate harm of children, and in the multi-disciplinary aspects of a child protection investigation, to support the revalidation of doctors described in the preceding recommendation. (paragraph 11.53)

3 **Recommendation 86** The Department of Health should invite the Royal College of General Practitioners to explore the feasibility of extending the process of new child patient registration to include gathering information on wider social and developmental issues likely to affect the welfare of the child, for example their living conditions and their school attendance. (paragraph 12.29)

3 **Recommendation 87** The Department of Health should seek to ensure that all GPs receive training in the recognition of deliberate harm to children, and in the multi-disciplinary aspects of a child protection investigation, as part of their initial vocational training in general practice, and at regular intervals of no less than three years thereafter. (paragraph 12.29)

3 **Recommendation 88** The Department of Health should examine the feasibility of introducing training in the recognition of deliberate harm to children as part of the professional education of all general practice staff and for all those working in primary healthcare services for whom contact with children is a regular feature of their work. (paragraph 12.29)

2 **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)

2 **Recommendation 90** Liaison between hospitals and community health services plays an important part in protecting children from deliberate harm. The Department of Health must ensure that those working in such liaison roles receive child protection training. Compliance with child protection policies and procedures must be subject to regular audit by primary care trusts. (paragraph 12.57)

Police recommendations

1 **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)

1 **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)

1 **Recommendation 93** Whenever a joint investigation by police and social services is required into possible injury or harm to a child, a manager from each agency should always be involved at the referral stage, and in any further strategy discussion. (paragraph 13.52)

1 **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)

3 **Recommendation 95** The Association of Chief Police Officers must produce and implement the standards-based service, as recommended by Her Majesty's Inspectorate of Constabulary in the 1999 thematic inspection report, *Child Protection*. (paragraph 13.66)

2 **Recommendation 96** Police forces must review their systems for taking children into police protection and ensure they comply with the Children Act 1989 and Home Office guidelines. In particular, they must ensure that an independent officer of at least inspector rank acts as the designated officer in all cases. (paragraph 13.68)

2 **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)

1 **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)

3 **Recommendation 99** The *Working Together* arrangements must be amended to ensure the police carry out completely, and exclusively, any criminal investigation elements in a case of suspected injury or harm to a child, including the evidential interview with a child victim. This will remove any confusion about which agency takes the 'lead' or is responsible for certain actions. (paragraph 14.57)

3 **Recommendation 100** Training for child protection officers must equip them with the confidence to question the views of professionals in other agencies, including doctors, no matter how eminent those professionals appear to be. (paragraph 14.73)

3 **Recommendation 101** The Home Office, through Her Majesty's Inspectorate of Constabulary, must take a more active role in maintaining high standards of child protection investigation by means of its regular Basic Commands Unit and force inspections. In addition, a follow-up to the *Child Protection* thematic inspection of 1999 should be conducted. (paragraph 14.132)

3 **Recommendation 102** The Home Office, through Centrex and the Association of Chief Police Officers, must devise and implement a national training curriculum for child protection officers as recommended in 1999 by Her Majesty's Inspectorate of Constabulary in its thematic inspection report, *Child Protection*. (paragraph 15.16)

3 **Recommendation 103** Chief constables must ensure that officers working on child protection teams are sufficiently well trained in criminal investigation, and that there is always a substantial core of fully trained detective officers on each team to deal with the most serious inquiries. (paragraph 15.24)

3 **Recommendation 104** The Police Information Technology Organisation (PITO) should evaluate the child protection IT systems currently available, and make recommendations to chief constables, who must ensure their police force has in use an effective child-protection database and IT management system. (paragraph 15.40)

2 **Recommendation 105** Chief constables must ensure that child protection teams are fully integrated into the structure of their forces and not disadvantaged in terms of accommodation, equipment or resources. (paragraph 15.45)

2 **Recommendation 106** The Home Office must ensure that child protection policing is included in the list of ministerial priorities for the police. (paragraph 15.46)

2 **Recommendation 107** Chief constables and police authorities must give child protection investigations a high priority in their policing plans, thereby ensuring consistently high standards of service by well-resourced, well-managed and well-motivated teams. (paragraph 15.46)

2 **Recommendation 108** The Home Office, through Centrex, must add specific training relating to child protection policing to the syllabus for the strategic command course. This will ensure that all future chief officers in the police service have adequate knowledge and understanding of the roles of child protection teams. (paragraph 15.53)