



The Victoria Climbié Inquiry report

## Key findings from the self audits of NHS organisations, social services departments and police forces

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Acting Chief Executive,  
Commission for Health Improvement

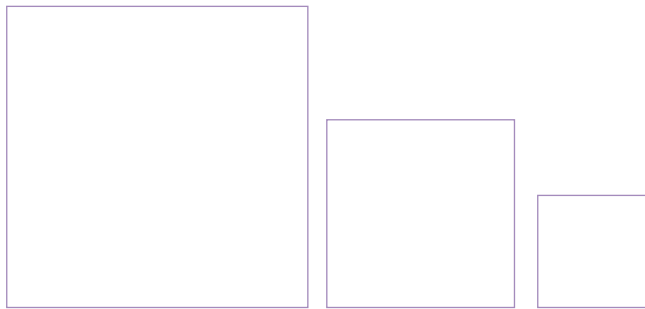


Her Majesty's Chief  
Inspector of Constabulary

**SSI** *Social Services  
Inspectorate*

Acting Chief Inspector  
of Social Services





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# 1 Introduction

Victoria Adjo Climbié died in the intensive care unit at St Mary's Hospital Paddington on 25 February 2000. She was eight years old. Victoria had suffered months of appalling ill treatment by her great aunt Marie-Therese Kouao and Carl John Manning. Both were later sentenced to life imprisonment.

Victoria's untimely death was not the first in such circumstances. The Secretary of State for Health and the Home Secretary, therefore, appointed Lord Laming to conduct an inquiry into the circumstances surrounding Victoria's death and to recommend action to improve child protection in England. The Victoria Climbié Inquiry report was published in January 2003.

Lord Laming was particularly concerned about the low priority given to child protection by the agencies involved with Victoria and strongly criticised people in senior positions who denied their own responsibility. Many of the 108 recommendations in his report aimed to improve accountability for child protection. Many were also concerned with basic good practice.

The Secretaries of State sent checklists of the relevant practice recommendations to all 625 NHS organisations and 150 councils with social services responsibilities in England, and to all 43 police forces in England and Wales. The Commission for Health Improvement (CHI), Her Majesty's Inspectorate of Constabulary (HMIC) and the Social Services Inspectorate (SSI) were asked to audit the implementation of these recommendations. All of the organisations concerned completed self audits. The results represent the first large scale audit of child protection arrangements.

CHI, HMIC and SSI each produced a report on the findings of the audits which they presented to ministers in relevant departments.

This is a report of joint key findings from the three inspectorates. It will be distributed to all relevant agencies, so that they can consider the implications and learn the lessons from the Victoria Climbié Inquiry.

## 2 Managing individual cases

Lord Laming made many recommendations about the handling of individual cases where neglect or abuse are suspected. Particular concerns were: obtaining and recording relevant information about the child; referral and communication between different agencies; carrying out prompt and effective assessment and investigations; and timely recording and auditing of decisions and actions.

The audits found examples of arrangements for managing individual cases that appear to work well, including:

- the use of innovative systems by some NHS organisations for accessing information about a child and for flagging up concerns
- common referral arrangements in many cases, agreed through the Area Child Protection Committee. However, the extent to which they are monitored varies
- the use of common paperwork and consistent use of the Framework for the Assessment of Children in Need and their Families between agencies in a number of areas

We were concerned to note, however, that:

- some NHS organisations have only limited access to the child protection register and to previous case notes
- referral may not always happen as quickly as it should. Only a third of councils say they normally receive written confirmation of referrals within 48 hours. Police forces currently have little way of knowing if concerns are reported immediately by social services where a criminal offence is suspected, although all social services say this usually happens
- social services report variations in the effectiveness of discharge arrangements from hospitals in child protection cases. Procedures for discharging children in need may need strengthening. There were also concerns about arrangements for children in hospitals outside the social services area in which they live



- there may be an over reliance in some areas on the use of police protection powers, which may not always be in the best interests of children. Some police forces have not issued updated guidance on police protection powers to operational staff
- communication with children is not always a priority. Access to interpreting services for children whose first language is not English varies. Some councils do not include children's views and wishes in assessments as a matter of course
- there is a high level of unallocated child protection cases in a few social services departments
- the majority of police forces have issued guidance on investigations involving child victims. These should be dealt with promptly, efficiently and to the same standard as cases involving adult victims. However, guidance mostly relates to intra familial abuse rather than extra familial abuse, which is mainly dealt with outside child protection units. There is little auditing of allegations involving child victims
- where the police and social services carry out joint investigations, supervisory staff involvement is sometimes affected by capacity. A few councils report problems with not having enough qualified staff to carry out enquiries involving joint interviewing
- record keeping needs improvement generally. Common problems in the NHS include timeliness, variable quality and lack of monitoring. Social services need to record and monitor decision making by staff and managers

### 3 Organisations' arrangements for child protection

The audits showed that there were positive things happening in relation to child protection arrangements. In particular:

- there are dedicated and professional people throughout the audited services who give priority to protecting children
- policies, procedures and staff guidance for child protection generally exist throughout the NHS, social services and the police. There are, however, some exceptions
- there are many examples of action plans for improvement in child protection services stimulated by the Victoria Climbié Inquiry. In some cases, partner organisations have collaborated to draw up a joint action plan
- the audits themselves appear to have raised the profile of child protection in all organisations, especially at senior levels, including non executive directors and councillors. There is evidence of organisations carrying out detailed work and involving staff at all levels in the audits

However, we are concerned to note that there is too much variation in the services provided by NHS organisations and that this potentially puts children at risk. Similarly, SSI considered that 67 social services departments (45%) could not be judged to be serving most or all children well.

Particular aspects that need attention are:

- dedicated NHS children's units or police child protection units have a clear focus on child protection issues, but this focus is not always evident in parts of the organisation that work primarily with adults
- there is a plethora of plans for children's services, both within and between agencies, some of which need to be better coordinated. These plans do not necessarily include child protection as a priority
- systematic review of policies and procedures is sometimes lacking. In addition, not all staff have seen, or have access to, child protection guidance, particularly guidance produced by Area Child Protection Committees

- the extent to which organisations monitor and audit compliance with policies and guidance varies considerably in the NHS, social services and the police
- the lack of clarity about strategic health authorities' and primary care trusts' (PCTs) responsibilities for performance management in child protection. PCTs in particular need to increase their understanding of the responsibilities of independent contractors and to clarify their role in relation to them
- not all NHS boards demonstrate sufficient awareness of, or responsibility for, child protection issues. In local government, the frequency and nature of information provided to councillors about child protection cases or issues also varies considerably

## 4 Joint working

Improving cross agency working and communication was a particular concern arising from the Victoria Climbié Inquiry. The audits reveal that organisations have mixed views about the effectiveness of cross agency and partnership working.

On the positive side:

- there are many references in the audits to working with a wide range of organisations in the public services and in the voluntary sector
- a range of fora exist, in addition to Area Child Protection Committees, to bring together senior management and professional staff of different agencies. How well these fora interact is not always clear
- there are examples of joint working, including jointly funded posts, shared locations, coordinated training plans and shared training, and a few examples of joint monitoring of practice
- Area Child Protection Committee guidance is generally widely (but not comprehensively) disseminated among relevant local organisations. Social services departments often mention that there is an agreed process for revising this guidance
- there are examples of coordination of procedures across Area Child Protection Committees where agencies cover several council areas, such as in London

However, the audits also show that there are aspects of joint working that require development, including:

- some NHS organisations felt that joint working was an important area for improvement, but believed their ability to influence day to day working in other organisations was limited
- the role and membership of Area Child Protection Committees varies and members' accountabilities are sometimes unclear

- there is often confusion about what information can be shared between agencies, and about compliance with human rights legislation, data protection regulations and Caldicott guidelines on patient confidentiality. Social services mention that some GPs are unwilling to share information about adult family members
- obtaining information in a consistent way on children from overseas, and their legal circumstances, is a particular problem for social services
- most councils have clear arrangements to track children in child protection cases who transfer in and out of social services areas. However, arrangements for children in need are less developed
- inter agency auditing is not well developed yet

## 5 Staff management and training

Skilled and competent frontline staff, adequate managerial support and professional supervision are crucial elements in child protection. The Victoria Climbié Inquiry highlights the importance of high quality practice underpinned by effective management.

We have already noted that there are many skilled and dedicated people working in the organisations audited.

However, organisations sometimes experience problems with recruiting appropriately skilled staff and ensuring that new recruits are properly checked. In particular, we noted:

- some vacant key posts and shortages of skilled and qualified staff. This can cause delays in allocating complex cases that need to be handled by skilled staff
- an over reliance on short term agency staff and unqualified staff in some councils
- inconsistent checking of new recruits with the Criminal Records Bureau, and of professional clinical staff with their statutory professional body. NHS organisations employ large numbers of short term agency and temporary staff but not all of the organisations make checks on these staff as a matter of course

Recruitment difficulties and a lack of managerial capacity have had a knock on effect on supervision and support for staff that handle child protection cases or investigations. We noted:

- a number of police forces say they do not have the capacity to ensure that a supervisor oversees every referral where a child victim is concerned. Some supervisors have high workloads themselves because of staff shortages within child protection teams
- not all NHS organisations have appointed named or designated doctors, nurses and midwives (where relevant) for child protection. These people play an important part in advising and supervising other staff. However, providing protected time for child protection professionals to carry out these roles can be a problem

There appears to be a considerable amount of training available in child protection. We noted in particular:

- good examples of child protection training plans that include systematic training needs assessment and induction training. However, in a significant proportion of cases there is a lack of earmarked funding for these plans
- clear training pathways for social services staff to ensure that they are appropriately trained before being allocated child protection cases
- guidance on and training in the exercise of police protection powers in most police forces. A few police forces mention providing joint training with social services to improve understanding of police protection powers. There has been a general improvement in training for child protection staff

However, we also noted the following areas for development:

- the provision of multiagency training varies and some key partners are not always included, for example staff from ambulance trusts
- there are problems in providing training for staff employed by agencies and induction for staff recruited from overseas
- systems are needed for monitoring the take up of training and the effect of training on practice
- take up of child protection training by key people varies, especially GP take up of PCT led training

## 6 Looking to the future

The audits found many examples of good practice in the protection of children. They also revealed some significant areas for development, as summarised in the previous sections of this report. This work will be followed up by further audits, assessments and inspection activity to stimulate continuous improvement.

However, responsibility for making improvements rests with the organisations themselves.

We were encouraged to see that many NHS organisations intend to take action in areas where they rate themselves as weakest, often on a multiagency basis. More than three quarters of councils are judged to have either excellent or promising capacity for improvement. HMIC is providing feedback to all police forces on the audits and will continue to monitor those forces that don't appear on course to meet the Laming recommendations within the timescales.

In addition, we encourage Area Child Protection Committees and individual agencies to address the issues identified by the audits in the light of these broader findings. They need to consider what action they will take to ensure they respond to the needs of vulnerable children and demonstrate tangible progress over time.

*"It is [our] hope 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."*

The Victoria Climbié Inquiry report, p16









