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SPEECH by LORD LAMING 25 JANUARY 2003.

In January 2001 Marie Therese Kouao and Carl Manning were convicted at the Central Criminal Court of the murder of Victoria Climbié. The Government announced its intention to establish an independent inquiry. In April 2001 I was appointed by the Secretary of State for Health and the Home Secretary to conduct three independent statutory inquiries under the Children Act 1989, The National Health Act 1977 and The Police Act 1996. Together these inquiries would be known as the Victoria Climbié Inquiry. The Terms of Reference required me both to investigate how the relevant statutory authorities had discharged their duties to Victoria and her carers, and also to make recommendations as to how the safeguards for children should be strengthened so that, and I quote, "as far as possible, events of this kind can be avoided in the future."

I chaired this Inquiry with the assistance of four professional assessors Dr. Adjaye, Mrs. Kinnair, Mr. Fox and Mr. Richardson. From the outset we were committed to this Inquiry being open, rigorous and fair. For this reason I decided that evidence should be taken in public. 277 witness statements were admitted as evidence and 158 witnesses were required to come to the Inquiry to give evidence. I am grateful to all those witnesses, and the seminar participants, whose co-operation was so crucial to the work of this Inquiry. I well understand that giving evidence in public before an Inquiry of this nature can be an exacting experience. Each evening a transcript of our proceedings was placed on the Inquiry website. I am delighted to say that the website has so far been accessed well over 3 million times which reflects the interest which many individuals and agencies have taken in the work of the inquiry.

We were also concerned to ensure that in formulating recommendations the Inquiry was not limited to the consideration of one case and the performance of a few agencies in North London. For this reason I decided that the Inquiry should have a second phase consisting of a series of seminars including people from all over the country and from a wide variety of backgrounds. Again, transcripts of the seminars were placed on the website. I was struck by the extent to which many of the concerns identified during Phase 1 of the Inquiry were confirmed by the

Seminar participants. Having listened to this broad cross-section of opinion I am in little doubt that none of the agencies engaged in the protection of children in this country can afford to be complacent about the standards of service they provide, although clearly some are doing very much better than others.

Victoria Climbié was born near Abidjan in Ivory Coast on 2 November 1991. She was the fifth of seven children. She progressed well. She was intelligent, articulate and enthusiastic. In October 1998 Kouao, who was her great aunt, came to Abidjan and offered to take Victoria to live with her in France where she promised to provide her with an education. Victoria's parents agreed and Victoria lived with Kouao in France until 24th April 1999 when the two of them travelled to England. Victoria travelled on Kouao's French passport, named as her daughter. Victoria lived in this country until her death on 25th February 2000.

During this gruelling Inquiry our increasing familiarity with the suffering experienced by Victoria did not make it easier to endure. I will not dwell on it. Suffice to say that at the end Victoria spent the cold winter months, bound hand and foot, in an unheated bathroom, lying in the cold bath in a plastic bag in her own urine and faeces and having to eat what food she could get by pressing her face onto the plate of whatever was put in the bath beside her. Little wonder that at the time of her last admission to hospital her body temperature was so low it did not register on a standard thermometer and her legs could not be straightened. So in a few months this once lively, bright and energetic child had been reduced to a bruised, deformed and malnourished state in which her life ebbed away because of the total collapse of her body systems. As the very experienced pathologist Dr Carey told us; "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 just about the worst I have ever heard of."

I well recognise that the frontline services charged with the protection of children have a difficult and demanding task. Adults who deliberately harm, neglect or exploit the vulnerability of children often go to great lengths to conceal their behaviour. Sometimes they can be very threatening and menacing to staff and they are often deceitful when questioned about their activities. The staff involved in this work have to tread a careful line between respecting the rights of parents and acting to protect a child from harm. It is work which demands not only great skill but also personal qualities including persistence and courage. I also acknowledge that it is work which is often done in the context of strict financial constraints. I was told at various stages during the Inquiry, often no doubt with some justification, that the services concerned were under-resourced.

One of the most striking features of Victoria's case, however, was the sheer number of occasions when the most minor and basic intervention on the part of the staff concerned could have made a material difference to the eventual outcome. In some cases nothing more than a manager reading a file, or asking a straightforward question about whether standard practice had been followed, may have changed the course of these terrible events.

Nor was Victoria hidden from view such that great time or resources would have been necessary in order to discover her needs. On the second day she and Kouao were in this country Kouao and Victoria visited the homeless persons unit in the London Borough of Ealing. In the months which followed Victoria was known to no fewer than four social services departments, three housing departments, two specialist child protection teams of the metropolitan Police. Furthermore, she was admitted to two different hospitals because of concerns that she was being deliberately harmed and was referred to a specialist Children and families centre managed by the NSPCC. All of this between 26th April 1999 and 25th February 2000.

What transpired during this period can only be described as a catalogue of administrative, managerial and professional failure by the services charged with her safety.

In Ealing the practice guidance available to front line staff when they came to deal with Victoria was so out of date that it pre-dated the Children Act 1989, that is before Victoria was born.

In Brent, Victoria's case was given no fewer than 5 "unique" reference numbers. Retrieving files, I was told, was like the national lottery, and with similar odds.

In the 7 months Haringey was responsible for the protection of Victoria the few conversations between her and her social worker hardly progressed beyond "Hello, how are you?" After her death Haringey could not even secure Victoria's file with the result that vitally important sections of it went missing.

A Police Officer in the Brent Child Protection Team placed Victoria under police protection without her having been seen; without the person who took her to hospital being interviewed and without Kouao being informed. The next day police protection was removed before any investigation had been carried out.

In Haringey, a police officer in the specialist team was fully aware that Victoria had been discharged from hospital to a house she was not prepared to visit because of her fears of the danger to her own health.

In neither the Central Middlesex Hospital nor the North Middlesex hospital was a full evaluation of

Victoria's needs completed and Victoria was discharged with no follow up in place despite continuing concerns about her welfare.

On the 5 August 1999 Victoria was referred to a specialist Children and Families Centre managed by the NSPCC yet no attempt was made to contact Victoria before she died some 6 months later.

The procedures devised by Enfield Social Services for use by social workers at the North Middlesex Hospital were a mess, and social workers had deliberately withdrawn from vital meetings concerning the welfare of children.

On each occasion that Victoria was admitted to hospital vitally important information went unrecorded and staff failed to act on their suspicions and observations. Telling marks on Victoria were seen and then all but ignored.

On the last occasions that the Haringey social worker visited Victoria's house and left, thinking that she had moved back to France, Victoria was in all probability a few yards from her, tied up in the bath, and in a desperate state, no doubt hoping that even at that late stage someone would do something to save her.

Haringey Social Services closed Victoria's case, no further action needed, on the very day that she died.

The dreadful reality is that although Victoria was in contact with all of the key services, at the end, little more was known of her needs than when she was first seen in Ealing some 10 months earlier. None had any idea what a day in the life of Victoria was like.

Ladies and gentlemen I could go on at great length but you will find these instances, and very many others like them, set out in more detail in the report. Let me simply say at this stage that the failure to protect Victoria by the agencies involved in this Inquiry was a disgrace. My colleagues and I found listening to it, day after day during this Inquiry, a thoroughly dispiriting experience.

Before leaving this matter it is right that a contrast is made between what went before with that of the great skill and dedication shown, at the end, by the hospital staff and the police first in trying to save Victoria's life and then in conducting a very successful criminal investigation of her murder. Alas it was then too late for Victoria but, I and my colleagues, pay tribute to the staff involved at this later stage.

Whilst it is easy to condemn the poor practice that was so apparent in Victoria's case, it is harder to understand how it could have been allowed to occur. It is with this question that much of the

report is concerned. This is important not least because I have concluded that the current legislative framework is fundamentally sound. I am persuaded that the gap is in its implementation. Having considered all the evidence it is not to the hapless front-line staff that I direct most criticism for the failure to protect Victoria. True their performance often fell well short of an acceptable standard of work. But the greatest failure rests with the senior managers and members of the organisations concerned whose responsibility it was to ensure that the services they provided to children such as Victoria were properly financed, staffed and able to deliver good quality services to children and families. The front-line staff were all employees acting on behalf of the organisations which employed them. Those in senior positions carried, on behalf of us all, the responsibility for the quality, efficiency and effectiveness of the services delivered. They must be accountable for what happened. That is why their posts exist.

Alas far too often that simple and easily understood fact was either not understood or not accepted by those in these top positions. Too often they attempted to distance themselves from matters of service delivery. Too often they claimed to be ignorant about what happened at the front door. Too often they attempted to justify their position in terms of bureaucratic activity rather than in outcomes for children. I am in no doubt that this Inquiry Report must have as its primary objective that it will bring about a major change in the way these key public services are managed. No longer should it be possible for senior staff to make a defence for service failure out of what often seemed to be inward looking and self serving procedures.

No-one who has followed this Inquiry can be left in any doubt about the importance of sound administration. But this is a means to an end. I have made it plain that if ever a tragedy of this kind happens again I hope those in leadership roles will examine their positions before they look more widely. Those who are either unwilling or unable to accept the public accountability which is part and parcel of senior management must be replaced. Bureaucratic activity cannot be a safe haven for poorly performing managers.

As is clear from the transcripts of the seminars conducted during phase 2 of the Inquiry, many of the concerns identified in Victoria's case are replicated elsewhere in the country. I heard nothing to persuade me that the deficiencies identified should be viewed as unique or that their significance extends no wider than the area of North London in which Victoria lived. As a result, I have considered how the services charged with the protection of children might be better organised throughout the country. I make clear in the report why I conclude that the well-being and safety of children cannot be achieved by one agency acting alone, but will continue to depend upon each of the key agencies fulfilling their distinctive and separate duties. More

exhortation that services should work better together manifestly is not enough. Actual change is required if the safety and welfare of children is not to depend to an unacceptable degree on the personal working relationships of individual professionals.

In order to achieve the level of change I consider to be necessary I advance three basic propositions. First, there must be a fundamental change in the capacity of the management in each of these key public services. No longer should inadequate delivery of services to vulnerable people be tolerated. The performance of each manager, and those in positions of leadership, must be judged by the quality of services delivered at the front door. Second, there must be a clear and unambiguous line of managerial accountability from top to bottom. There should be no hiding place for managers if a tragedy of this kind were to happen again. They must ensure that services are properly funded and adequately staffed to deliver services in a consistent and competent manner. The public need to be reassured that children at risk will be safeguarded. Third, the current arrangements of Area Child Protection Committees, depending as they do on goodwill and best endeavours, should be replaced by a new National Agency for children and families with powers to ensure that all of the key services carry out their duties in an efficient and effective way.

The achievement of these objectives calls for some radical changes. I recommend that, with the support of the prime minister, a ministerial committee for services to children and families be set up at the heart of government. This committee should be chaired by a minister of cabinet rank and be responsible for ensuring that policies, legislation and departmental initiatives affecting children and families are properly considered, financed and co-ordinated.

Reporting to the new ministerial committee should be a new national agency for children and families responsible for advising on policy and practice at a local level and reporting to Parliament on a regular basis on the quality and effectiveness of local services to Children and Families. The Chief Executive of this agency could include the functions of a Children's Commissioner for England.

At a local level every local authority with social services responsibilities should appoint a member committee for children and families and members should be drawn from each of the key services of Education, Police, Probation, Health, Primary Care, Social Services etc.

Reporting to this committee must be a local board of management for services for children and families, chaired by the chief executive and with senior managers from each of the key services. The management board must identify the needs in their area, the resources available to meet

those needs and to be accountable for the quality of the outcomes for children.

A director of services for children and families must report to the board on the effectiveness of the services, the flexibility of the ways in which the resources are being used and the effectiveness of the inter-agency collaboration.

I hope that never again will any senior manager or member be able to say "But I did not know. Nobody told me."

But ladies and gentlemen, this report is not primarily about a change in due course. On the contrary, it is an agenda for action now. It contains some 108 recommendations. Of those, 46 should be implemented in 3 months and a further 36 in 6 months. So before those in senior management positions across all the services think about their summer holidays, they have before them a challenging programme of work. Some of the recommendations are disarmingly self-evident. That they have had to be made should be a reproach to everyone with responsibility for the safety of children. Now is the time for every senior manager in these key public services to conduct a thorough audit of the quality and effectiveness of services to children and families and to have in place before summer an action plan to speedily remedy any defects. Nothing less will do.

This Inquiry has been a most arduous task. I readily pay a warm tribute to Mr and Mrs Climbié who were present throughout Phase 1. They displayed both courage and dignity at all times. The best that we can hope for from the terrible ordeal suffered by Victoria, who was brought to this country for a better life, is that this Report is the last of its kind and that, in future, the aspiration of the legislation will be reflected in day by day practice across the country. That is the challenge to us all.

Finally may I pay a very warm and deserved tribute to each of the staff who have worked with me on this Inquiry. It has been a real team effort. Special thanks are due to the four Professional Assessors whom I introduced earlier, the Secretary to the Inquiry Mandy Jacklin, Counsel to the Inquiry Neil Garnham QC and the Inquiry's Solicitor, Michael Fitzgerald. I am indebted to those who have helped me produce this report. I hope it will be well read, and will promote better and safer services for children and families, Also I hope it will be used in the training of staff not least as a stark warning of the damage that can be done to children as a result of bad practice. Too many inquiries have had to be held following terrible harm to a child. I and my colleagues hope that this will be the last.



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