FROM MARIA COLWELL TO VICTORIA CLIMBIE: REFLECTIONS ON A GENERATION OF PUBLIC INQUIRIES INTO CHILD ABUSE

Plenary paper by Professor Nigel Parton for the BASPCAN conference, July 2003 (published in Child Abuse Review (2004), 13 (2), pp80-94)

In his statement to the House of Commons when presenting Lord Laming's Inquiry Report into the death of Victoria Climbié, on 28 January 2003, the Secretary of State for Health, Alan Milburn, said:

> It is an all too familiar cry. In the past few decades there have been dozens of inquiries into awful cases of child abuse and neglect. Each has called on us to learn the lesson of what went wrong. *Indeed, there is a remarkable consistency in both what went wrong and what is advocated to put it right*. Lord Laming's Report goes further. It recognises that the search for a simple solution or a quick fix will not do. It is not just national standards, or proper training, or adequate resources, or local leadership, or new structures that are needed. It is all of these things. (my emphasis)

This theme, of the failure to learn the lessons of the many public inquiries over the previous thirty years, was a central one which was picked up in the ensuing House of Commons debate and in the media and press coverage of the publication of the report, both on 28 and 29 January 2003. It was as if the frontline professionals, and the key organisations and agencies who have responsibility for children and families were quite incapable of learning the lessons and, crucially, putting these into practice in such a way that such horrendous tragedies could be avoided. It is hoped by many, therefore, that the report by Lord Laming, and the changes brought about as a result, will mean that this will be the last report of its type.

In many respects, we can see the publication of this most recent child abuse inquiry report as the end of an era. It is now a generation since the publication of the first of these reports in 1974 into the care and supervision provided in relation to Maria Colwell, who had died in January of 1973. The intervening twenty-nine years have seen the publication of over seventy reports, which have not only been concerned with children who have died as a direct result of physical abuse and neglect, but have also included inquiries into abuse in residential and day care (Corby et al, 2001) and the apparent, over-intervention, of state agencies, the most infamous of which was that into the events of Cleveland in 1987 (Secretary of State, 1988).

In this paper, I wish to reflect on some of the changes we can identify over this thirty year period. More particularly, I intend to compare and contrast the Maria Colwell and Victoria Climbié inquiries. In doing so, I am reading the reports as being emblematic of their respective times. I will be reading them as particularly high profile instances of the contexts in which they are located. As such, they can be seen to provide fascinating insights into the changes we have lived through over this thirty year period. As I will point out, there are very many similarities between the two reports and the respective cases and the way they were handled. However, my central argument is that rather than concentrate on the similarities it is important to consider and analyse the differences. It is my view that these differences are crucial, both in terms of understanding the changes in the nature of practice and the contexts within which it is located, but also in terms of what might be done in the future. While my primary purpose is analytic, I will, by way of conclusion, try and identify some key themes which I feel might be helpful in informing how we might think about, reframe and reform policy and practice in the future.

Of course, because inquiries have pointed to similar weaknesses in services does not mean that inquiries have failed to influence policy and practice. Far from it. In many respects public inquiries have proved to be the key vehicle through which changes in policy and practice have been brought about over the last thirty years in relation to child protection policy and practice in this country. Rather than public inquiries being ignored, they have been fundamental to the way child protection operates. In this respect, they are as much a part of the problem as they are the solution. It is in this context that I am interested in comparing and contrasting the Maria Colwell and Victoria Climbié inquiries.

There are, of course, many important similarities, not least of which were the terrible circumstances in which both children died and the horrendous injuries inflicted upon them, together with the neglect which they had experienced. Both were of a similar age; Maria died eleven weeks short of her eighth birthday, while Victoria was eight years and three months when she died. While both were living at home with their primary carers (more of this later) and had been in frequent contact with a range of professionals in different agencies for a period of time, no professional was able to intervene appropriately. More particularly, both inquiry reports identified numerous opportunities when professionals had failed to intervene; these individual failures, it is argued, need to be understood in their wider context. Both reports argue that these failures were not simply a consequence of individual incompetence but were a reflection of fundamental inadequacies in their respective systems. The comments by Lord Laming that 'the suffering and death of Victoria was a gross failure of the system and was inexcusable' (para. 1.18) had in many respects been prefigured in the Maria Colwell report when it concluded that:

> What has clearly emerged, at least to us, is a failure of the system compounded of several factors of which the greatest and most obvious must be that of the lack of, or ineffectiveness of, communication and liaison. A system should so far as possible be able to absorb individual errors and yet function adequately (para. 240, 1974).

And more specifically:

> Many of the mistakes made by individuals were either the result of, or contributed to, by inefficient systems operating in several different fields, notably training, administration, planning, liaison and supervision (para. 241, 1974).

Both inquiry reports identify a number of common themes: considerable confusion and a failure to communicate key information, so that as a consequence both children fell through the elaborate welfare net; there was very poor and often confusing recording of very basic information relating to visits, phone calls, conversations and messages passed between different professionals, and a general failure to use the case file in a productive and professional way; considerable failure to engage and communicate directly with the children themselves about their feelings and circumstances; there was considerable deceit on behalf of the key primary carers and insufficient critical analysis and scepticism on behalf of the professionals as to what was being told and being presented to them; and there was a severe lack of consistent and rigorous supervision. Both cases attracted considerable media attention and can be seen as not just politically sensitive but as posing fundamental questions about the

health and welfare systems available to children and families. It was the Maria Colwell inquiry that ushered in major practice changes following the DHSS circular in April 1974 and which in effect introduced the modern child protection system in this country, in terms of the establishment of what we now call Area Child Protection Committees, the institutionalisation of the case conference system and the establishment of child protection registers, as well as all the procedures which have been refined and updated over the subsequent thirty year period. Both inquiries seem to demonstrate failure and that 'something needs to be done'. It is in this context that it is likely that the Laming Inquiry seems to be ushering in another major period of change.

Finally, both inquiries were established by the relevant Secretary of State. However, this is perhaps the first important area of difference, for whereas the Maria Colwell inquiry was set up by the Secretary of State for Social Services, the Victoria Climbié inquiry was set up by the Secretary of State for Health together with the Secretary of State at the Home Office. In effect, the latter was to conduct three parallel statutory inquiries in relation to local authority social services, health services as well as the police. Similarly, its terms of reference were somewhat broader, for rather than only being concerned with the circumstances leading to and surrounding the death of Victoria Climbié, the Inquiry was also required to make recommendations as to 'how such an event may, as far as possible, be avoided in the future'. The Victoria Climbié inquiry thus had a much wider brief. I now want to look more explicitly at some of the key differences, beginning with the inquiry reports themselves.

The Differences

The Inquiry Reports

While similar in many respects, there are also important differences in the two reports. These differences are indicative of the different times in which they are produced. The Maria Colwell inquiry report is much smaller in terms of the size of the pages and is 120 pages in length, consisting of approximately 50,000 words. It has a very official looking green cover to it, which was common for its time and has the Department of Health and Social Security, together with the official insignia on the cover, and is published by Her Majesty's Stationery Office. It is entitled 'Report of the Committee of Inquiry into the care and supervision provided in relation to Maria Colwell'. It is written by the inquiry team which consisted of three people, chaired by a QC, but has a minority report from one of its members, Olive Stevenson, who had a different interpretation of some of the key elements and decisions, particularly in the way the case was handled prior to Maria being placed on a supervision order and returned home to her mother and stepfather from foster care.

In contrast, the Victoria Climbié inquiry report is over 400 pages in length, and consists of around 200,000 words. Not only was the final report available on the Internet but all evidence, both written and spoken, was available on the Internet also. In this respect it can be seen as a global event. The report itself is simply entitled 'The Victoria Climbié Inquiry' and the cover also states that its Chairman was Lord Laming. It was made clear that the report is the responsibility of Lord Laming and

the inquiry panel was set up with four assessors to help him with the task. It is a much bigger and more expensive operation. The counsel for the Maria Colwell inquiry consisted of two QCs and the inquiry team was supported by one secretary. Seven parties to the inquiry had legal representation.

In contrast, the inquiry staff for the Victoria Climbié consisted of: one secretary to the inquiry; one solicitor to the inquiry; three counsel to the inquiry; a secretariat consisting of seven people; a legal team consisting of thirteen people; two special advisors; two people listed as communications; and seven people as being provided by two separate groups of contractors; plus one person as sound. The legal representatives for the interested parties before the Victoria Climbié consisted of: four London boroughs; three health trusts; one health authority; the Metropolitan Police; the NSPCC; eight police officers; and one social worker. Added to this, there were twenty witnesses with legal representation. In the Maria Colwell inquiry: sixty-five witnesses were examined; there were five witnesses who gave expert evidence; and thirteen witnesses who provided statements which were read in whole or in part by the committee. In contrast, in the Victoria Climbié inquiry: 159 witnesses presented evidence both orally and in writing; 119 witnesses presented evidence in writing only; and just one witness provided oral evidence only; a total of 278 witnesses. In addition the Victoria Climbié inquiry – in order to address its recommendations for the future – organised five seminars which had 120 participants.

The Maria Colwell inquiry had its preliminary hearing on 24 August 1973 and then was sitting between 9 October 1973 and 7 December 1973. In contrast, the Victoria

Climbié inquiry had its preliminary hearing on 30 May 2001 and was formally opened on 26 September 2001, taking its final evidence on 31 July 2002, having been reconvened earlier that year. As already noted, the Victoria Climbié inquiry had a web site where all the evidence, both oral and written, to the inquiry was made available. In the case of the oral evidence it was available on the web within hours of it being presented and was available verbatim. The web site received around three million hits between 30 September 2001 and 30 September 2002 (2003 para. 1.48). It is also important to note that while there are a number of implicit recommendations within the Maria Colwell inquiry, the Victoria Climbié inquiry quite clearly specifies 108 recommendations of which 82, it argued, should be implemented within six months of publication.

There is also a much more personalised dimension to the Victoria Climbié inquiry. Not only were her parents present, with legal representation, throughout phase one of the inquiry, and present in the House of Commons when the Secretary of State, Alan Milburn, presented the inquiry report to parliament, but as the inquiry itself states:

> It has felt as if Victoria has attended every step of this inquiry, and it has been my good fortune to have had the assistance of colleagues whose abilities have been matched by their commitment to the task of doing justice to Victoria's memory and her enduring spirit, and to creating something positive from her suffering and ultimate death (para. 1.66).

And earlier:

> The most lasting tribute to the memory of Victoria would be if her suffering and death resulted in an improvement of the quality of the management and leadership in these services (para. 1.28).

Similarly, there is a sharp contrast in which the respective inquiries begin their reports. The Maria Colwell report begins in paragraph one with a simple factual statement:

> We were appointed by Sir Keith Joseph, then Secretary of State for Social Services, on 17 July 1973 to inquire into and report upon the care and supervision provided by local authorities and other agencies in relation to Maria Colwell and the coordination between them (1974 para.1).

In contrast, the Victoria Climbié inquiry report begins with a colour photograph of a smiling Victoria, taken in much happier circumstances. Underneath this we have a quotation from Jiro Hirabayashi from Yasunori Kawahara's translation of *The Little Prince* by Antoine de Saint-Exupéry which says, 'I have suffered too much grief in setting down these heart-rending memories. If I try to describe them, it is to make sure that I shall not forget them'. It is stated, 'that this sentiment applies also to Victoria Climbié. This report is dedicated to her memory'. The introduction to the report begins as follows:

> 'Victoria had the most beautiful smile that lit up the room.' Patrick Cameron.
>
> 1.1 This Report begins and ends with Victoria Climbié. It is right that it should do so. The purpose of this Inquiry had been to find out why this once happy,

smiling, enthusiastic little girl – brought to this country by a relative for 'a better life' – ended her days the victim of almost unimaginable cruelty. The horror of what happened to her during her last months was captured by Counsel to the Inquiry, Neil Garnham QC, who told the Inquiry:

> 'The food would be cold and would be given to her on a piece of plastic while she was tied up in the bath. She would eat it like a dog, pushing her face to the plate. Except, of course, 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.'

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

This much more personalised writing style in the Climbié inquiry report is particularly powerful in the way it contrasts the guilty and the innocent, and the way key actors were seen to have failed in key responsibilities. More particularly the inquiry report sees itself, partly a reflection of its much broader brief, as having a key mission on behalf of many children well beyond Victoria. Victoria is portrayed as a symbol of what can happen to children when they are not appropriately protected and cared for. For example, if we look at the second half of paragraph 1.66 quoted above, it reads:

> . . . throughout, we have all kept a clear focus on the facts and on finding out what happened to Victoria, why things happened in the way they did and how such terrible events may be prevented in the future. I am convinced that the

> answer lies in doing relatively straightforward things well. Adhering to this principle will have a significant impact on the lives of vulnerable children.

The Victoria Climbié inquiry provides a coherent, convincing and powerful account of what happened to Victoria, how she was failed and how this can be avoided in the future. While the account in the Maria Colwell inquiry is of a similar nature, it is also much more equivocal. This is in part because the inquiry report has within it the minority report written by one of the inquiry team, Olive Stevenson. It is not that the report has a major dispute over the facts, but it is in their interpretation, particularly in relation to some of the early decisions leading up to why Maria was returned home, from her foster carers, that there is something of a difference of opinion. In her minority report, included as chapter five in the Maria Colwell report, Olive Stevenson writes as follows:

> As a social worker, my education and experience has taught me that in such matters, there is no one truth; in considering the subtleties of human emotions everyone is subjective. One's feelings, attitudes and experience colour one's perception. This is as true for me as it is for my colleagues. And when one is dealing with events now some time in the past, drawing to a large extent on records for evidence, and inevitably affected by the eventual tragedy, the probability of distortion in interpretation is all the greater' (para. 2.47).

And later:

> Those who have worked in child care social work have learnt of the impossibility of predicting the future (para. 2.62).

Clearly, the Maria Colwell inquiry and its subsequent report had the impact of catapulting the issue of child abuse as a professional multi-disciplinary responsibility onto public and political agendas. The way this was picked up, particularly by the high profile exposure in the media, inevitably lost some of the subtleties and nuances embedded within the report. In many respects, this is similarly the case with the Victoria Climbié inquiry. At the same time, I think it is interesting that the way the respective stories are constructed within the reports is in many respects very different. As the quotations above from Olive Stevenson demonstrate, there was no suggestion in the Maria Colwell inquiry report that the answers to the problems were necessarily simple or straightforward. While the systems set up following the Maria Colwell inquiry publication provided the key policy, practice and procedural frameworks for the ensuing thirty years, there was never an assumption that solutions were necessarily straightforward or the issues anything less than complex. These are points I will return to as part of my conclusion.

Before looking at more substantive differences between the two cases, I think it is also important to reflect on an important contextual issue within which both were reporting and operating. The Maria Colwell inquiry was the first of the modern child abuse inquiries, and in many respects had the impact of establishing child abuse as a social problem about which we as a society, and certain organisations and professionals in particular, had a responsibility to do something about. As a result the issue of child abuse in the subsequent thirty years has received considerable

attention. More specifically, a whole variety of procedures and systems have been set up particularly to enhance inter-agency and inter-professional coordination in order to share information and to ensure that children do not fall through the health and welfare nets with such tragic consequences. Similar comments, about the system, are clearly reported in relation to Victoria Climbié. There is, of course, an important difference. Whereas the Maria Colwell inquiry can be seen to have been a major factor in the introduction and subsequent refinement of child protection systems in this country, and which are seen as the major vehicle by which such tragedies might be avoided, it is these systems which are in part the subject of the Victoria Climbié inquiry. When the latter says: 'The suffering and death of Victoria was a gross failure of the system and was inexcusable' (para. 1.18), by implication it is these child protection systems which are seen as much a part of the problem as the solution. Of course, the intervening thirty years have witnessed an exponential explosion of actual and potential child abuse referrals and allegations of 'significant harm' coming the way of certain agencies, particularly social service departments. While we have no figures in this country, statistics from North America and Australia are instructive. In the US the number of child abuse and neglect reports to statutory child welfare agencies increased from 9,563 in 1967 to 669,000 in 1976, and to over three million in the 1990s. In the State of Victoria in Australia, the figure increased from 517 in 1977/8 to 26,622 by the mid 1990s. It is not surprising, therefore, if policies and procedures were developed in the UK to try to allocate very scarce resources in the context of this huge potential growth in awareness and need. It is particularly ironic that in the Victoria Climbié inquiry the allegations of child abuse had the effect of skewing the way the case was handled procedurally. In the early weeks of the Haringey involvement there was a major issue about housing and how Marie-Therese

Kouao and Karl Manning were dealing with Victoria's behaviour, together with the sleeping arrangements provided for her. Essentially, Kouao was demanding new accommodation. In paragraph 6.375 we are told:

> During the course of the conversation Ms Arthurworrey made the point that the council "only accommodated children who were at risk of significant harm" and that Victoria was not, in the council's view, at such risk. It is perhaps no coincidence that the next time Ms Arthurworrey saw Kouao was because of Kouao making allegations which, if true, would have meant that Victoria was at very real risk.

Just four days later Marie-Therese Kouao telephoned the social worker making allegations about the sexual abuse of Victoria by Karl Manning.

I am not suggesting that the systems and procedures that were in place in Haringey were appropriate. What I am trying to demonstrate, however, is that the systems, which the two inquiries were critically reporting on were very different. Essentially, in the Victoria Climbié inquiry many of the systems which were seen as so wanting, had been set up following the Maria Colwell inquiry. It is in this context that I am suggesting that such systems are therefore seen as much a part of the problem as the solution, and as contributing to the tragedy which was to unfold.

I now want to look at a series of discrete but interrelated issues which I feel crucially differentiate the inquiry reports and the events and contexts within which they are located.

Globalisation and Identity

Perhaps the major difference between the two cases is literally in relation to issues about the identity of the two children. There was never any doubt in relation to the Maria Colwell inquiry that everybody, including the inquiry team and the professionals involved, knew who Maria Colwell was. There was never any doubt that her mother was her mother, her stepfather was her stepfather, and that Maria had both brothers and sisters and half-brothers and half-sisters. While complicated, and often highly charged, nor was there any doubt about the nature of her extended family and that her immediate family were well known on the estate where they lived, often for quite infamous reasons. The neighbours were heavily involved in reporting concerns to the local social services department and the NSPCC, and similar concerns were evident in the schools which she attended. A major issue was related to the failure of the appropriate agencies to respond appropriately to these referrals and to piece the information together. In many respects it was the furore within the local community in Brighton which provided a major impetus for establishing the public inquiry in the first place.

Not only was Maria white and English speaking but that was also the case with everyone, including the worker, involved with her. The estate on which she lived was almost exclusively white and fairly traditional working class, and this was one of the issues which exercised the inquiry. For in many respects the Colwell/Kepple household had all of the characteristics associated with ‘a problem family’ which marked it out as troublesome and disreputable in an essentially solid, respectable working-class and lower middle-class environment. However, it is clear Maria had a

name, a known mother, an address and a school. In this respect she could be seen to have a clear identity and location.

Hardly any of these characteristics were evident in relation to Victoria Climbié. While the two children were of similar age and suffered similar injuries, in many respects these are the only things they have in common. It was only after Victoria's death that her 'real' identity became known. Similarly, it was only after her death that it became apparent that Marie-Therese Kouao was not her real mother but was 'a great aunt' and that her parents lived in the Ivory Coast. There are major issues about her national identity, the nature of her entry into the UK, whether she ever had a permanent address, the fact that she did not have a school or a GP, and that on numerous occasions the various health and welfare departments did not realise they were actually dealing with the same child and 'family'. Who had 'parental responsibility' was particularly confusing and was never clearly addressed or resolved within the inquiry report. In many ways all of these important issues reflect many of the significant social and cultural changes that have been going on in this country during the intervening thirty years.

In the Maria Colwell inquiry a major issues was concerned with trying to judge how significant the issue of the 'blood tie' was in relation to the decision making, and how this was appropriately addressed. Such issues now seem remarkably old fashioned. There is now considerable variation and complexity in household and family structure and relationships, such that the model of the traditional nuclear family no longer seems to represent the majority of the population. As a consequence we now usually refer the 'family' as opposed to the family. Such changes pose major

challenges for professionals and agencies whose prime responsibility is to children and families in the context of these huge variations (Featherstone, 2003).

The other major area for social change over the intervening thirty years is probably concerned with globalisation. Issues related to and arising from this are core to the Victoria Climbié in a way which is hardly evident with Maria Colwell. While both reports discuss the importance of cultural differences between the workers and the adults and children with whom they work, the way this is discussed is very different. For example, in Olive Stevenson's minority report she discusses (see in particular para. 285) the cultural differences that were possible in the way Mr Keppel, Maria's stepfather, made sense of and responded to Maria's behaviour compared to the way the professionals might have analysed this.

> It is not in the least uncommon for men and women from such backgrounds to view with astonishment the notion of problems of emotional adjustment. And Mr Keppel was quite right in reminding Miss Lees (the social worker) that in some cultures children are 'borrowed and returned' between relatives, with no fuss or bother! . . . Furthermore, even in our own society, it is not uncommon for men to leave such matters 'to the wife' and for both men and women to have difficulty in imagining in advance what difficulties may arise' (para. 2.85).

The cultural differences are seen essentially in terms of social class and gender. I find it notable that Diana Lees, Maria's social worker, when she left social work, took up a post with the Foreign Office. While not necessarily typical we are pointing here to

major class differences between social workers and the families with whom they worked.

This is not to say that these issues of social class and gender were not evident in the Victoria Climbié inquiry. However, it is issues around ethnicity and race which are more evident. The report discusses some of this in chapter 16 under the heading of 'Working with Diversity'. However, the diversity referred to is incredibly complex. This is illustrated at various points. For example:

> At the time Victoria's case was handled in Brent, all the duty social workers had received their training abroad and were on temporary contracts (para. 5.14).

> (In Brent) at least 50 per cent of social workers' time was spent working on cases of unaccompanied minors (para. 5.17).

> I heard evidence that Haringey has one of the most diverse populations in the country, with 160 different languages spoken locally, a long tradition of travellers settling in the borough and a high proportion of asylum-seeking families (9 percent of the total population) (para. 6.5).

The report in relation to all the London boroughs involved comments on the high levels of poverty and deprivation, the diverse ethnic, cultural and linguistic nature of the boroughs and the diverse backgrounds of the workers themselves. In many respects, it seems Victoria's situation was not unique in these respective boroughs.

The impact of increased global mobility, more specifically the rapid increase in asylum-seeking families, together with the diverse backgrounds of the workers themselves increasingly seems to characterise work in many metropolitan areas. It has a particular impact on the nature, stability and cohesion of local communities. It is notable that, compared to the Maria Colwell case, no referrals are noted in the Victoria Climbié case from neighbours or other members of the community apart from the 'child minder' Mrs Cameron. We are not simply talking about diversity here but incredible complexity and fluidity. Not only does it pose major linguistic challenges but it poses major challenges for statutory departments in relation to the familial and cultural identities of those with whom they work and to whom they have responsibility. Issues around racism are clearly important here, however they cannot be reduced to a simple black and white community and cultural divide.

Expert Knowledge

A major theme identified throughout the thirty year period has been the importance of various professionals sharing not just factual information but also their respective expertise. It is argued that each organisation and profession has particular expertise which needs to be mutually understood and worked with in relation to each case. This is particularly illustrated in relation to the role of the medical profession. There has been a strong feeling that medical expertise is important in relation to identifying problems in children's health and development and to help make sense of particular behaviours. This was something clearly underlined in the Maria Colwell inquiry. For example:

> It is obvious to us, as was Dr White Franklin's (an expert witness to the inquiry) opinion that the child had very strong feelings and was demonstrating them in a significant way . . . what we do consider wholly wrong is that no effort, even at that late stage, was made to obtain a medical opinion as to the depth and significance of Maria's continuing protests (para. 66).

A major problem identified in the Maria Colwell inquiry was the failure to persuade Maria's mother to get her medically examined at certain key times when there seemed to be evidence of injuries. She was not medically examined, her injuries were not treated, and crucially the nature and possible implications of these injuries were not included as part of the overall picture. Such physical signs were seen as a key indicator of what had previously been called the 'battered child syndrome' but which was little recognised by professionals (see Kemp et al, 1962). A major element of the subsequent DHSS circulars was to bring this phenomenon to professional attention and try to encourage professionals, particularly social workers, to recognise a syndrome which had previously gone unrecognised. Medical diagnosis was seen not simply as a part of the clinical picture but a key mechanism for raising professional and public awareness. Medical diagnosis was seen as something to be encouraged and developed and was not seen as problematic in other ways.

The situation in the Victoria Climbié case is, however, very different, where two hospitals played a significant role. A major issue in the inquiry is to establish the nature of the clinical symptoms that were being presented, and in particular whether and how far these could be seen as 'scabies'. There are numerous points in the report

where disagreements and disputes between hospital doctors are discussed (see, for example, paragraphs 6.347 to paragraph 6.379); there is one section of the report in particular, however, which is very illuminating.

> Dr Dempster duly faxed a letter across to the duty team on 15 July 1999, the content of which Dr Schwartz was subsequently to describe as 'very superficial'. The key passage that was to have such an impact on how Victoria's case was handled not only by Brent Social Services but also by Haringey Social Services thereafter reads as follows: 'She (Victoria) was admitted to the ward last night with concerns re possible NAI (non-accidental injury). She had, however, been assessed by the consultant, Dr Schwartz, and it has been decided that her scratch marks are all due to scabies thus it is no longer a child protection issue (para. 5.147).

Not only does the report demonstrate numerous examples where 'erroneous' medical diagnosis and communications had a tragic impact on the way the case was handled by other professionals, but it also clearly argues that medical diagnosis and opinion must not be treated at face value and uncritically. Both social workers, police officers and other doctors were found culpable in this respect. The contribution of medical expertise cannot, therefore, be seen as providing either easy answers or be treated unproblematically. This is clearly quite a challenge. Whereas the introduction of child protection procedures over the previous thirty years could be seen to have had the explicit intention of trying to circumscribe professional discretion, particularly on the part of social workers, it is now seen as important that they should exercise this discretion and in particular have the ability and authority to challenge other

professionals, in particular paediatricians, as appropriate and act with a degree of independence.

Problems with doctors and nurses, however, are not only seen as residing with the nature of their clinical assessments and diagnoses. A major issue identified in the Victoria Climbié inquiry concerns the way information is managed within hospitals and between hospitals and other health and welfare organisations. There are a number of examples where it is felt there was no system operating which was designed to ensure that requests for information and work to be done were followed up and that there was a lack of what the inquiry terms 'systematic care'. It argues:

> The accurate and efficient recording of information cannot be left to the individual diligence of the doctors and nurses concerned. They must be supported by a clear system that minimises the risks of mistakes and provides a mechanism for recognising mistakes when they occur. The greater the pressures are on staff, the greater the need for a system to support them. The busier the organisation, the more important it is to have a system that ensures agreed actions are recorded and completed (para. 11.36).

It was felt that the management of Victoria's care at the two hospitals concerned was thoroughly inadequate.

Systematic Care, Responsibility and Accountability

However, these comments about the importance of systems and information are seen as not only pertinent to the work of health professionals but to all who are actually or potentially involved in the protection of all vulnerable children. While both reports talk about the failures of the respective systems, as I have already intimated, the nature of these systems is very different. There are major systematic failures in relation to Maria Colwell, but primarily in relation to the sharing of information and the failure of professionals in different agencies to liaise. More specifically, the Maria Colwell inquiry report suggests that the flow of information should quite clearly be from the other agencies to social services who should take the lead in gathering and making sense of the information coming to it. In relation to the failures of coordination in relation to Maria's situation, the report identifies the failure to communicate and liaise between two workers in particular as absolutely crucial in the final eight months of Maria's life.

> At this time Miss Lees (Social Services) and Mrs Kirby (NSPCC), who were thinking in terms of collaboration on the case by 17 April, should have consulted together and having carefully defined their respective roles should have notified their seniors accordingly. These decisions should have been put into writing. Much of what followed after April 1972 can be attributed to a failure between these two case workers to be precise about what function each was exercising and what exactly was left to the other. No possible objection to collaboration as such in this case can be made; it is the lack of clarity and precision of definition which caused confusion (para. 100).

It was this failure and their respective failures to involve others, preferably via a case conference, which was seen as key.

The failures of communication and interagency collaboration, together with their respective confusions, seem much more complex in the Victoria Climbié inquiry. These problems seem to be located: between workers; between frontline workers and first line managers; between different professionals and workers in different organisations and agencies, whether these be social services, health or police, and to a lesser extent the NSPCC; and between senior managers and their employees and between senior managers themselves. Similarly, we are not talking only of verbal communication and written records but the whole systems of exchanging information and the way information is collated and gathered on a variety of sophisticated yet inadequate information systems. A major recommendation of the Climbié inquiry report is the need for a national database in relation to all children, and which is accessible to all professionals, who would also have responsibilities for inputting data. However, the examples of failures in existing information data systems are many and varied. Rather than aid communication such systems seem to both complicate and make things worse. For example, in commenting on the situation in Brent:

> During Victoria's brief involvement with Brent Social Services, and partly as a result of the Children's Social Work Department running both manual systems and a completely separate client-based computer system from the rest of Brent Social Services, Victoria acquired five different identifying

> numbers, creating ample scope for information loss and case mismanagement (para. 5.116).

What we see here is an important and significant shift. Whereas in the case of Maria Colwell the problems were derived primarily from failure to communicate between case workers, in relation to Victoria Climbié the problems were much more in relation to wide-ranging and complex system failures, of which communication between individual workers is simply a part. This is a consequence not only of the growth of a variety of new procedures which has taken place over the intervening thirty years, but also the growth in use of information technology of one sort or another for a variety of purposes. The failures were not so much in sharing information but *managing* information, and it is in this respect that the notion of 'systematic care' is seen as so important for ensuring that information and knowledge are managed rigorously, and where there are clear lines of accountability and responsibility. All of these have seen important developments over the intervening thirty years. The growth of information technology, the increasing hyper-circulation of knowledge and communication, and the need to try to manage this, have all become important organisational issues. It is in this context that there has been a growth of concern not just about coordination but about how these things are managed.

Managerialisation

For many, including the media, one of the unique contributions of the Victoria Climbié inquiry has been the identification of senior managers as well as frontline

practitioners as being responsible for the tragic outcome. The report itself is very different in this respect to the Maria Colwell report. There are large sections which talk about the organisational and managerial contexts of the work. This is particularly in relation to the four social service departments involved, as well as the child protection teams in the police. Interestingly, rather less is said in relation to the organisational and managerial contexts of the health service personnel. Again, we are presented with something of a conundrum. There is no doubt that the last thirty years have witnessed a tremendous sea change in the way health and welfare services are organised with an increasing emphasis on the need for clear and strong leadership, and more specifically the growth of managerialisation (Clark, Gerwirtz and McLaughlin, 2000; Newman, 2001). The increased emphasis on managerialism has been seen as a key way in which the failures of the old welfare systems could be overcome during the 1970s, 1980s and 1990s. The previous emphasis on the role of professionals and administrative bureaucrats was seen as inadequate for the new situation that welfare found itself in. In this respect local authority child welfare work could be seen as a key exemplar of 'old' welfare. What the Climbié report seems to indicate, however, is that rather than resolving the problems these changes have simply changed the nature of the problems. The report argues that senior managers and others spent far too much time not taking responsibility and not appreciating the nature of the work that was going on in 'the front office'. A major focus of the report is to try and ensure that in the future issues concerning responsibility and accountability are addressed.

However, there is another area where the changes over the last thirty years are also evident in the Climbié report. Unlike the Maria Colwell inquiry, at various points

there is extensive discussion about the role, import and appropriateness of a number of joint reviews and external inspections and audits that were carried out in relation to both local authority social services and the police. Again, the last thirty years have seen an enormous growth in 'audit' (Power, 1998) of which public inquiries play a key part. However, rather than clarifying and resolving issues it seems that these changes have again simply changed the nature of the problems to be addressed. The growth of managerialisation, audit, procedural guidance and new systems of information technology and information management, all seem to have contributed to an increasing complexity in the nature of the work as far as frontline professionals are concerned. While introduced with all the best of intentions, it is not self-evident in the Victoria Climbié report that their impacts have been positive. In trying to manage and order uncertainty it seems that new uncertainties and complexities have been unearthed.

Trust and Uncertainty

The introduction of new procedures and systems have been designed not simply to aid internal communication between system members, but to try and ensure a more transparent and accountable system to the wider public. As already intimated, this at best has only been partially successful. However, another, probably unintended, consequence has been the undermining in trust of the professionals themselves which also has an impact upon their morale and mutual confidence. Diana Lees, the local authority social worker at the centre of the Maria Colwell inquiry, was subjected to considerable opprobrium by both the local community and the national media. She was perhaps the first social worker to receive such high profile and critical publicity.

However, nobody associated with the Maria Colwell case lost their job as a result of the inquiry itself or the practices it was reporting on. The inquiry report also comments:

> Although we had no power to compel the attendance of witnesses all those from whom we considered it necessary to hear evidence agreed to assist us . . . it is right to record that all the agencies concerned were entirely co-operative and made available for use all their relevant records (para. 5).

This is a very different situation to that reported in the Victoria Climbié inquiry. Again, the practitioners, not just the key social worker involved, were subjected to considerable and high profile media and public criticism. A number of them have since lost their jobs. The social worker at the centre of the inquiry, Lisa Arthurworrey, has not only lost her job but has been placed on the register to indicate she is no longer suitable to work with children. However, there has also been considerable criticism, reflected in the media, of senior social workers, police officers and doctors, as well as senior managers in the relevant organisations. However, the most crucial difference is, perhaps, in relation to the way the inquiry itself operated. A number of witnesses were clearly very reluctant to appear, and in one case the senior social worker was subsequently charged and fined £500 by a court. Numerous papers and files seem to have been destroyed or lost. There were various delays in the proceedings because of the non appearance of files and witnesses, and the inquiry reconvened on two separate occasions as a result. This was in relation not only to a senior social worker involved but also the Chief of the Social Service Inspectorate. At numerous points in the inquiry the report is quite clear that a

number of witnesses were at best 'economical with the truth', or were blatantly lying. Certainly, there were numerous points where the inquiry attempted to arbitrate about who was actually telling 'the truth' in a very forensic way. For example:

> It remains Mr Armstrong's contention that he never saw Esther Ackah's referral of 18 June, but instead dealt with a less serious referral which he appropriately identified and responded to as 'a child in need case'. I find this version of events wholly unbelievable. I am left in no doubt that Mr Armstrong's evidence to this inquiry in relation to a referral on 21 June 1999 – a referral that I conclude never existed – is an attempt to cover up his team's inept handling of a genuine child protection referral that slipped through the net . . . inevitably, my conclusion as to Mr Armstrong's credibility in relation to this matter will have some impact on the weight to be attached to the rest of his evidence to the inquiry (para. 5.98).

These are very strong words, and similar comments are littered through the inquiry report.

Not only the tone of the report but the issues it is attempting to adjudicate on seem to be of a qualitatively different order to that within the Maria Colwell inquiry. It is as if all trust both in the inquiry process itself and trust between the various parties giving evidence to it had collapsed. How far this is a reflection of the high anxiety and tensions that are now generated by such public inquiry events, how far they are a reflection of a particular local and pathological set of relationships in North London at the time, or how far they are a reflection of the state that child protection and child

welfare practice in this country has come to, is open to debate. Simply comparing these two reports, however, suggests there have been huge and fundamental changes over this thirty period which cannot be underestimated in terms of their impact on professionals or the people they are working with. In part, it may reflect the changing responsibilities and remit of those agencies over the period.

Legislative Contexts and Focus of Responsibility

At the beginning of the DHSS study of child abuse inquiry reports published in 1982 (DHSS, 19820) there is a quotation which reads:

> . . . a story unfolds in the report of small carelessnesses, pressures of other work, difficulties of staffing and human procrastinations and failure to cooperate, by which few workers, if they are honest, have not at times been tempted from their standards, but which collectively resulted in individual tragedy and public scandal (this quotation is taken from Jean Heywood, writing in 1958 about the Monckton Inquiry, which was set up in 1945 after the death of Dennis O'Neill whilst in care. (Jean Heywood: *Children in Care*; Routledge and Kegan Paul, 1959) (DHSS, 1982, p.iii).

In many respects this quotation could have been taken from either the Maria Colwell or the Victoria Climbié inquiry reports. At a superficial reading the issues are remarkably similar. I would suggest, however, there are some very important differences. Dennis O'Neill was literally in the care of the local authority and had been 'boarded out' with foster carers in South Wales; Maria Colwell had been in the

care of the local authority, again with foster carers who were relatives, but had subsequently had the care order removed and was now on a supervision order, again to a local authority; Victoria Climbié was none of these. There was a very brief period when she was on a police protection order but otherwise issues in the report are centrally concerned with trying to discuss whether the case was handled appropriately as a child in need or a child protection case. Put at its crudest, the legislative context in 1945 was such that Victoria Climbié would not have been seen as the responsibility of the local authority. Similarly, it is unlikely that she would have been seen as the responsibility of the local authority in 1973 either. However, following the 1989 Children Act the responsibilities of local authorities changed significantly, particularly a Section 17 of that Act which gives statutory responsibilities in relation to children in need. As the Victoria Climbié inquiry illustrates, the resources available to the local authorities are not available to fulfil these wide-ranging responsibilities, although clearly they are responsibilities which they have to be seen to be fulfilling. This places them in a very difficult situation. Up until now these have been addressed in terms of debates, for example, concerning the relationship between family support and child protection (see, for example, Parton, 1997). What the Victoria Climbié inquiry demonstrates quite explicitly is that the prioritisation of work in this way is no longer adequate. If a child is responded to inadequately as a child in need, particularly if this is done in an unfocused and unsystematic way, the implications for all concerned are no different than if it was a Section 47 investigation. If we look, therefore, over the last sixty years, and even over the last thirty years, it becomes apparent that the responsibilities of local authority social service departments, and in many respects the other agencies with

which they work, have broadened considerably. It is in this context that we now talk of safeguarding children, together with their well-being and vulnerability:

> . . . the single most important change in the future must be the drawing of a clear line of accountability from the top to the bottom without doubt or ambiguity about who is responsible at every level for the *well-being of vulnerable children* . . . (my emphasis, para. 1.2).

The implication of this to me is that while at any one time there will only be a small minority of children in a local authority who will be on the formal case loads of a social worker, and an even smaller proportion who will be on either a child protection register or in the care of the local authority, its responsibilities are very wide. The wording of 'Children in Need' as the key rationale for these developments is such that the department has responsibilities for all children, all of the time, in its geographical area, and, as we have seen, the nature of this child population, in certain areas, is itself extremely mobile and diverse.

Conclusion

I am thoroughly in support of Lord Laming's argument that the answer to our current problems is in 'doing the relatively straightforward things well'. At the same time, I do not think we should underestimate the considerable complexity that has come to characterise the child protection systems and child welfare work more generally over the last thirty years. In comparing in a very crude way the Maria Colwell inquiry and the Victoria Climbié inquiry, I have demonstrated that issues around globalisation,

the increased impacts of managerialisation, the decline in trust and the changing nature of expertise all contribute to a somewhat unstable situation. It is also clear the nature of the responsibilities of the relevant agencies, particularly social services, have broadened considerable. These are clearly major challenges which should not be underestimated. If the history of the last thirty years demonstrates anything, surely it must be that there are no simple answers. It also demonstrates that the responsibilities that we put on certain professionals, particularly social workers, are enormous. I would argue that to move these things forward two key things are required and these are very interrelated. First of all, recognise that the authority and status of these frontline professionals needs to be raised. While some of the developments over the last eighteen months are helpful in this, they are extremely incremental and grossly underestimate the tasks ahead. If we are serious about child protection, the salaries of those taking the lead responsibility in the area have to be at least doubled, in my opinion. If they are going to have the authority to challenge senior professionals like paediatricians and others, they will need to have the pay and status to reflect this. In the process the quality and qualifications of those wanting to enter the profession will be increased. Along with this, of course, is the need for extra resources. In some respects these are already coming in by a variety of new initiatives, such as Sure Start. However, it does appear that the key professional grouping which is at the centre of child protection work social work, has, to all intents and purposes, been 'hollowed out'. We should not underestimate the complexities involved, the moral issues at stake, and the considerable sensitivities, intellectual and emotional, we are working with. Issues around expertise, authority and trust are key.

I would like to finish with a couple of quotations from the Maria Colwell inquiry. As Olive Stevenson commented:

> There are few, if any, situations of the kind in which Maria was involved which are 'black and white' . . . there are very few situations in which choices are clear cut and outcomes predictable. Unhappiness in children is something which the ordinary humane person finds very difficult to bear and, in consequence of this, frequently seeks simple solutions or suggests that they are attainable (para. 316).

And, finally, to return to a quotation I have used earlier:

> The overall impression created by Maria's sad history is that while individuals made mistakes it was 'the system', using the word in the widest sense, which failed her. Because that system is the product of society, it is upon society as a whole that the ultimate blame must rest. Indeed, the highly emotional and angry reaction of the public in this case indicates society's troubled conscience. It is not enough for the state as representing society to assume responsibility for those such as Maria. It must also provide the means to do so, both financially and by ensuring that the system works as efficiently as possible at every level so that individual mistakes which must be accepted as inevitable, do not result in disaster (para. 242).

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