A management solution to keeping children safe

Can agencies on their own achieve what Lord Laming wants?

Ian Sinclair and John Corden

This paper was written shortly after the publication of the Laming Report and before the publication of *Every Child Matters*. Much that has happened since then has addressed the concerns we raised. To bring the paper up to date with these developments would require rewriting it altogether. That said, it is, perhaps, not merely of historical interest. Those reading it may like to consider two issues. First, how far have services in fact moved to address the concerns we outline? Second, how far do services continue to be dogged by an unrealistic desire to eliminate risk? Insofar as the paper prompts these reflections, it will have met its authors' aims.

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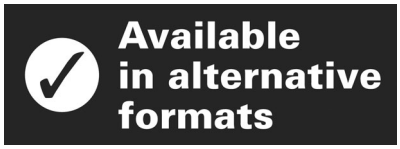

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Introduction

In the introduction to his report, Lord Laming succinctly describes the tragedy of Victoria Climbie:

> The purpose of this enquiry has been to find out why this once happy, smiling, 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 enquiry, 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.
> (Laming, 2003, para. 1.1)

The horror of these events dominates Lord Laming's report. It is a moral document written with vehemence and clarity, and dealing with questions of guilt, innocence, responsibility and blame. In general, it locates the causes of the tragedy in the behaviour of particular people, rather than in general social conditions. Certainly, it identifies wider corporate failings: inadequate resources, poor organisation, poor leadership. In the main, however, such failures are laid at the door of chief executives or other senior officers. This analysis influences the recommendations he makes.

In essence, Lord Laming believes that the social services departments (SSDs) in touch with Victoria should have identified her as a child at serious risk. They failed to do so because of the bad practice of individuals. The risk of such poor practice can be greatly reduced by organisational safeguards and by making clear the accountability of individuals. By identifying clear lines of responsibility, providing appropriate training and putting in place appropriate monitoring and procedures, individual bad practice will be avoided or at least identified before it does harm. A high-level government board will be created to ensure that these reforms are implemented. In this way, and through actions that can be taken by identified departments, tragedies such as that of Victoria will be prevented.

In seeking to contribute to the debate following this report, our own position is in some ways similar to that of Lord Laming. We accept that many of the actions taken proved subsequently to have been wrong. We do not argue that what happened to Victoria was defensible or that the practice relating to her care was of an adequate standard. We share Lord Laming's sense of outrage at the working conditions experienced by the social workers and their managers in some of the authorities he so strongly criticises. Nevertheless, while agreeing with Lord Laming on these points, we also stress others. These lead us to very different conclusions.

In the first place, we argue that some judgements were reasonable in the light of what the professionals knew at the time and the demands on their organisations. To have acted otherwise would have been, as it were, to detain all those with flu-like symptoms on the grounds that they might have SARS. This would have hospitalised enormous numbers of people who did not have SARS, ensured that those with possible symptoms would think twice about approaching health services and consumed great quantities of resources. Such wide-ranging intrusions into personal freedoms are rarely acceptable in western democratic societies, except at times of acute crisis or panic. Agencies have to take risks and make over-optimistic assessments to keep the demands on their resources within bounds. They have to conduct their affairs within legal constraints and adapt their approach to the sensitivities of those approaching them. These points apply to all agencies and social workers. They are not specific to those involved in this case.

In the second place, we argue that Lord Laming suggests there should be a more suspicious approach to clients and a greater readiness to report any possible criminal offences to the police. In our view, this risks alienating the clients, infringing their human rights, jeopardising preventive and collaborative work with them, increasing costs and delays, and generating an unmanageable workload. More generally, we believe that the recommendations will tend to make things worse, make no impact or provoke different but equally negative outcomes for children in different parts of the child-welfare system.

Our own contrary view emphasises the importance of trust. We argue that the effective monitoring of children is crucially dependent on the 'ordinary' settings in which they may be – particularly schools and childminders – where trust may grow in the context of daily interaction. We argue against strict top-down control of social work – a currently distrusted profession. In our view, such an approach is ineffective, not supported by the evidence of this case and inimical to professional practice. We argue that, the less social workers have to act as police informants and defenders of scarce resources, the easier it will be for them to create the trusting, collaborative relationships with clients on which effective prevention and intervention rests. These

things will come about only if social services have a manageable role and adequate resources to fulfil it. This in turn depends on appropriate relationships with others such as childminders in day-to-day touch with children.

In order to make these arguments we need to review:

- what happened
- whether the assumptions on which the professionals acted were reasonable
- what predisposed them to make these assumptions
- how this influenced the interaction between the professionals and the other key actors
- how far the report's recommendations would make such events less likely
- what different or additional recommendations might be made.

What happened?

Victoria Climbie came to Europe from the Ivory Coast to get a better education. She arrived with her great aunt, an EU citizen who lived in France. The pair travelled, however, as mother and daughter. After living for five months in France they came to England, possibly in order to escape the French authorities, which were trying to reclaim benefits that had been incorrectly paid.

The first contact between Victoria and the British welfare agencies was through Ealing homeless persons' unit. Ms Kouao presented herself and Victoria at the unit as homeless. The unit placed them in a hostel in the borough of Brent. Ealing social services subsequently had contact with them on 17 occasions. The focus of the contact was on Ms Kouao's need for subsistence payments, which she received, and her wish for better housing, which she did not.

While they were in the hostel, a distant relative, with whom Ms Kouao had made contact in London, made two anonymous telephone calls to Brent social services. In these, she expressed her own and her neighbours' concerns about Victoria, stating that she was wetting herself, had a cut on her face apparently caused by a fall on an elevator, was not going to school and was living in a hostel 'surrounded by drug

addicts'. Brent social services failed to efficiently record and collate this information. Nevertheless, two social workers eventually called at the hostel to check out the situation. By that time, Victoria and her great aunt had gone. On being told this by people around the hostel, the social workers left and took no further action.

Unfortunately, Victoria's new environment was not an improvement on her last. Ms Kouao's boyfriend, Carl Manning, with whom she was now living, objected to Victoria and in particular to her incontinence. Hardly a week after moving in with him, Ms Kouao asked Victoria's childminder, Mrs Cameron, to care for Victoria on a long-term basis. Seeing that Victoria was ill, Mrs Cameron arranged for someone to talk to her in French and then took her to the hospital. By this time, Victoria was very poorly, with bruises all over her body including her back and cuts to her face.

Brent social services were informed and, in spite of various mismatches of information, the duty manager linked this referral with the family whom other social workers had been sent to locate, without success, earlier in that day. Victoria was made the subject of a police protection order and a child protection investigation was initiated. Before any enquiries were undertaken, however, the paediatric consultant overruled her registrar and concluded that Victoria was a child with scabies and not a victim of non-accidental injury. Rather than challenge this decision, the social workers and police officers called off the investigation and took no further action.

Within ten days of her discharge from one hospital, Victoria was back in another. On this occasion, Ms Kouao took Victoria herself, explaining that the child had been scalded when she put her own head under a hot tap to treat itching. As before, the first doctors to see Victoria strongly suspected physical abuse. The police were again alerted. However, the conclusion from the second admission was rather unclear. The consensus seemed to be that Victoria was a neglected child who was being emotionally maltreated and that this might have included some physical abuse. In keeping with this, the emphasis was on her emotional problems of 'anxious attachment'. Even at this stage, there was no clear medical diagnosis of non-accidental injury to Victoria.

These conclusions were insufficiently strong to support urgent police action. They were sufficient to raise Victoria's priority with Haringey social services department, into whose area Ms Kouao had moved when accepting Mr Manning's offer of accommodation. The priority, however, was not raised very much. The SSD did not feel the case justified a child protection conference. A strategy meeting was held and child protection enquiries were initiated. Progress, however, was desultory. The strategy meeting set no dates for completing the recommended actions. Almost none of them were carried out.

The SSD also allocated a long-term social worker to the case. She instigated two contacts with Ms Kouao and Victoria at an interval of more than two months. Four days after the second of these encounters Ms Kouao and Victoria alleged that Mr Manning had sexually abused Victoria. This allegation was retracted almost immediately but a further strategy meeting ensued. This produced similar recommendations to the first. However, the retraction of the allegations persuaded the workers that Victoria was being coached as part of a strategy to obtain housing. This undermined any enthusiasm they might have had for pursuing S.47 enquiries. The recommendations of the second strategy meeting were as little pursued as those of the first.

Instead, the social worker wrote somewhat belatedly to Ms Kouao. She made various abortive telephone calls and visits in an attempt to contact her and Mr Manning. She also checked with a family friend and a school in an attempt to find out if they were still there. None of this bore fruit. It was concluded that Ms Kouao and Victoria had gone. There was no subsequent contact with them. Approximately four months later Victoria was dead.

The ‘reasonableness’ of the workers’ interpretations

A striking feature of this history is the consistency with which the same hypothesis was adopted by almost all of the professionals in contact with Victoria. The French authorities, all three social services departments and, with some exceptions, the key professionals in the hospitals all agreed on the salient facts. There was a housing problem, a ‘difficult mother–daughter relationship’ and Victoria was not going to school. By the end, the ‘poor mother–daughter relationship’ was being redefined as emotional abuse leading to ‘attachment difficulties’. Even then, Victoria was not seen as in danger of starvation and death.

This story must prompt other professionals to contradictory reactions. They may ask the following questions.

- How could the workers have been so negligent and incompetent?
- Why should we all share the blame for these mistakes?

At the same time they may feel that ‘there but for the grace of God go I’.

Forced day by day to listen to the appalling details of this case, it was only natural that Lord Laming should adopt the less sympathetic of these interpretations. How right was he to do so? To answer this question, we need to distinguish the events before the hospital admissions and those after. It is easier to make a case for the reasonableness of the workers' actions in the earlier period.

A distinction also needs to be drawn between the reasons behind the workers' actions and the reasonableness of what they did. The reasons behind their actions are a matter for speculation. They may have been good or bad. Our case is only that many of their actions were reasonable, in the context of what they knew at the time. For substantial periods during the management of the case, the social workers did not have the information to conclude without doubt that Victoria was being ill-treated. They gambled on the most optimistic interpretation of the information and got it wrong. Social workers (and other professionals) are frequently faced with the need to evaluate the level of risk in situations where they have only partial knowledge. A proportion of the judgements they make in such situations will always turn out to be mistaken.

Interpretations before the admissions

According to Lord Laming, it should have been clear from the beginning that Victoria was a child at risk. It was probable that she was not genuinely Ms Kouao's daughter. Her skin colour was lighter and she looked different from the passport photograph. Ms Kouao's story was implausible. She had a poor relationship with Victoria, showed no concern for her welfare, coached her in what she was to say and failed to enrol her in school. Victoria was badly dressed and under-developed, and therefore neglected. The cut on her forehead was a mark of physical abuse. All this should have triggered a full enquiry under S.47 of the Children Act.

Even with hindsight, the features noted by Lord Laming are hardly conclusive. The French social worker and French and British Passport authorities had all accepted that Victoria was Ms Kouao's daughter. Many children are a different colour from their mothers and are not particularly like their passport pictures. Victoria's stunted growth was not much of a sign either. She had only one year's developmental delay. None of the doctors or the practice nurse who were to see Victoria before she was admitted to hospital close to death reported evidence that she was suffering from malnutrition. The 'mother–daughter' relationship may have been difficult. However, short episodes of conflict, emotional rejection or 'anxious attachment' are difficult to interpret when the child comes from a foreign culture and is being used to support an application for benefit. As for the cut on her face, an explanation was offered for this.

In listing these features of Victoria's case, Lord Laming ignored others that might suggest a different interpretation. Ms Kouao was also an immigrant in difficulty. In this position she had to get work, hence perhaps her need to be well presented while Victoria was not. She had to make the best case she could for housing, hence perhaps the inconsistencies in her story. She had to reinforce her case, hence perhaps her use of a solicitor to pressurise social services and her coaching of Victoria. Finding a school for Victoria was not a priority. The accommodation was temporary and hopefully she would soon move and need to change schools. All this might suggest that Ms Kouao was a well-intentioned woman struggling to look after her child in difficult circumstances. As we have seen, this interpretation prevailed.

It remains possible that, when the family first came to Britain, this interpretation was true. In the report, Ms Kouao is portrayed as an evil figure whose motives, while obscure, are probably quite unlike those of the rest of us. Nevertheless, it appears that she had brought up her own children without obvious mishap. She was said to have had a difficult relationship with Victoria in France, but she was not obviously abusing her there.

Why did Ms Kouao behave as she did? Let us speculate. Like other immigrants, but perhaps with a more fragile personality than most, Ms Kouao is likely to have been stressed by living in a new country. When it turned out that Victoria did not provide a passport for housing, she became less useful to her. Victoria was enuretic and Ms Kouao's new boyfriend did not want her in the house. So Victoria may have become a scapegoat for the frustrations of both. Slaps developed into assaults, as Victoria appeared indifferent to pain but the behaviour that the slaps were intended to reduce persisted. An explanation for this intransigence offered itself. Victoria was inhabited by Satan. Religious rather than medical remedies were then sought.

Our case is not that this explanation is true, only that it is possible. This hypothesis would suggest that Victoria's situation deteriorated over time as a result of Ms Kouao's reaction to stress and the involvement of Manning. The situation encountered by workers in the early stages of the family's arrival in the UK would thus not have been the same as the situation that Haringey social workers failed to address in November 1999.

Contact with Mrs Ackah who made the anonymous telephone calls might have made a difference. However, the essential point made in these calls was that Victoria's injuries reflected her housing situation. In this way, they could have been seen as part of the case for rehousing. Contact with the childminder, Mrs Cameron, would almost certainly have made a difference. However, the authorities were as unaware of her existence as they were of Mrs Ackah's address.

As a result, the social workers who did eventually visit the hostel seemed to believe that they were dealing with a family with problems of accommodation and housing rather than a possible child protection referral (para. 5.108). Had they located Victoria and her great aunt, they might have been able to re-examine their belief, but they did not have this opportunity.[1]

Events after the admissions

The result of the two hospital admissions was that the story communicated to social workers remained effectively unchanged. Victoria's poor clothing was now placed in a rather wider context of 'neglect'. The poor mother–daughter relationship first noticed by the French social worker was now put in the much stronger context of 'emotional abuse'. It was also associated with attachment behaviour. There was a suspicion of some physical abuse but no more. Many children can be described in this way. Hardly any of them die within a few months of the description.

The failure to identify physical abuse was indeed surprising. Nurses and the junior doctors responsible for admitting Victoria had described abundant evidence of serious physical assaults. Particularly on the second occasion, Ms Kouao's account was quite inadequate to explain the injuries. Even if it had been adequate, the changes she made to her story, and the interval between the events and Victoria's admission to hospital should have aroused suspicion.

The simplest explanation is that both the two senior doctors made mistakes. Both were experienced. The first consultant had examined Victoria with particular care. At this stage she already had bruises, which, implausibly, were accepted in the doctor's assessment as having arisen through 'rough and tumble' and other historical factors (para. 9.43). Our own view is that the hospital's interpretation was not reasonable. This, however, raises the question of whether social services should have challenged it.

Lord Laming's view is that Victoria's injuries were now so blatant that social services should have challenged the doctors' interpretation. The example given is that of a broken leg. When a break is manifest, even a lay person is entitled to assert it. In this case, however, the injuries were not manifest to the social workers. They were not entitled to examine the skin lesions and say whether or not these were scabies. They were entitled to think that any injuries that were so manifestly non-accidental and had been closely examined by a doctor would be identified as such. In this sense, their acceptance of the doctors' view was not unreasonable. The priority they gave the case may be criticised. The judgement on which they based it was not perverse.

Why were social services likely to make these judgements?

Clearly, social services were not compelled to judge as they did. They could, from the beginning, have judged as Lord Laming thinks they should. We look below at some possible reasons for their over-optimistic view.

Organisational malaise

Lord Laming's report devotes considerable space to describing the office tensions and poor relationships between managers and staff in each of the four local authorities, two hospitals and two police child protection teams. A range of different organisational cultures are identified, all of them inimical to the development of a culture of independent and questioning professional autonomy and responsibility.

In Ealing, we read of serious rivalry between the team manager and the senior practitioner; of seriously inadequate administrative resources and procedures; and of a defensive and siege mentality towards incomers from other countries, seeking access to the very limited resources of a London borough.

In Brent, the picture is, if anything, worse: there is a history of chronic, long-term under-funding of children's services, a chaotic system of administration, little value given to the skills of social workers and heavy dependence on agency workers, many of whom were themselves recruited from other countries and were thus having to familiarise themselves with local practice.

In Enfield, there is confusion about the role of hospital social workers, who do not even attend key hospital meetings and whose management is the subject of a territorial dispute; there is a poor relationship with their neighbouring authority, from whose area many of their hospital patients are admitted.

In Haringey, the situation is dire. Social workers receive no effective supervision. The social worker supervising Victoria received three supervision sessions in the seven months in which she held the case. All were conducted by different managers. Most of the discussion seems to have involved the worker in bringing the managers up to date with developments. Apart from this, there is evidence of a complete absence of workload management, a chronic suspicion of the role of the police in child protection, reluctance to co-operate with paediatricians and poor case-file management.

Lord Laming is very critical of these situations. He points up the absence of proper supervision and the chaotic and disorganised arrangements for managing information, and communicating with other agencies. He identifies the failures on the part of local authorities to spend on their children's services the amounts recommended by the Government. Nevertheless, he continues to think that individual workers should have got it right.

How far can this organisational malaise explain the tragedy? Clearly, the effects of working under such pressure, and with so little supervision and for such apparently uncaring authorities, is likely to corrode employee commitment to sound professional standards and to compromise their ability to carry out their core tasks. This is strongly to be deplored. In addition, we do feel that the lack of urgency given to the case in its later stages was a critical feature of the organisational malaise present in Haringey. Having decided that the case was worthy of a strategy meeting there was everything to be said for proceeding with dispatch and determination.

In practice, Victoria was 'on the books' of a social worker for 211 days, seen on only four occasions and on only two of these seen on her own. Social workers had no idea of how she spent her days. Instead, she remained 'on the back burner', a hostage to fortune, a source perhaps of background anxiety and a child whom no one seems have seriously and imaginitively considered. All these are points well made in the report. They are also plausibly attributed – at least in part – to a lack of 'organisational grip'.

That said, this organisational perspective does not, in our view, take us very far.

First, there is no evidence that Haringey – the department most strongly criticised – was, *in general,* badly organised. The Social Services Inspectorate (SSI) had collaborated in a very positive joint review of the department not long before Victoria died. It provided a second, much more critical review of childcare practice soon after Victoria's death. Lord Laming, having finally extracted the papers relating to the first report from his successor as Chief Inspector, notes negative points made in its text. Nevertheless, the joint report makes strong positive references to senior management and the overall grip they were getting on the department.

Second, for reasons given above, we do not agree that the judgements made by social workers were unreasonable. We do think that senior doctors made mistakes. The most serious of these was made by a doctor who examined Victoria carefully, had available information about her admission and concluded that she had scabies. It is not obvious that this judgement resulted from organisational malaise.

Third, we think that social services, however well organised, have to err on the side of optimism. This is the point we argue below.

Need of organisations to take risks

SSDs are expected to provide a widely accessible service. This aspiration was implicit in the Seebohm Report (1968). It is embodied in the concept of a 'child in need', originally envisaged as a child who was in the kind of temporary difficulty that may afflict any family, although subsequently interpreted as being in a rather more serious predicament. In practice, the service offered is not widely accessible. Studies from different periods suggest that up to four out of ten of those referred may have no face-to-face contact with a social worker within four weeks of referral (Thoburn *et al*., 2000), that only 15 per cent of child abuse referrals make it to a child abuse conference (Gibbons *et al*., 1995), that child protection investigations may alienate families and rarely lead to substantive help, and that only around 3 per cent of those referred have a full assessment as defined by the Department of Health (Cleaver, personal communication). In practice, around 60 per cent of the money spent by social services on children goes to children looked after, and more than half of this to the small minority in residential care (for varying estimates, see Sinclair and Gibbs, 2002, p. 132; also Department of Health, 2002).

This extreme 'funnelling' can be achieved only if social services are prepared to take risks. The cases of many children who may be being abused must be ignored, closed prematurely or given ineffectual surveillance. In most cases, on the laws of probability, no catastrophic harm will occur. In a few cases, however, the decision will be found to have been over-optimistic with dire consequences for the individual and the employing agency. What is at issue is pattern recognition and probability. All children are at some risk of being abused. However, for administrative purposes, SSDs like to categorise cases as either 'child protection' (high priority) or 'child in need' (low priority). What is a matter of probability is thus treated as a 'matter of fact'.

Some examples from other fields may help to make this point clearer. In practical matters, it is usually the case that one is not operating on the basis of certainty. For example, in screening for cancer, criminal trials or the assessment of business plans, some judgements that are 'reasonable' on the evidence available will not turn out as predicted. There is a 'trade-off' between identifying false 'positives' (e.g. identifying cancer, criminality or business winners where the judgements turn out to be 'wrong') and 'false negatives' (i.e. missing people with cancer, letting off criminals and turning down good investment opportunities). The balance that is struck between these different kinds of risk has implications for cost. The best way of identifying all

criminals who are charged is to convict anyone who is charged. This would involve great expense on prisons and the like. The least expensive way would be to convict no one.

For these reasons, self-interest would seem to encourage a cautious approach. Cases should not be closed until it is apparent that all is well. Such an approach would, however, ensure two things.

- The numbers requiring a full or core assessment would escalate dramatically. Lord Laming recommends that current practices of filtering out many referrals at an early stage to avoid the need for a full investigation should be abandoned (Recommendations 25, 26, 34, 35, 40). This will result in a substantial increase in the number of S.47 enquiries, child protection conferences and core assessments.

- Each investigation would have a finite probability of, rightly or wrongly, detecting abuse. The numbers found to require looking after would increase proportionately. There is widely believed to be a serious shortage of foster carers in many areas of the country, and certainly in parts of London. Recruitment of greater numbers would almost certainly require a considerable increase in their fees and allowances.

This need to increase resources would conflict with the need to limit demands – a central theme of Victoria's story. Ealing chose to temporarily subsidise the family. Their basic conclusion was that the family had made themselves intentionally homeless and would be a continuing drain on the department's resources. The best and cheapest course was to persuade them to go back to France. Brent seemed equally reluctant to take responsibility for homeless families from other boroughs, preferring if possible to move them out of their own area for financial reasons. Learning that Victoria had gone, they needed little incentive to close the case. A central concern of the second supervisor involved in Haringey was to weed out low-priority cases – hence the closure of Victoria's case around the time she died.

Lord Laming recognises the potential costs of his recommendations but holds fast to a belief that 'doing simple things well' may actually save money. In this belief he ignores important features of the situation.

- *The cost of raising the number of 'correct identifications':* if all those referred to social services were regarded as potential abusers, all those who were actually abusing would be identified. However, the cost would be very great and many of those not abusing would be investigated. Any substantial increase in the numbers suspected would similarly lead to a substantial increase in costs.

- *The cost of community interventions:* identification without action has no point. Serious problems in families can arguably be addressed through intensive focused interventions (Pithouse and Lindell, 1995; Webster-Stratton, 1998; Aldgate and Bradley, 1999; Berry *et al.*, 2000; Thoburn *et al.*, 2000; McCartt Hess *et al.*, 2000). Such interventions are costly in terms of both money and professional time.

- *The consequent cost of prevention:* preventive measures are costly not because community care costs more than foster care but because of difficulties in accurate identification and effectiveness. If it were true that all those at serious risk of entering care could be identified then preventive measures could be targeted at a relatively small number of children. If all of these could be prevented from entering the care system the cost of prevention could well be lower. In practice, preventive work typically fails to target a high proportion of risk and is of unknown efficacy. As a result, money is spent on children who would not in any case have become looked after and children who are in the event looked after.[2]

In our view, serious attempts to reduce the numbers abused through the kind of mechanisms proposed by Lord Laming will bear fruit only if accompanied by a large increase in the numbers in the care system, a sharp rise in the scale of provision and a dramatic increase in costs.

Other reasons for taking risks

There are other reasons for taking risks. Any decision to leave a child at home involves some element of risk. This is a risk social workers want to take. They are encouraged to work in partnership with families (Department of Health and Social Services Inspectorate, 1995; Department of Health *et al.*, 2000). Moreover, they also encounter the failures of the care system to protect children from further emotional damage, and even abuse, on a regular basis.

This professional stance is reinforced by legal requirements. The Children Act requires local authorities to promote the upbringing of children by their families (S.17 [1] [b]), so far as this is consistent with the duty to safeguard and promote their welfare. In care proceedings, courts have to be satisfied that making an order is better than making no order. The obligations imposed by the Human Rights Act 1998 are also believed to make it more difficult for social workers to take preventive action, as illustrated by Mr. Justice Munby's recent ruling that:

> Councils taking babies from mothers at birth, before the case against them was proved, had to allow the parents daily contact and let the mothers breastfeed. Nothing less would 'meet the imperative demands of the European Convention on Human Rights'.
> (*The Guardian*, 16 April 2003)

Given the difficulty of taking drastic action, social workers have to tread softly with their clients. To imply that a parent is failing may destroy the possibility of voluntary collaboration without acquiring the statutory power to ensure compliance. Only within the context of a reasonably strong relationship can hard things be said without the risk of losing the client.

There are also wider considerations. Social services departments were set up following the Seebohm Report (1998) to serve the whole community. In the public mind, however, their responsibilities for children are often associated exclusively with child protection. The fear of many parents that referral to a social services department implies suspicion of child abuse will be reinforced by the implementation of Lord Laming's recommendations. As an earlier commentator remarks:

> These [the recommendations of child abuse enquiries] have sometimes run counter to the supposedly ambitious principles on which these services are supposed to be based, namely offering an integrated generic service and promoting social welfare at all stages of the life course.
> (Hill, 1990, p. 210)

This consideration may explain the actions of the Ealing and Brent social workers. When people seek help with accommodation, it is more likely that this is their main problem rather than that they are abusing their child. The concept of welfare agencies as business units delivering services to customers has promoted the idea of accepting the service user's definition of the problem, at least until the evidence contradicts their view. Social workers have accepted this approach.

Strategies of clients and workers

The lack of resources presents both social workers and their clients with a problem. Clients have to balance their wish for a service with a realisation that this may be available only following a stigmatising confession. Social workers have to manage a heavy workload and deny service without putting themselves or their clients at undue risk. This situation was particularly acute for Victoria's Haringey social worker. At the

time she was involved with Victoria she was overworked. She had accumulated 52 hours' overtime in seven weeks and was at one point carrying eight other cases of possible 'sexual harm'. She had to have some way of managing her workload.

The interactions between Ms Kouao and the first two social services departments illustrate a number of strategies that social workers may adopt to deal with this problem.

- *Keeping a narrow focus:* by concentrating on the housing problem, Ealing social services limited the amount of work they had to do. They also ensured that what they did was related to what the client (or at least Ms Kouao) wanted of them. A wider investigation would have taken time and generated extra work, and might have failed to engage anyone on a manageable task.

- *Managing by legal or administrative category:* a key issue for both Ealing and Brent was whether Victoria was a child protection case or a child in need. Once the decision was made that she was a child in need, the case acquired a lower priority to be handled as time and resources permitted. The use of these categories provided a justification for inaction. For example, the family's placement in a hostel within the boundaries of Brent meant that any obligations under S.17 or S.47 of the Children Act fell on Brent rather than Ealing, although the requirement to deal with their housing need remained with Ealing, as the placing authority.

- *Delay, unenthusiastic or discouraging engagement and case closure:* patients attending their doctor with minor ailments are commonly told to try something and come back if the situation does not improve. Doctors provide this advice because they know that most minor illnesses improve without treatment. The doctor's workload is more manageable as a result. Social workers' reluctance to act quickly may similarly reduce the burden of 'non-urgent' cases. Clients find their own solutions, which in most cases alleviate their situation.

- *The use of re-referral:* even serious abuse is rarely immediately fatal. Abused children whose cases have been closed often come again to the attention of the authorities. The chance of such repeated referrals reduces the risk of closing cases where abuse may occur. The number of previous referrals becomes an informal indicator of the need to intervene. Social workers may not consciously rely on this process. Its existence may nevertheless reduce the risk of the decisions that are made.

Before criticising these stratagems and assumptions, it should be noticed that in the case of Victoria they appeared to be working. Refusal to provide housing was followed by Ms Kouao finding her own (admittedly unsatisfactory) accommodation with Manning. Failure to identify that Victoria was at risk was followed by two hospital admissions when the extent of her injuries was clear.

Ms Kouao, for her part, tried to use Victoria's need as a ticket to housing and a subsidised child-minder place. This need, however, was insufficient to guarantee the help she wanted. At times, she wanted to get rid of Victoria and she asked the childminder to look after her on a permanent basis. The main social worker seems to have specifically told her that, according to department policy, housing could not be provided because Victoria was not at risk. Within four days, Ms Kouao returned with the allegation that Carl Manning had sexually abused Victoria. This, however, led only to a suggestion that Ms Kouao and Victoria move out to a friend's accommodation. Ms Kouao withdrew the allegation and went back.

Action that might have ameliorated the situation was prevented, because of the following.

- Ms Kouao had deceived the authorities in bringing Victoria into England. She could not tell the social worker Victoria was not her child and get her repatriated to the Ivory Coast.

- Housing that might conceivably have parted Ms Kouao and Mr Manning was not available, partly because of the reluctance of the Government to respond positively to the needs of new arrivals into the United Kingdom.

- Ms Kouao's need to present herself as a responsible person led her to deceive the social worker into thinking that she was going to get Victoria into a school – somewhere that would have monitored her.

- Lack of engagement between Ms Kouao and the social worker meant the social worker did not have a basis for trying to alter the cold relationship between Ms Kouao and Victoria, or her view of Victoria as 'wicked' or even satanic. In any event she did not have the time to do so.

- Mr Manning had no reason to trust the social workers and little incentive to bring the dire situation to light.

It is interesting to speculate at this point as to the course Victoria's life might have taken if Ms Kouao had been welcomed on her arrival in this country with a positive

resettlement programme, including the provision of good-standard accommodation and a school place for Victoria, to enable her to take up employment within the NHS. Such a response would have been within the spirit of Section 17 of the Children Act. For political reasons it would have been impractical in the current climate.

In any event, it turned out that the SSD could neither remove the child, nor give the case high priority, because neither adult was known to have been actively abusive. The best it could offer was ineffective monitoring by a social worker, who could not have daily contact with what was going on and whose relationship with Mrs Kouao was almost necessarily characterised by a lack of trust. Such a situation is almost certainly not uncommon. In most cases nothing dramatically untoward occurs. In this case murder was the result.

Will Lord Laming's recommendations improve matters?

Far more child maltreatment exists within our society than is ever reported to social services or the police (Cawson, 2002). Our analysis suggests that many cases that are reported also attract little attention. Resources are short. There is a lack of proven community methods of intervention. Parents are assumed to be competent and safe until proven otherwise. In response, the system rations by fault, makes difficult the creation of trust between worker and client, and discourages removal of children from home. Case closure or ineffective low-level monitoring is commonly the result. The laws of probability ensure that, in a small proportion of cases judged not to present serious risk, scandal results. Enquiries then ensure that the result is seen as stemming from human and organisational error. If implementation of their recommendations ensures that more 'high-risk' parents are identified, the resource implications are politically unacceptable. A return to the status quo is then likely.

Lord Laming's analysis is very different. In the body of his report he identifies a shortage of resources as a factor. (Curiously, he lays responsibility for this more at the door of directors and chief executives than at that of the politicians.) A high proportion of his recommendations would require additional resources. At the least their implementation will require a great deal of time on the part of professionals. Despite this, his report makes no direct reference to the need to increase resources. He makes no attempt to consider whether professionals have the time to undertake the tasks he specifies. He requires authorities to have properly trained and experienced workers but does not consider how they are to be produced – not least in London, where the management of mortgages on social work salaries is almost impossible. Nor does he consider the likely impact on workloads of his requirements

for extra training and induction. His report describes a world where resources and social workers appear magically and without a major change in political priorities. He is reported to have rejected claims by the Association of Directors of Social Services (ADSS) that his child protection reforms could be implemented only if substantial additional finance were provided, dismissing such claims as 'the usual kneejerk response' (http://society.guardian.co.uk).

In other respects, Lord Laming's analysis is based on hierarchical, bureaucratic and legalistic assumptions. Monitoring is given great importance. Supervision is not a matter of enabling a responsible professional to reflect on difficult and troubling situations. Rather it is a matter of quality control and authoritative action. Supervisors are to check that agreed actions have been completed by specified times. They are to read properly completed files based on meticulous recording and checks on all possible sources of information. They read records and sign off cases. There is much reliance on seniority. Junior doctors are not to have certain kinds of discussion with patients. The chief executives of trusts are to put numerous procedures in place. Directors of social services are to ensure that no one in their department goes on holiday without adequate arrangements for dealing with their post. Key decisions are to be taken at an increasing distance from the client or patient. Discretion is reduced. Social workers must always talk to the child where a case of suspected deliberate harm is referred. Risk is to be eliminated. No child about whom there are child protection concerns is to be allowed home from hospital until it is clear that it is safe. All should be aware that child abuse is a crime. If there is a possible criminal offence, social services should always involve the police.

These assumptions sit uneasily with the facts of this case. In this instance, senior doctors were less likely to identify physical abuse than junior ones. Social services managers appeared more often as people who close cases rather than keep them open. The quantity of information available was as much of a hindrance as its absence. So, professionals failed to absorb voluminous faxes or, as in the case of the first consultant, took one feature of a complex situation, scabies, as an indicator of a whole picture. The sheer quantity of procedures required to deal with such complex and varied situations meant that key procedures either were absent or, if present, were unknown or ignored. The close association between the criminal law and child protection proceedings meant that evidence that would not stand up in a court was difficult to use as a basis for action. In short, the belief that safety will be enhanced through an emphasis on seniority, information collection, procedures and the police comes from Lord Laming's presuppositions rather than the facts he presents.

In the light of this analysis, our own view of Lord Laming's recommendations is that they can be divided into four groups.

- Those that are already generally accepted as good practice. For example, few doubt that there should be arrangements for dealing with post whose addressee is on holiday. What is at issue is why good practice does not occur.

- Those that 'would be nice if one could get them'. There is no doubt that it would help to have more experienced and adequately trained front-line social workers. The issue is how to get them, especially without the additional funding that Lord Laming fails to recommend and appears to consider unnecessary.

- Those that would make the identification and assessment of child abuse more difficult.

- Those that would make no difference.

Space does not allow for a full discussion of these recommendations, but we offer illustrations of recommendations in each category, drawn from the general and social care recommendations.

Those that are already generally accepted as good practice

Recommendation 25 states that all social services assessments of children and families, and any action plans drawn up as a result, must be approved by a manager; and that the manager must ensure that the child and the child's carer have been seen and spoken to.

If this is not happening already throughout England and Wales, we are confident that most social workers and their managers would agree that failures to do so are only the result of extreme pressures of work and the inability to stretch limited resources to meet all the requests for assessments. The requirement to adhere to these criteria is already implicit in the *Framework for the Assessment of Children in Need and their Families:*

> As part of any initial assessment, the child should be seen. This includes observations and talking with the child in an age-appropriate manner. (Department of Health *et al.*, 2000, para. 3.10)

We suggest that 17 of the 63 general and social care recommendations would fall into this category, with the proviso that some of them are difficult to implement reliably at times of staff shortage or sickness, in areas where interpreters are in short supply, and so on. In many of these instances, Lord Laming is right to suggest that lack of money is not at the root of the problem. The more serious issue is lack of adequately trained staff, a situation that was allowed to fester by the Department of Health over many years, in spite of warnings about the developing problems.

Those that would be 'nice if one could get them'

Recommendation 43 states that no social worker shall undertake Section 47 enquiries unless he or she has been trained to do so, and that gaps in training and experience must be addressed immediately. Recommendation 52 states 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. Local authorities, however, carry a statutory duty to undertake enquiries when receiving information that a child may be suffering harm, irrespective of the availability of qualified staff.

Lord Laming is to be congratulated on his courage in highlighting the historical neglect of proper training for social workers beyond the time of their basic qualification. Recent efforts to address this by the introduction of requirements that social workers should undertake the Child Care Award training programme, or even the earlier training requirement for joint investigations with police, are, however, severely constrained by the shortage of staff available to provide cover while social workers are being trained in these ways. Here, again, the immediate problem is the shortage of qualified personnel. Local authorities consistently report that they are unable to recruit social workers to cover for the staff seconded to complete these training programmes.

Our assessment is that 24 of the 63 recommendations fall into this category. They constitute an ambitious shopping list of demands that would significantly and substantially improve the quality of child protection services offered within SSDs. Unfortunately, any suggestion that these reforms could be implemented without far more money being allocated is disingenuous. Lord Laming himself gives the game away in recommendation 54. This begins with an absolute statement:

> Directors of social services must ensure that all cases of children assessed as needing a service have an allocated social worker.

He immediately follows this with an acknowledgement that this is an unrealistic aspiration:

> In cases where this proves to be impossible, arrangements must be made to maintain contact with the child.

Those that would make the identification and assessment of child abuse more difficult

In our view, a small number of the recommendations would, if implemented, make the current situation worse. Social workers often have their 'beats' in inner-city (or even in outer-city) estates, neglected by planners, and ravaged by drug misuse, poverty, unemployment and violence. In some of these areas, local authority social workers are not always welcomed into people's homes. Establishing trust, and working in partnership with families, in these situations is not an easy task. Because Lord Laming's recommendations are expressed in universalistic language, eliminating scope for discretion and judgement, their implementation risks making the task of child protection social workers even more difficult.

We are particularly concerned about recommendations 26, 34, 35, 40 and 56, if they are to be implemented literally. Recommendation 26 states that no case involving a vulnerable child should be closed until the child and the child's carer have been seen and spoken to, and a plan for the ongoing safeguarding of the child's welfare has been agreed. But many referrals of vulnerable children are made without the support of the parent or carer; and, when social workers visit, the parents do not accept the concerns of the school, the health visitor, the alienated ex-partner or whoever has made the referral. The social worker's assessment may be that a plan is desirable but not essential to safeguard the child; or even that the plan is essential to safeguard the child, but unacceptable to the carer. Judgements then have to be made about whether to remove the child from the main carer (assuming there are sufficient grounds to convince a court) or whether to avoid alienating the carer in the hope that they are able to work more gradually to engage their trust.

Recommendation 34 states that no visits must be undertaken without the social worker checking the information known about the child by other child protection agencies. The implication is that this must be done in advance. In default of effective email systems, this could involve considerable time and delay. In any event, to do it without seeking the consent of the adult(s) involved is potentially not only a breach of their human rights but also a way of undermining any partnership that one would be trying to establish.

Recommendation 35 fails to take account of the number of malicious or false allegations received in SSDs. Where there have been bitter and acrimonious marital separations, ex-partners sometimes harrass the children's carer by making frequent allegations to child protection agencies. Were recommendation 35 to be implemented, social workers would have to collude with such harrassment.

Recommendation 40 repeats some aspects of the previous three recommendations.

Recommendation 56 states that directors of social services should prevent any child about whom there are child protection concerns from being discharged from hospital until the home environment is safe, the concerns of the medical staff have been fully addressed and there is a social work plan in place. But children about whom there are child protection concerns go into hospital for many different reasons and, in many cases, there is no means of ensuring that the home is safe or that there is a social work plan in place. The current law would not allow directors of social services (or anyone else) to prevent a carer with parental responsibility from discharging their child from hospital unless a court could be convinced that discharge would be likely to result in the child suffering significant harm. This is a rather more stringent criterion than 'being a child about whom there are child protection concerns'.

This small group of recommendations suffers from being set out in rigid and universalistic language, which attempts to eliminate the use of professional judgement and discretion. If this was Lord Laming's intention, it seems to contradict his other recommendations for improved training and greater professional confidence on the part of social workers to challenge the judgements of other professionals.

Those that would make no difference

A number of recommendations are aimed at a complete reshaping of the structures by which personal social services to children and families are delivered. These include the creation of 'a ministerial Children and Families Board' with a chief executive. The remit of this child welfare tsar is somewhat obscure. The agency will arise from a child protection scandal. Future scandals will continue to preoccupy it. Nevertheless, it will also apparently have responsibility for 'setting nationally agreed outcomes for children'. For the vast majority of children, such nationally agreed outcomes concern their education, health and mental well-being. Is it the function of the new board to supervise the work of all government departments on welfare, education and health? Or will it confine itself to the narrower remit of child protection?

A particular responsibility of the agency will be to ensure that policy and inter-agency collaboration will be monitored closely at a local level. There is no evidence from this enquiry that such monitoring will reduce scandal. As noted earlier, the social services department most criticised by the report had been given a good review by a joint inspection carried out just before Victoria came in contact with it. This review found 'clear signs of both management and strategic grip' and no reason for concern about child protection. A social services inspection completed after Victoria's death had the benefit of knowing this had happened. Unsurprisingly, it was more critical. On balance, there seems to be little evidence that monitoring by inspection can identify future scandals.

In general, it is not clear what the remit of the new national agency will be, although it will clearly replace the current area child protection committee structure. It will provide a new location for ambitious managers in SSDs, an additional drain on the limited resources of the Department for Education and Skills and another layer of inspection and monitoring of front-line services. Although we are now supposed to operate within a climate of evidence-based practice, no evidence is offered that this new agency will provide added value in delivering high-quality child protection services.

We would classify 12 of the 63 recommendations in this group.

Recommendation 13

This recommendation does not fall easily into any of the above categories. It proposes the amalgamation of *Working Together* (Department of Health *et al.*, 1999) and *Framework for the Assessment* (Department of Health *et al.*, 2000) into a simplified document. It seems to recommend driving a coach and horses through some of the assumptions about what the Human Rights Act permits or restricts in relation to respect for family life. And it appears to promote the idea of separate tracks for managing cases according to whether they fall within the requirements of S.17 or S.47 of the Children Act. Within the report, Lord Laming seems to be critical of simplistic categorisations of referrals as either S.17 or S.47 – a position that we would support. This recommendation seems to undermine that position. It also recommends the abolition of child protection registers and a greater emphasis in child protection conferences on establishing agreed plans.

Curiously, the thinking behind both of the policy documents to which it refers took place within the Department of Health, when Lord Laming was the Chief Inspector. Lord Laming's report never suggests that any of the social workers or other

professionals involved with Victoria were inhibited in seeking information by the restrictions of the Human Rights Act, which had not come into force when these events occurred. Victoria was never the subject of a child protection conference, but, if she had been placed on a child protection register as a result of such a conference after the two hospital admissions in July, her death might have been avoided. Nor had the *Framework for the Assessment* been introduced at the time Victoria's case came to the notice of any of the four SSDs involved. Nowhere is it explained how the proposals in this recommendation could have influenced the outcome for Victoria if they had been in place at the time of her arrival in England.

What might help?

Our overall conclusion is that the report's recommendations will substantially increase costs, do little to prevent further child abuse scandals and increase the threshold of mistrust that social workers have to overcome in engaging families in work to change their circumstances. So, if Lord Laming's recommendations would not help, what might? Unfortunately, there is no short or easy route to improving social services. The following are by way of broad principles. They are not easy to implement. They do, however, arise from our analysis of the case.

First, it is apparent that SSDs have too much to do. In Victoria's case, they were fending off demands on their services rather than welcoming them. The role of SSDs in respect of children and families has to be compatible with the resources available to them. There are not sufficient resources to provide an adequate response to all children in need, to ensure that all children are protected from harm, to provide a high quality of care for those children removed from home and to meet Lord Seebohm's aspirations of an agency responsive to its local communities. A balance has to be struck between these four major roles and Government must acknowledge that, in achieving certain priorities, others will be neglected until sufficient resources are provided. A clear national statement of the order in which these tasks should be prioritised would sharpen strategic planning. Whether responsibility for each of these tasks should continue to be carried by the same agency is a more complex issue.

Second, and within this context, it is apparent that occasional monitoring by social workers not in daily touch with the children monitored is an ineffective method of preventing child abuse. The family that was childminding Victoria identified her abuse and wanted to do something about it. School teachers, day nursery staff, childminders and primary health care workers are appropriately placed to identify children in serious difficulty. Schools in particular are additionally routes whereby

children surmount and escape adversity. Their quality is key to children's development. These resources are central to developing an appropriate response to the problems of child abuse.

Lord Laming virtually ignores these sources of monitoring and support. By contrast, we believe that families who are struggling to care for their children (including refugees, asylum seekers and immigrants of doubtful legal status) need to be given much easier access to these resources. Social workers have to give as much attention to the schooling of their clients in the community as they are now urged to do in relation to those in care. Support for childminders has to be a priority, as has their relationship with social services (why was the latter not seen as a natural port of call by the unregistered Mrs Cameron?).

Third, it needs to be easier to provide appropriate help for those children who are identified as at risk. Victoria's tragedy could have been avoided if Ms Kouao had told the social workers that Victoria was an illegal immigrant and not her daughter. In this respect, the close connection between 'wrongdoing', the allocation of resources and the involvement of the police is not always helpful. Victoria was not helped because there was not conclusive proof of abuse. As a result, social services were not in a position to remove her compulsorily and unwilling to provide substantive material help. They then seemed to have little else to offer.

In our view, the link between proof of wrongdoing and the authoritative provision of help needs to be weakened. We do not agree with Lord Laming that the police should be alerted given *any* suspicion of a crime. Taken literally, this would criminalise many contacts with social services and make honest relationships between clients and workers even more difficult. Social workers may have varying degrees of suspicion of a very wide variety of crimes. This remains a very difficult ethical dilemma for social workers, who, in practice, may end up trying to draw a distinction between the vulnerable and exploited end users of criminal activity, and the dealers, pimps or sellers of pornography who benefit financially from this exploitation. This is an area where there is room for much more debate.

At present, and in relation to child abuse, we are in danger of getting the worst of all worlds. A standard of evidence may be required that is not appropriate for a welfare system. So, social workers may not be able to take authoritative action because the police lack evidence suitable for a court of law. Conversely, decisions that, in practice, it is very difficult to appeal may be taken by social workers. So, it is expensive and rare for families to take a decision to register a child as at risk to judicial review. Individuals may be treated as criminal when they would more helpfully be treated as stressed or psychiatrically disturbed. And there may be a link

that is counter-productive between confessing to wrongdoing and getting access to resources. Those who need help may not make the necessary confession. The law-abiding may grow cynical at the money expended on those who cope less well.

In relation to the latter point, we do think that there should be a much more open-minded approach towards accepting that a child needs to be looked after. Arguably, Ms Kouao wanted to drop responsibility for Victoria. This is certainly what she told Mrs Cameron. However, her pleas for help with accommodation were not backed up by a sufficiently plausible account of wrongdoing even to justify priority for a council flat. Need as well as risk of abuse needs to be treated as grounds for accommodation in the care system – something that the Children Act intends. This policy has to be combined with adequate availability of a high quality of foster care. It also requires packages of support in the community that are sufficiently well resourced to act as a realistic alternative to the care system. Research is needed to show that these packages work.

Fourth, the belief in organisational, procedural and bureaucratic solutions should be challenged. No one doubts that good organisation is important. It is not a panacea. The SSDs involved with Victoria were suffering from a chronic shortage of resources and from reorganisation. The way they were organised was arguably less important and did not explain the judgements that were made. As it turned out, the workers failed to make a correct analysis of a complex and very unusual situation. If better judgements are to be made, there is no alternative to the employment of skilled, experienced professionals on the front line. Salaries, support and levels of discretion need to be appropriate to produce and retain them. Blanket rules that seek to limit discretion may reduce the anxiety of higher managers. They certainly facilitate the allocation of blame when things go wrong. They are not appropriate for skilled front-line workers.

Conclusion

Lord Laming's report ranges widely. At the end, it moves far beyond the individual tragedy of Victoria to consider the well-being of all children. In our view this may well be unhelpful. Childhood is not a problem. The organisational upheaval associated with attempts to treat it as one may well spread more widely the errors we see in the Laming Report. Our concern, however, is not with what may or may not emerge from the Green Paper (which is unknown at the time of writing), but rather with Lord Laming's analysis of social services.

In our view, the key mistake in the case of Victoria Climbie was the failure of the hospitals to identify her abuse. This mistake did not stem from the organisation of social services. Given this mistake, many of the judgements made by social workers were reasonable although wrong. If they did not make judgements of this kind on a frequent basis, the system would be overwhelmed.

Against this background, Lord Laming's recommendations are likely to be ineffective or harmful. What is required is a combination of measures designed to create for social services a more feasible role, backed by a more appropriate philosophy and a less adversarial relationship with their clients. Adequate resources and high-quality services and workers are essential. They will not be achieved through organisational change.

Notes

1 Suppose, as Lord Laming thinks appropriate, Ealing or Brent social services had visited more quickly, contacted the French authorities, followed up the no-contact visit by making enquiries as to where the child was and interviewed the child on her own. Would this have changed the picture? Perhaps so but perhaps not. Contact with France would, if successful, merely have confirmed what was in any case apparent. 'The mother–daughter relationship was difficult' and there were problems over school attendance. At various times, Victoria was seen on her own by a doctor, social worker, police officer, teacher and nurse. The last two spoke French and had reason to think that the child had been abused. However, she disclosed to none of them.

2 A numerical example may make this clearer. Suppose a preventive programme targets a group with a one in three chance of being looked after and is capable of preventing half those who would have been looked after from being so. The money spent on the whole group now serves to prevent the half the third would actually have otherwise been looked after from being so – that is, they prevent a sixth of the total from being looked after. The relevant cost comparison is therefore between the cost of looking after, say, two children with no preventive work and providing six children, one of whom goes on to be looked after, with preventive work. There are of course other cost considerations (e.g. how long interventions last, the combination of them, and so on). Many other reasons apart from cost have to be considered (e.g. the effects on other aspects of a child's life) but the basic point should be clear.

References

Aldgate, J. and Bradley, M. (1999) *Supporting Families through Short-term Fostering.* London: The Stationery Office

Berry, M., Cash, S. and Brook, J. (2000) 'Intensive family preservation services: an examination of critical service components', *Child and Family Social Work*, Vol. 5, pp. 191–203

Cawson, P. (2002) *Child Maltreatment in the Family: The Experience of a National Sample of Young People.* London: NSPCC

Department of Health (2002) *Children in Need in England: Preliminary Results of a Survey of Activity and Expenditure as Reported by Local Authority Children and Families Teams for a Survey Week in September/October 2001.* Accessed from http://www.doh.gov.uk/cin/cin2001results.htm

Department of Health and Social Services Inspectorate (1995) *The Challenge of Partnership in Child Protection: Practice Guide.* London: HMSO

Department of Health, Department for Education and Employment and Home Office (1999) *Working Together to Safeguard Children*. London: The Stationery Office

Department of Health, Department for Education and Employment and Home Office (2000) *Framework for the Assessment of Children in Need and their Families.* London: The Stationery Office

Gibbons, J., Conroy, S. and Bell, C. (1995) *Operating the Child Protection System: A Study of Child Protection Practices in English Local Authorities.* London: HMSO

Hill, M. (1990) 'The manifest and latent lessons of child abuse enquiries', *British Journal of Social Work*, Vol. 20, No. 3, pp. 197–214

Laming, Lord Herbert (2003) *The Victoria Climbie Inquiry. Report of an Inquiry by Lord Laming.* Cm. 5730. London: The Stationery Office

McCartt Hess, P., McGowan, B. and Botsko, M. (2000) 'A preventive services program model for preserving and supporting families over time', *Child Welfare*, Vol. LXXIX, No. 3, pp. 227–65

Pithouse, A. and Lindell, S. (1995) 'Specialist referred family centre and field social work: a comparative study of user views on service impact and outcome', *Research, Policy and Planning*, Vol. 13, pp. 13–18

Seebohm Report (1968) *The Report of the Committee on Local Authority and Allied Personal Social Services*. Cmnd. 3703. London: HMSO

Sinclair, I. and Gibbs, I. (2002) 'Looked after Children', in J. Bradshaw (ed.) *The Well-being of Children in the UK*. London: Save the Children Fund

Thoburn, J., Wilding, J. and Watson, J. (2000) *Family Support in Cases of Emotional Abuse and Neglect*. London: The Stationery Office

Webster-Stratton, C. (1998) 'Preventing conduct problems in Head Start children: strengthening parenting competencies', *Journal of Consulting and Clinical Psychology*, Vol. 66, No. 5, pp. 715–30

Appendix: Categorisation of the general and social care recommendations in Lord Laming's report

Already recognised as good practice	Unlikely to make any positive impact	Nice if we could get them	Liable to make things worse
10, 12, 18, 19, 21, 23, 24, 25, 27, 29, 30, 38, 39, 42, 45, 48, 50, 51, 63	1, 2, 3, 4, 6, 7, 8, 16, 17, 28, 33, 42	5, 9, 11, 14, 15, 20, 22, 31, 32, 36, 37, 43, 44, 46, 47, 49, 52, 53, 54, 55, 57, 58, 59, 60, 61, 62	26, 34, 35, 40, 56