House of Commons

Education Committee

# Child Safeguarding

## Oral Evidence

### *15 September 2010*

*Sharon Shoesmith*

*Dr Maggie Atkinson, Professor Frank Furedi, and Colin Green*

*Tim Loughton MP and Dr Jeanette Pugh*

*Ordered by The House of Commons to be printed 15 September 2010*

**HC 465-i**
Published on 2 November 2010
by authority of the House of Commons
London: The Stationery Office Limited
£5.50

# Oral evidence

## Taken before the Education Committee

## on Wednesday 15 September 2010

Members present:

Mr Graham Stuart (Chair)

Nic Dakin
Damian Hinds
Liz Kendall
Charlotte Leslie
Ian Mearns
Tessa Munt
Lisa Nandy

---

*Witness:* **Sharon Shoesmith,** Former Director of Children's Services, London Borough of Haringey, gave evidence.

**Q1 Chair:** Good morning, and welcome to this meeting of the Education Committee on child safeguarding. I welcome Sharon Shoesmith to our deliberations and thank her for coming in to give evidence. I believe that you would like to say a few words, and I am happy for you to do so.

***Sharon Shoesmith:*** Yes please, Chair, if I may. It will only be for a couple of minutes—no more than that. First, I want to thank you for inviting me here this morning. I really want to start by saying that there was never any doubt about how sorry I and everyone else at Haringey was about the murder of Peter Connelly—absolutely no doubt at all. To construct a narrative so simple, which told the public that Peter Connelly died because Haringey was uniquely weak, and that sacking everyone from the director to the social workers meant that all would be well, was frankly absurd. The other story will be told eventually, but I want to start this morning by saying to you, Chair, that if you and your Committee members believe the narrative put to the public by some elements of the press and some politicians, we begin on different pages. The impact for children has been far-reaching. I think we all know that. Since 2008, the number of children coming into care has increased by 30%—that is 60,000 children up to 80,000 children, or 0.5% up to 0.7% of our 11 million children in care. The number of children subject to a child protection plan has doubled—that is 30,000 to 60,000. Yet, sadly, this wider net seems to have had very little impact on the number of children who die. In the year that Peter died, sadly 54 other children also died. When I say that and give these numbers, I mean that they died at the hands of their parents, close family members and wider family. In the 10 months into 2009, when we had this much wider net, 56 children died—an increase on the year before. Social work vacancies are high, fostering cannot meet demand, and almost a third of Directors of Children's Services left in just over a year. Over 30 years, the rate of child murder has remained largely the same. In the decade 1999 to 2009, 539 children died in this way. Those are shocking statistics, which are not known. They are too abhorrent to contemplate. Hence my saying that that simple narrative was so absurd. Some would argue that taking more children away from the parents is the right approach, and I really think that we need to explore that thoroughly—is it the better approach? We would have to say that if half the children who are now subject to child protection plans—that's 300,000—were to be taken from their parents, it would cost the country an extra £1.5 billion. Whatever the answer, the whole sector is now, in my view, motivated by a fear of failure and not the conditions for success. Clearly, there is much to do and the issues that stand clear in my mind are around five areas: public accountability, inspection and development, multi-agency or inter-agency work, levels of risk, and professional representation. Chair, in closing, I would like to say that I am as committed as I ever was in the years that I have worked for children to the care and protection of those children, and I am here to help you and your Committee as best I can. Thank you.

**Q2 Chair:** Thank you very much for that. You talked about some of the short-term effects. Can you tell us what you think the long-term effect of the Peter Connelly case may be and why you described the Minister's response to the case as "reckless"?

***Sharon Shoesmith:*** There are two levels there. On the long-term impact, I went to Haringey as Director of Education and saw the aftermath of the death of Victoria Climbié and the huge struggle to put things right. I inherited a service that had a large of number of children in its teams—these were the children who had come into care after the same reaction back then to Victoria's death. One of the pressures I had in my time in Haringey was to try to bring those numbers back down to match similar authorities. That was the pressure I was under. That was the direction of travel—to bring the number down.

**Q3 Chair:** Do you think that was right? As a result of the Peter Connelly case, hundreds of millions of pounds extra a year have been spent by local authorities on bringing more children into care, as you set out in your opening remarks. A central question for this Committee is whether we now have a more appropriate intervention regime, or whether there has been an overreaction. Perhaps it is too

early to say in terms of the number of children who die at the hands of their families but, as you say, the evidence so far is not of a material change for the better.

***Sharon Shoesmith:*** Social care for children requires a very delicate balance of a number of factors. One is the confidence of social workers. One of my biggest issues after the news of Peter's murder on 3 August 2007 was to hold the service steady, not to see the same impact on that service that we have seen nationwide. In that period of time, we managed to stabilise the service, to hold the confidence and go forward. That was a very difficult process. We had begun to move forward again. Then—this is why I referred to the Minister as "reckless"; I think you are referring to my interview in *The Guardian* in February 2009—I watched the broadcast on 1 December as I was waiting to hear when I would get a copy of the report, and I was shocked and horrified that anyone did not realise the impact that that was going to have across the whole social work sector, the whole social care sector. It was obvious to me and to everyone else at that moment that that whole sector would virtually collapse, and that is what we have seen. It will be a long haul to bring it back. A lot of things that have been done are good, such as the Social Work Taskforce and the Munro Commission that you have set up. I never ever want to use the dreadful phrase, "Peter Connelly's death was not in vain." That would be a dreadful way in which to reflect on anyone's death. What is sad for me is that many of the things that we knew to be wrong in the sector weren't heard until we had such a tragedy.

**Q4 Chair:** The second Serious Case Review into Peter's death concluded that the ethos that informed the professionals' interactions with his family were inadequate and that expectations were too low and interventions insufficiently authoritative. Why was that so, and do you believe that the culture/ethos of safeguarding, not only in Haringey but elsewhere, has changed for the better since?

***Sharon Shoesmith:*** I think one of the lasting issues of this case surrounds why all those professionals—police, doctors, consultants, nurses, health visitors and social workers—were caught in the trap of feeling that the mother was being genuine. Why did they not question that more? I think that has to be the overriding question, and therein lie research opportunities and lessons to learn. I was in the room when the police officer came in and said that the mother had been charged with murder. Remember that no one was ever sentenced for murder, but I was in the room when that happened and those who knew Peter Connelly and the mother were completely taken aback and said, "That couldn't possibly be the case. You must have it wrong: this couldn't be the case." That was their reaction, having known this person. I, of course, didn't know her or Peter Connelly.

**Q5 Charlotte Leslie:** Thank you very much for coming along. My questions revolve around responsibility. I am a layman without great expertise in this issue, but issues of responsibility strike me as important, both in terms of who takes ultimate responsibility for an individual child as they move through the social care system, and of who takes responsibility at every level up to the top. What did you feel responsibility meant in your role as Director of Children's Services, and what was your role of responsibility in the case?

***Sharon Shoesmith:*** I was responsible as a DCS for approximately 1,300 staff, including about 500 social care staff. I was responsible for the operation of that service, both in education and social care.

**Q6 Charlotte Leslie:** In terms of your general responsibility for the entire department over which you presided, for which you were paid as Director of Children's Services, what did the concept of responsibility mean to you?

***Sharon Shoesmith:*** I was there to make sure that the quality and provision of education was there in Haringey. Indeed, the massive improvements that we made in education are well known. I was also there to provide good quality children's social care, which included the protection of children. Once this dreadful news came, I was responsible for understanding what went wrong—and understanding it in some detail. That was why I was present at the first Serious Case Review—to understand fully what went wrong, particularly in relation to my own staff, the social workers. What I can't be responsible for—I think this is quite a big issue for your Committee—is the conduct and operation of other services. I can't be responsible for health and I can't be responsible for police, although it has been suggested that a DCS should be responsible for those services. I wasn't.

**Q7 Charlotte Leslie:** One thing that I think is interesting is to look at the future of social care, at where we go from here. One of the issues that we are looking at is the parity of professionalism between social care and, say, medicine. It strikes me that, in medical circles, someone who is at the top of the pile and at the top of the pay scale—getting paid a considerable amount for responsibility—is obviously not responsible for every single individual over whom they preside, but they are ultimately responsible if something goes wrong under them. They are paid for that responsibility. If something goes wrong, they tend to step down as a mark of taking responsibility. I wonder if you feel that that is something that analogously should apply to the social services sector. Perhaps this failure to take responsibility for something that happens is one of the things that prevents social services from being seen in the same professional light as medicine.

***Sharon Shoesmith:*** Yes. I don't know the detail of the cases in the health field that you refer to, but I know generally that that kind of decision—

**Charlotte Leslie:** If something goes wrong on someone's watch, they step down. They say, "I was the one who was responsible for this. I will step down because it happened on my watch." That is one of

the very important things about the accountability and professionalism of health care and medicine, which is why they have such great respect.

***Sharon Shoesmith:*** My responsibility, as I understood it then, was to understand what had happened, for the social workers to go through the council's procedures and to look carefully at what their conduct had been. I said this on television at the time, and in fact it was the only thing that the press wanted to run: what came out of that was that there was not the evidence to sack those social workers. The issue of where you pin responsibility is to do with the complexity of services working together—we have health, police and social workers working together. Quite honestly, if a child has died and you decide that the automatic route, no matter what the conduct has been, is that the Director of Children's Services steps down or resigns, you'll lose all Directors of Children's Services across the country; there'll be more than a 50% annual turnover. But I have not, at any point when I have spoken about this case, attributed blame. That is not the culture that I'm in. But I have to ask, in response to your question: where were the resignations in health, if you tell me that this is why the sector is held in such high esteem? Where were the resignations there, if we had a consultant and a GP who made some very serious mistakes? I would have to discuss this in much more depth with you to really—

**Charlotte Leslie:** I would respond by saying that the Department of Children's Services is the department that is commissioned to look after the welfare of that child overall. That is why it was formed. I would expect, therefore, the responsibility to lie with the Department of Children's Services, as it is named.

***Sharon Shoesmith:*** Could I comment on that? I think that you raise a very important point. Again, I preface my comments by saying that it has never been my approach to criticise and blame anyone else. So, you're telling me, given that Peter was presented to health settings on 34 occasions, and when he turned up to his appointment with the consultant, that that consultant had not a single record of any of those presentations—only the letter from the social worker—that I should take responsibility for a complete breakdown of systems in health? I would say no.

**Q8 Charlotte Leslie:** Moving on to Ofsted, when the initial Ofsted report came out on the performance of Haringey, what did you think of it? Did you think that it was an accurate or an inaccurate reflection of what was going on?

***Sharon Shoesmith:*** It is very difficult to answer that in a few minutes. I have written down all my recollections of these things.

**Q9 Charlotte Leslie:** But broadly, did you think, "Yes, that's pretty much what I expected," or, "Oh, I'm not sure about that"?

***Sharon Shoesmith:*** The inspection report did not reflect the inspection itself or my experience of the inspection—what was said to me in the inspection. One of the inspectors later in the court case was very clear that they had not found any cases that made them feel that they needed to react in an urgent way. That was the wording in his statement. The written report didn't reflect what I had experienced at all. I was sitting, on 1 December, waiting to read the report when I learned of my demise on live television. That was why I was there, because the experience didn't match the report. Indeed, the comments made about leadership on that occasion were made up. They don't actually appear in the inspection report, or in the inspection evidence. I now have reams of material on the inspection evidence, and some of the statements that were made are not in the inspection report, nor did they appear in the record of evidence. They are not there.

**Q10 Liz Kendall:** Thank you for coming today. As Director of Children's Services, you said that you could not have been held responsible for what happened with the NHS staff and the police, but you were responsible for your department and your staff. Do you think you or your department made any mistakes in handling the case of Peter Connelly?

***Sharon Shoesmith:*** Yes, undoubtedly.

**Q11 Liz Kendall:** What were those mistakes?

***Sharon Shoesmith:*** There were errors of judgment—professional errors of judgment. It is a very difficult issue for everyone in the professional world who works in these sorts of services, and indeed for your Committee in considering these matters.

**Q12 Liz Kendall:** What was your error of judgment? You said there were professional errors of judgment.

***Sharon Shoesmith:*** I didn't have any personal dealing with the case at all.

**Q13 Liz Kendall:** Should you have had?

***Sharon Shoesmith:*** No. Haringey had 55,000 children—0 to 19-year-olds. We had about 1,000 children—about 600[1] of those in care. We had several hundred asylum-seeking children—you've seen "Newsnight"—and we had about 250 children who were subject to a child protection plan. So I wouldn't have known the case, and that would be expected. If you ask any DCS, they will confirm that position.

**Q14 Liz Kendall:** Coming back to the question, do you feel you made any mistakes in the case of what happened with Baby P?

***Sharon Shoesmith:*** The question is very broad.

**Q15 Liz Kendall:** What would you have done differently?

***Sharon Shoesmith:*** That's one heck of a question, given what I have experienced. I have dealt with death threats and so on, and brought myself back from the brink.

**Q16 Liz Kendall:** But I'm sure you've learnt from the case. What have you learnt and what would you do differently?

[1] *Witness correction:* Haringey had about 400 children in care in November 2008 and this figure included asylum seeking children, many unaccompanied.

***Sharon Shoesmith:*** I go back to 3 August 2007 when I heard the news of Peter's death. The cynical view would have been to jump then. I didn't, because I was always very deeply committed to Haringey, and I still am. I wish them well as they go forward. I worked very hard for the borough. I could have gone, and sometimes I think, why didn't I? But I don't really get into the realms of regret in all walks of life. I stayed. I did what I did.

**Q17 Liz Kendall:** Having looked back at the case, there's nothing that you would have done differently as Director of Children's Services?
***Sharon Shoesmith:*** I had no contact with the case at all.

**Q18 Liz Kendall:** There's nothing about the way the department was structured or the way the staff were supported that you think should have changed, if you'd gone back in time? It was your responsibility.
***Sharon Shoesmith:*** The issues that social care staff were managing were huge—things that were way beyond the imagination of the public. I had been in education. When I took over the social workers, one of the first things that occurred to me—that I could see—was, why are they in the department so much? Why are they sitting in front of computers?

**Q19 Liz Kendall:** Would you have done anything to change that? Was there anything you could have done to change that?
***Sharon Shoesmith:*** At that point, that was how the system worked. We had an IT system that had to be completed in a certain way. Records and so on were very important. That's how the thing operated. A number of DCSs were looking together at different ways of supporting social workers to get that material on to computer systems so that they could be released to use their professional skills. Work was going on to do that—we were very much hoping to see something sensible coming out of ContactPoint and so on, but I think I heard a cheer go up across London when you got rid of it. There are massive issues around the IT systems. Yes, I had expectations of education staff—that I should not see them in the office. If they are about schools, then they are in schools. Many education staff were expected to be in the department only on a Friday afternoon. To me, this whole thing about having directors who came from an education background was a red herring. In actual fact, we were raising some of these issues—indeed, our colleagues who had been in social care for longer were also concerned about these things.

**Q20 Ian Mearns:** This raises an interesting question about the role of a Director of Children's Services. Many Directors of Children's Services were former Directors of Education, and many others were former Directors of Social Services or of Children's Social Services. Certainly, when the role of Director of Children's Services was created, to a lot of people the breadth of the role was very great, and an enormous responsibility. Has that in itself had any bearing on the depth of the role that is meant to be undertaken by Directors of Children's Services, given the different areas of expertise that they come from? Has that had any bearing on how things have developed in policy terms and on delivery mechanisms in local authorities?
***Sharon Shoesmith:*** It is a huge role, there is no doubt about that. The way in which the organisation is structured, from the director down, is very important. Whatever background the DCS has come from, most departments around the country—in fact, probably all departments—would have a lead for children's social care and a lead for education; people who are professional in those areas. You have to ask the question, how do those people then progress to being a DCS? I know that is being tackled through the NCSL programme, which I think is very good indeed, but I don't think that therein lie all the answers. I really don't. For me the answers lie in how we support inter-agency working on the ground—for me, that's where it is. When you look at the cuts coming down the line, the tragedy will be that these different departments begin to sort out the cuts that they have to put in place as separate entities—they won't actually work together, as a whole body and as a team around the child, in an area to support and protect children. The approach has to be multi-agency. That is where the real answers lie. Add to that some of the bigger discussions around having 0.7% of children in care. If we have 2% in care, have we failed or succeeded? If we have 10% in care, we have definitely failed, have we not? That would say something very serious about family life in Britain. Where is the point that we feel is right? How do we compare with other countries? We need to look at adoption. We know that a large proportion of adoptions break down if children are adopted over the age of two. Even if they don't break down in a formal sense, we know that adopted young people grow into adults who search for their birth family. We have also seen tragic cases where we have had children adopted erroneously—we have made mistakes. There was a case in Norfolk, I think, where that happened. Yet it is too late, because the law is in place. Is there another way of supporting children, which is not a permanent adoption and keeps them in touch with their birth families? We need a serious, in-depth debate, possibly to run alongside the Munro review, which I think is very good, although I would like to see it focus a little more on inter-agency work. Possibly Eileen Munro will do that—possibly it is already happening. From what I can read, from what is available to me, those are the things that we need to take forward. I would also like to ask, if I may, whether the death of children and the protection of children have to be party political issues. Can we have an all-party approach that asks what happens to these children who are murdered? How do Serious Case Reviews work? Can we look at them all across the country, and can we ever get a handle on the statistic to draw it down? Those are some of the big questions that I feel persist.

**Q21 Nic Dakin:** Thank you for coming, Sharon. We are cross-party here, looking at this issue in a very cross-party way, and we're very focused on the

welfare of children. Thank you very much for coming today. You mentioned inspection as one of your five areas that are important for getting this right. What do you consider to be the hallmarks of a safeguarding inspection regime that would be effective, accurate, fair and command confidence?

***Sharon Shoesmith:*** I wish I could give you a slick answer. I think Ofsted, like everyone else around the country, had to work very hard to try to bring two parts of a service together. I feel that it grafted social care inspection on to an education model, and I think that's where some of the problems have been. I understand the need to run with the snap safeguarding inspections, but again I would say: does that mean, if you get a clean bill of health, that a child won't die in your authority, or would we simply have a different narrative if that happened? So it can't ever guarantee that all will be well. I always liked the thematic inspections that Ofsted did, looking in depth across the country at a certain area, and I think that would be very good. You saw yesterday the report about SEN, which was a piece of thematic inspection—obviously, there is always controversy. Thematic inspection can look in depth at some of these areas, possibly at thresholds or at how agencies work together, and some learning can be done. So while we have inspection, it seems to me that we lost some of the development side that was with CSCI when the whole responsibility went to Ofsted. We've lost that development side, so where would I, as a DCS taking in social care, go to have an in-depth discussion about how this is being developed and what some of our objectives would be? Where would I have gone to do that? Nowhere, except to other colleagues and other forums that we've built ourselves, or through the ADCS. But development is a very important part—the other side of inspection. Yes, we need inspection. I would like to look at the thematic approach. I hear that Ofsted now talks to social workers. Of course, it must talk to social workers. In the inspection of Haringey, no social worker on any case that was scrutinised was ever spoken to—going back to pick up your point. I had no concern about it, but of course it became a concern later when we saw the impact of that inspection. But the inspectors explained that they hadn't the time to do that, and they realised that they had missed that part out. They now talk to social workers. But get out there, on the ground, with social workers, into the homes, and see what's happening with the multi-agencies. Get out there and see it. I think that that's what needs to be done.

**Q22 Charlotte Leslie:** I would like briefly to come back to inspection. I'm sorry if this has been answered, but I just want to make it clear for the sake of the Committee and the meeting. The initial Ofsted report that was done, the annual performance assessment in 2007, assessed the council's services as "good". Did you feel at that point that that reflected those services, or did you have misgivings that perhaps things were not as well as Ofsted had said? If you did, did you do anything about it?

***Sharon Shoesmith:*** When the annual performance assessment happened in 2007, yes, we got the "good". I was obviously very pleased with that, as was the department.

**Q23 Charlotte Leslie:** Did you feel it reflected accurately the organisation over which you presided at that time?

***Sharon Shoesmith:*** At the time, yes, it did, and the council were very behind children's social care. They put as much money as they could into it, albeit they were a floor authority; remember they had a very poor financial settlement during that period. So yes, I was pleased with that, but there is always some criticism in that. There is an overall "good" but there were things we needed to work on, which we were working on, and I always expected my deputy directors to commission other pieces of work—and there were other pieces of work commissioned—to help inform me in greater depth. And that went on.

**Q24 Charlotte Leslie:** So when after full inspection the Ofsted assessment was changed from "good" to "inadequate" were you surprised at its findings? Do you think there were things that Ofsted picked up, which changed its assessment from "good" to "inadequate", that you had not picked up on—if you felt that the original assessment of "good" was a valid assessment for the local authority?

***Sharon Shoesmith:*** The two things you are talking about are 2007, with the "good"; then they came back, because it is an annual thing, in 2008. What we do is put in a self-assessment. We always did it thoroughly, so they had a self-assessment that was kind of an inch thick, with lots of evidence and so on. We took these matters very seriously. They came and spent a day with us on 20 October 2008 and the news broke on 11 November 2008. We had a very good day on 20 October and we were expecting that we would break through into some areas of outstanding work; that was around the participation of young people, in that area—not children's social care, because children's social care was the one that was taking the hardest work all of the time to keep it there. We had had a huge wobble in that year of holding the service steady, and I might have expected some issues to have been drawn through that, ie some concerns that they might have had; but overall, as they left that day, we were expecting an overall "good". There was absolutely nothing to indicate that it wouldn't be an overall "good", and Ofsted knew all about Peter Connelly's death. It was informed one working day after he died, in fact. So we were expecting that.

**Q25 Charlotte Leslie:** So all the time that things were going on, you felt things were good—all the time that the misdemeanours and problems were going on that caused the tragic death of baby P—you felt the service was good all the time that was going on.

***Sharon Shoesmith:*** The service during that time, from Peter's death, took quite a knock, quite a hit.

**Q26 Charlotte Leslie:** But your assessment of it was still that it was good.

***Sharon Shoesmith:*** You are wanting me to say that, and I can't say that as categorically as you would like me to.

**Q27 Charlotte Leslie:** I am just trying to make it clear for the sake of the Committee.
***Sharon Shoesmith:*** Yes. The service had taken quite a knock. It was good; we were concerned to try and hold it there. There were huge issues of confidence among the social workers. They were deeply distressed. The department went into turmoil during that period, before the public knew, and there was a lot of, really, steadying that service. Now, there are about seven, eight, nine areas that the APA looks at, and they were all fine; they would stay good. We were concerned that the "good" recommendation we had on children's social care could go to "adequate". If anything, that's what I would have expected, because when you look at the detail of what happened around Peter, there were a number of errors of judgment—professional errors of judgment—on behalf of the social workers. They thought they could keep this little boy in that family, and they were wrong. It was as simple as that. They were wrong, sadly; very sadly.

**Q28 Chair:** Some other local authorities, including one of the largest, have a systematic record of failure in child safeguarding, which has been sustained over quite a period, and would appear, from inspection, to be considerably worse than Haringey, and of course have also had deaths at the hands of families—some of them quite horrific—after many notifications. Yet in many of those other cases the Directors of Children's Services have not found themselves in the position that you have found yourself in—that is being seen as the central figure in the tale. Do you feel bitter about the way things have worked out in Haringey, and for you in particular, in comparison to other areas of the country?
***Sharon Shoesmith:*** Do I feel bitter? Quite early on, once I had got through the stage of being at risk myself, and, indeed, having dealt with death threats and other nasty things that come through letter boxes, which I'll not tell the Committee about, I realised that the No. 1 thing that I had left was my health; and I decided to look after my health in a very serious way. So I had a regime of walking, etc. I won't go into the detail, but I have decided not to go in any bitter or twisted direction. I want to try to stay that way. In fact my earlier comments about health are as much as I would have said to have pointed at anything else. I think it is a very complex story. Of course I look back on it and there are parts of it where I cannot believe what has happened, but an awful lot of people need to reflect on their behaviour in this case. They can do that quietly themselves. A lot of people need to reflect on how they have behaved and why we have got here.
**Chair:** Thank you very much for coming and giving evidence to us this morning.

---

*Witnesses:* **Dr Maggie Atkinson,** Children's Commissioner for England, **Professor Frank Furedi,** Professor of Sociology, University of Kent, and **Colin Green,** Association of Directors of Children's Services Spokesperson on Safeguarding, gave evidence.

**Q29 Chair:** Good morning. Welcome to our Committee deliberations this morning. We have with us Professor Frank Furedi, Colin Green and Dr Maggie Atkinson. If you are comfortable with it, we will use first names. We are talking about that most serious of issues, child safeguarding. I know that you have all heard the evidence given already this morning. Given that Directors of Children's Services do not have powers over all the agencies that operate for children, is their role an impossible one? Have they been set up in a sense to fail, especially when the number of deaths at the hands of family members has been consistent, although variable, at around 50 children a year?
***Dr Maggie Atkinson:*** I was one, so if you want I can start and then pass to someone who still is. You will know that in my current role I come very largely from the point of view of what children tell me. We talk to hundreds of children a year who have experience of the systems right across the piece from schools to social care to health, to mental health, to youth justice and to others. It is, as Sharon explained, a very complex and broad-ranging job with a strong sense of a very wide span of control, even within the council. Children and young people tell me that they would rather have one door to go through, no matter which services they are then referred to if they have a need for additional help and additional support and service. Having a Director of Children's Services—and don't forget the political dimension of a lead member for everything to do with children in any local authority—is a job that is worth continuing to press on with, whether or not there is a legal requirement for a Children's Trust. I say that because former Councillor Mearns, who was deputy leader of Gateshead council when I was DCS there, will tell you that the structures which Sharon said that everybody needed under them, with strong expertise in social care, education, youth justice and health, within the council or able to be held to account by the council, are a means of getting in earlier with children who are in difficulty, answering their needs once and for all and helping them through to safeguarding or other services that they may need. People in a place feel that their endeavour is about the community in that place. What Sharon also indicated is that there are still difficulties in getting all partners—I come back to some of the other questions—to sit at the same table and decide together what is best for the children and young people in an area. That is where the hard work has to come. The role is difficult and is very big, but it is worth the candle.

**Q30 Chair:** Can it be done? They don't have powers over health. They don't have powers over the police. In a London context, in particular, there are

typically huge numbers of locum social workers. If you have somebody, like Sharon Shoesmith, who had a background in education and becomes the director, is it likely that they will succeed?

***Dr Maggie Atkinson:*** Many, many do. Cases such as those of Peter Connelly, Khyra Ishaq, the two boys in Doncaster and others make the news not only because they are truly horrific, but because they are exceptional. There are 11.8 million children and young people in this country aged 0 to 19. You can add another million or so to that figure if you include those who have been in care, because they remain the responsibility of services for children and young people until the age of 21. In most cases, and in most lives, they are kept safe, well, properly educated and are prepared to be the citizens that they will become. Most of the children and young people who we meet at the Children's Commissioner's office are rounded and truly great human beings in the making. That is in no short measure due to the quality of most services for children and young people—I am sure that you, as constituency MPs, have seen great examples that you could quote—but, none the less, it is necessary to intervene in those exceptional cases that we have discussed. Such interventions should be robust, but should always be made with a view to improving those services. If you were to read the latest Ofsted reports on Haringey, you will discover that, even in a struggling borough, such improvements are under way.

**Q31 Chair:** If you read the reports published before baby Peter's case, you might have thought that improvements were being made then, too.

***Dr Maggie Atkinson:*** You would, and, as president of ADCS, I said so, because that inspection report was the only evidence that I had to go on. Sharon has mined deeply into what lay behind those inspection reports and the evidence files concerned. This Committee, or its predecessor, has questioned the inspection and regulation systems, and it has also questioned the practitioners.

**Q32 Chair:** Colin, is it an impossible job?

***Colin Green:*** No, I would not be doing it if it were impossible. It is an exciting job, and in many respects it is the best job that I have had in my career in children's services. In addition to what Maggie has said, the job, like any large job, is a team effort. The job is made possible by the team you build around you in the local authority and in the partner agencies. The role's statutory basis, among other things, gives some leverage with the other partners. That leverage is not always easy to exercise, but it is significantly better than what we had before. You started at the top by talking about the small number of children who are murdered and might have been protected, and reducing that number will require the best quality universal services for all children. In a sense, the rationale for having a Director of Children's Services is the connection between providing universal services and providing additional or quite specialist services to those children who need them. In many ways, the job of a Director of Children's Services also covers young people and taking the lead for families in the local authority, which makes sense. All of those services must work together if we are to do better for those families who have the greatest difficulty. Prior to being a Director of Children's Services, my career was in social services—I was also a civil servant for a short time—and that hard end of children's social care was too often in a little ghetto of its own, where it was not sufficiently connected with all of the other services for children. That meant that the needs of those children, particularly looked-after children, were not well served, because, as they were with children's social care or social services, other people said, "They are being looked after," so such children became less of a priority for education or parts of the NHS. The rationale for the role remains as absolutely forceful as it was in 2003–04, when the role was developed. The job can be done, but only with a good team and political support.

**Q33 Chair:** Interagency working is important, but so is the ethos of the services provided through children's services. The interagency working seems, in some ways, to have been fine in the Khyra Ishaq case, and Maggie has remarked on the generally high standard. Certainly the schools attended by the children, who were starving to death, before some of them were taken out, were doing everything possible to raise the issue with social services. Social services simply batted it away. Once the children were withdrawn from school, social services seemed to think that it had no role in welfare, because of confusion caused by its lack of training and understanding. That was in Birmingham, which is one of the largest authorities in the country and which has a record of sustained underperformance in this area. How can we have confidence in social services?

***Colin Green:*** I'd like to add to that in a broader way, rather than talking about a neighbouring local authority. Clearly, because I work in Coventry, I know a fair amount about Birmingham. First, there are serious issues in the work force, and the key to improvement is about improving the work force. The work force, it is fair to say, has had decades of neglect in terms of the key profession, which is the social workers. Importantly, however, there are others involved in that. The guidance and legislative framework for child protection is sound, but it has become enormously cluttered and excessively elaborated. The work force weaknesses and that elaboration are connected, because work force weakness has been dealt with by trying to prescribe the system in excruciating detail. In this case, which obviously I have read something about, you can see that people were following the process, but they were not thinking. I think we have got too much process and not enough thinking.

**Q34 Chair:** Social services did not follow the process, though—they did not even know the process. They thought that if a child was home educated, they did not have a welfare role. They thought that that welfare role was the home educated team's job, but it wasn't and it never was. It was quite clear in all the

guidelines on home education and on children missing school, yet they were confused about the most basic functions of their role in protecting children. How was that possible?

***Colin Green:*** It was possible because people get into a tramline mindset in following the process. They thought, "Ah, this is home education, I have categorised it as that." They did not think about it in a broader sense, about understanding the meaning of what had happened to that family and to many of these other challenging families. Social services did not try to understand why things were going catastrophically wrong for these children who had been reasonably well cared for, up to a certain point. People were in their tramlines, and when you have that mindset and a service under enormous pressure, with—as we do currently—increased demand, increased complexity and high expectations, that is when things can go wrong.

***Dr Maggie Atkinson:*** One of the things that I want to add to what Colin has said is that when you interview children who have had contact with the system, they are remarkably consistent with what Lord Laming had to say after the baby Peter case. Professionals need not only to work with each other, but to listen to what children are saying, listen between the words of what children are saying—sometimes there is a hidden disclosure going on—not to take the adult's word for what is being said, to be consistent and approachable, and ready to be accessed and to listen and to act on what a child says. Very often, a child has screwed up their courage to say what needs to be said about their home situation. Lord Laming discussed maintaining professional scepticism, going in with an eye for the child, not for what the adult is telling you and for probing beneath apparent compliance. There were many recommendations from that report. What children tell me as Children's Commissioner is exactly what Lord Laming told the country in that report. Children find it difficult to disclose and they find it difficult to put their parents in a situation where they would feel that they were betraying them. There is a need for the system to take the child's interests first and to always listen and look at what is going on. One of the things that the Birmingham report indicated was that they took the adult's word too easily. You have to get behind the adult and get to the child.

**Q35 Chair:** A whole raft of children in that family starved to death and suffered malnutrition, with schools which were highlighting it. You didn't need to listen to the child; you just needed to see that they couldn't pay attention and that their trousers were falling off them, to use one of their teacher's phrases. Somehow nothing happened.

***Professor Frank Furedi:*** A couple of points from the outside. Some questions were raised about process. One of the problems with process is that it is not straightforward when it becomes a substitute for professional judgment. As a result, we have a situation where leadership is measured on the basis of how well you know the process, whereas the underlings are the ones who need the process interpreted to them. For example, a friend of mine who is a legal scholar called the helpline of the Criminal Records Bureau to find out what the law was and she had to wait an hour and a half before she was given any kind of answer, because the person at the other end had no idea what process should have been followed. You get conflicting interpretation. One of the problems that we have had in Haringey, apparently, and elsewhere is that the one-dimensional dependence on process leads to a lot of impression management—a lot of rituals of pretending to do things that are not actually happening. Children are let down because of that. Another issue that the review should consider is inter-agency co-operation. At the moment, that has become a form of outsourcing authority and responsibility to somebody else—somebody else will do it. We are seeing that although it is a very good idea in the abstract to co-operate and to have all these little committees where we sit together, it becomes a way of bypassing responsibility for whatever is going on. That issue needs to be confronted and it comes up time and again in almost all of these cases.

**Q36 Lisa Nandy:** I want briefly to follow up on the point that you raised, Maggie, about the voice of the child. Sometimes it is not just about listening to children, it is also about making sure that that voice is elevated to a level where it is heard and put at the heart of the intervention. We have seen time and again with these high-profile cases that the voice of the child has not been at the centre of the intervention and has not been heard, despite the fact that they were saying things that ought to have been listened to. Do you think that there is a particular role for the Children's Commissioner in highlighting that voice, particularly in areas where children's voices are not routinely heard, such as in custody and in immigration detention?

***Dr Maggie Atkinson:*** There is a very central role for the Children's Commissioner. We are under review, but we will say that there continues to be a role in elevating that voice. One of our current roles is in helping Eileen Munro in her review by bringing children and young people into her research environment. We have not only been getting them to answer questions formally, but we have held several evidence sessions, where members of her research team have come to listen to children who have experience of the system. What those children are saying is, for me, a blueprint model for what the profession ought to look like. They are saying: "Make it consistent—do not chop and change;" "Do not assume that when you have solved the first problem, the family is healed and you can simply walk away;" "Do not close the case just because I no longer ticks your boxes;" "I need you to continue to be with me and to listen;" "I have had my case opened and closed enough times now;" "Stay with me, be consistent, make it happen for me;" "Broker my access to other agencies;" and "I'm a young carer, I'm looking after my mum, who has a mental health problem. Don't just walk away when you've looked at my mum—I need help as well." What we

submit to the Munro review, which is heavily influenced by the voices of children who have had experience of the system, will be very much a blueprint for the profession. That is one concrete indicator of how the Children's Commissioner's office can influence what happens in professional development and training. We think that children who have experience of the system should be used in helping to define whether somebody who is entering social work training has the mindset to work with children and young people in the first place. We think that children and young people's voices from the youth justice system could and should be pushing the Youth Justice Board and others towards only ever employing people, in lock-up situations, who have declared themselves wishing to work with children, and not just as a prison officer. You know that we had influence on the situation for asylum seekers and the end of detention, because Damian Green has said so. Those are really important roles for the Commissioner. Children who are in difficulty, in danger, or at risk find it very difficult to lie about their personal circumstances, so their voices are very powerful. We quote them extensively in everything that we publish and send to MPs, so you are welcome to read what we do.

**Q37 Lisa Nandy:** Thank you. I also want to touch on the issue about the social work profession, because how we empower social workers to do their jobs is particularly important. It has been established beyond doubt that the high-profile cases, in particular the baby Peter case, have had a really demoralising effect on the social work profession. I want to ask all of you on the panel whether you would accept that? On the issue of media coverage, what do you think the impact of it has been, and what could have been done differently that might have protected the social work profession from such effects in those cases?

***Colin Green:*** May I start on that? Certainly, it has had a big effect on the social work profession, which of course is far wider than children's services—there are thousands of social workers working with adults, people with learning disabilities and people with disabilities. It has had a big impact for children's services, as did the Victoria Climbié case and as have a number of horrific cases over the past 30, 40 or more years. The response to that, of trying to rebuild the social work profession, and the work that Eileen Munro is doing, which there is considerable optimism about, are important steps in trying to put some of that right. In terms of the media, I have spent considerable time thinking about this. In Coventry, we have taken a number of initiatives in this area. Social workers have, because of what has happened, shied away from explaining what they do to the media and from allowing the media in, there needs to be more of that. You have to see the media as essentially like the weather—you probably can't do a lot about it, but at least you can be prepared for the kind of weather coming your way. So, there is something about being well prepared and understanding that perspective. But we need to be proactive in trying to explain what we do—there are real difficulties about that, but some of them can be overcome—and in trying to help the media present what we do with some balance, using those parts of the media who are open to that approach.

***Dr Maggie Atkinson:*** I would echo what Colin has said. I would come back to saying that the most powerful voices you have are the children and young people themselves, if they are properly guided and prepared, and if the media understand that they have a responsibility to reflect back to the nation how fantastic most of our children and young people are—how well parented, looked after, nurtured and brought up they are, how well schooled they are and what contributions they are already making to society as volunteers and in other ways. It is within that context that the media should look, when the light of heavy criticism needs to be shone. My issue with the media is that, in this country, it seems that good news is not news. That is a real issue, and no doubt it is one for you in your constituencies and in the roles you play. Good news isn't news; it's always the bad news that makes the front page. That is a real issue for children and young people as well, including those who are exposed to the system that we are talking about this morning, the safeguarding system. They get to the stage, as you know, in our work on transparency in the family courts, where they say, "Why would I want to tell my story if I am going to be portrayed as a broken child in a broken society from a broken family in a broken estate? I am not going to talk to anybody. I am not going to talk to my lawyer or my social worker, if you let the press at me." We have to work with the media to get them to the stage where not everything is tarred with the same brush. Of the social workers that I left in Gateshead at the end of February, I would say, because we spent a lot of time with them, because elected Members came to see them, because we supported them and because we celebrated what they did, as winners of awards in the council—we had some of the longest staying social workers in the country, including some who had been in Gateshead for 27 years and who wouldn't have wanted to go anywhere else—that they were fantastic. They were great because we celebrated them as, every now and again, so did the local press. The picture of a profession that is absolutely under the cosh, or living under a stone somewhere, is not universal. There are some real heroes, doing fantastic work every day, and we need to find a way of getting the media to say so.

**Q38 Lisa Nandy:** Do you think that we could do more to promote that as well?

***Dr Maggie Atkinson:*** Absolutely. Go and see the teams. Get yourself out on a day with a preventive worker, a youth offending worker or a social worker who is attached to a children's centre. Go and spend some time with such teams, who will value you, including just for having the name—"Such and such an MP is coming to see us." They will feel really supported.

***Professor Frank Furedi:*** There is a danger of missing the big picture by pointing a finger at the media. Of course, the media do horrific things as they did in the

Haringey case and they are responsible for promoting all kinds of panic. But when you talk to social workers, especially the more creative, dynamic sort of social workers, you will find that what demoralises them is not the occasional media representation that they are uncomfortable with, but the very fact that they spend a phenomenal amount of their time not doing social work. So when Sharon Shoesmith was talking earlier about her being surprised by seeing all these people hanging around the offices, that is not unusual. You often find that, if you look at the amount of time a social worker spends out with real people, it tends to be less and less compared with the amount of paperwork you are doing, and the extent to which you are forced to cover your rear end rather than think creatively about the job you are engaged in. That is what is demoralising. I talk to my ex-students who went into social work, but who have subsequently left social work precisely for the reason that they got fed up with not being social workers, but being petty little pen-pushers.

**Q39 Tessa Munt:** I am quite interested in your analogy of the weather and, if you can see the storm coming, how much of an impact that storm has on people's behaviour, and since 2008 and the Baby Peter case, looking at the reaction of the general public and of the services to the possibility of a storm coming? Have people changed their reactions, their reporting and their actions as a result? Do you get that sort of effect where stories happen? How do you balance out people's responsibility to report and react to circumstances they may be aware of, particularly the general public, but also the services concerned?

***Colin Green:*** It is quite hard to separate out some of the components, but certainly one of the responses is a very defensive response, a response that is about compliance. In a sense, it is hard to separate out some of the response that is about the media. It is also about the response of the Government and the regulators. The response of the regulator, Ofsted, is often about compliance and too much talk, in a sense, of "How did we get the process right" not "Did we get the result right?" The two are linked in the way they operate. While the media are more of a storm, the regulator is more a kind of thing that is with you all the time. It is about changing both, and the regulator, the impact of the regulator, and the wider comment in society are more of a constant feature. So it is important that both get adjusted or we make some change. We will have to have a more positive discussion about what it is we want from our safeguarding child protection system. What do we think should happen in families with the most serious difficulties and are really struggling to care for their children? How do we want to intervene? What risks are we willing to take around intervention, and so on?

**Q40 Tessa Munt:** I was going to ask you about risk, in particular, and whether attitudes have changed to risk and whether they just change as a result of storm or whether it is consistent. Has there been a change of attitude to risk since 2008?

***Colin Green:*** I think it is quite hard to unpack it because there is some evidence that the rise in work load started actually before November 2008 and therefore other things were going on, some of which are about improved recognition of things that are harmful to children, in particular a much better appreciation of the impact of domestic violence. There has been a lot of attention on the long-term impact of neglect, still an issue we don't tackle as well as we might. Those are part of the picture, alongside possible impacts of the recession, possible impacts of our society becoming much more complex—certainly I would feel that in a major urban area in terms of how diverse the population is, how volatile it is in terms of people moving around. All those things are making a difference. I am not sure there is real evidence that we are necessarily notably more risk averse in that sense, but we are identifying more need and responding to that, perhaps more assertively.

***Dr Maggie Atkinson:*** I am on record in public as regretting some of the "cotton-woolling" that goes on of some of our children and young people. I am in my mid-50s and as a child, I used to disappear for a day at a time, climb trees, fall in water and all sorts of things with kids my parents did not know, and I was very pleased that they didn't know them. Twenty years ago, that was at the end of the street, and only with children you knew. Ten years ago, it was—maybe—a play area that your parents had sight of, and then only with a select group of children and young people. For some of our children these days, there are the twin pressures of having something to fill every minute—dance, horses, music and goodness only knows what else—and only being allowed to play in the garden if somebody can see you. We have to get to the stage where we as a society understand that childhood is childhood and needs to be allowed to be so. That's so whether you are vulnerable, poor, affluent, disabled, or terribly able-bodied and very bright—every child needs the right to be a child. You have to work out between you, as a family, what the length of the leash is on which children are allowed to play. In families that are dysfunctional and chaotic, or where children and parents are not bonded or attached, the leash can sometimes be far too long. That is the point at which children become out of sight, out of mind and not properly parented. It is also the point at which parents either abdicate their responsibilities or claim not to have them, and that happens not only in difficult, inner-urban estates but elsewhere as well. It seems to me we need a national conversation about what childhood is for. Who are the adults in this situation, and how do we keep our children safe without so locking them behind closed doors that nobody actually knows how safe they are and they are not taught risk as opposed to foolhardiness? We need an ongoing national conversation about those things, because it is about rearing, educating, health and everything in between.

**Chair:** Can we bring Frank in on this?

***Professor Frank Furedi:*** There is no doubt about the fact that we have become steadily more risk averse. When I wrote my study, "Paranoid Parenting", in

2001, there were many things that children could do that are now no-go areas. Every week, I get four or five e-mails from parents telling me that they have been reported to the headmaster, the police, or to somebody in local government, simply for trying to give their children independence—getting their kids to walk to school. The other day, I got an e-mail from somebody in Kent. She had been planning for months to get her daughter, a 13-year-old girl, to come up to London for the first time, with another 13-year-old girl. It was a big day for them, but they got into trouble because of that. It seems that we have an intensification of risk aversion, which hides something more profound, which is responsibility aversion. When we deny children the opportunity to engage with risk, we are saying "No, you cannot do it. Don't go outside. It's impossible to do it". It is much easier to say that and not take responsibility for our kids than to work out ways in which children can manage that risk for themselves, so that they live in a community where it is expected of all adults to be responsible for their welfare. Instead, we have created the situation where adults have become entirely estranged—physically estranged—from children. They are no longer allowed to go anywhere near kids. You literally need a licence to be near a child. As a result, perversely, children are far less secure. We have to remember that even if you have 1 or 2 million social workers, in the end, the safety and security of children depends on the quality of communities, and the responsibility that communities take for them. Risk aversion, which really means responsibility aversion, has the paradoxical consequence of compromising our children's existential life.

***Dr Maggie Atkinson:*** I think we are generalising from the specific very much in what has just been said. We cannot, as a society say at one minute, "They are locked away and never allowed to take risks", and the next minute, ask, "What are they doing outside my house playing football?" Are these the same children or are they not the same children? We need a balanced conversation about how to keep children safe without absolutely locking them down, and we need a balanced inter-generational conversation about how best to approach youngsters who are simply being children in our communities, not out to cause trouble because there's more than three of them. It is more subtle and complex than is being portrayed to my right.

***Professor Frank Furedi:*** I don't know about subtlety and complexity, but all I know is that if you now have mums who want to go into the playgrounds of their schools, and they are told that they cannot enter unless they are CRB checked, there is no subtle balance. If you talk to the headmaster about it and say, "Why are you not allowing this woman to go into the playground?" and he talks about process and everything else, and instead of being embarrassed, says, "I'm just being sensible about it" that is not subtle or complex. When you have a situation where children, who used to be able to bicycle or walk to school, are now regarded as eccentric if they do so, and their parents are regarded as irresponsible, that is not a subtle or complex situation. What we are doing is creating a world where children are forced into their digital bedroom more and more. At the same time, we have a small minority of children who are tremendously at risk, and who are also suffering from the fact that adults in their communities no longer keep an eye on them, because they think it's not their business any more.

***Dr Maggie Atkinson:*** The generalisation I would point out is that there are 11.8 million of them. I got on the tube this morning, and it was full of children going to school on their own. I walk the streets around Southwark, where my office is, and there are children walking from school to home and from home to school all the time on their own. If there are 11.8 million of them, not all of them can be as has just been characterised—that is my issue.

**Q41 Damian Hinds:** We would all recognise some aspects of the obsession with "credentialisation", process and so on. As a candidate, I remember visiting schools and being asked whether I was CRB checked, which I thought was absolutely ludicrous. I was more interested in what Maggie was saying about the need for a national conversation, and that we as a society need to talk about these things. In my experience, people are talking about them, and there is a national conversation going on. All sorts of sensible and normal people say that some of these things have got completely out of hand. As Children's Commissioner, what do you think should be done about that?

***Dr Maggie Atkinson:*** Many of the changes that Roger Singleton steered through before he stepped down, particularly the vetting and barring scheme, were good developments. It is sensible to stand back from the vetting and barring scheme, as is happening now—as we speak—to look at what we actually need. But I would remind the Committee why the vetting and barring scheme was introduced in the first place. It was introduced after the murders of two little girls by their school caretaker. As a nation, we need to work out where between the two extremes of "lock them down" and "don't lock them down" we are actually going to sit. That is why the conversation that you have just characterised, which is ongoing, is important.

**Q42 Damian Hinds:** I meant in terms of risk aversion in general. Even people who complain about children being outside their house are the same people who say, "We want the children to have a childhood." You are the voice of youth, so what can the public, government and local communities do to turn that conversation, which has a large consensus, into something that makes a difference for children?

***Dr Maggie Atkinson:*** One of the great moments of opportunity is with us at the moment. If localities are having to make stringent cuts to things like how many public buildings they run, one of the things that is incumbent on them, and is entirely in line with what all three parties were talking about in terms of community development, is to bring the generations together in a properly structured way to talk about their communities and what is needed, which is what children and young people are asking me. How do

we make it possible for youngsters to play football after dark without them being reported to the police 15 times by people who would rather have "No ball games" signs than "Children welcome here" signs? What children are asking for, particularly the teenagers, is to be helped to talk to the older generations in ways that frighten neither of them, in proper community settings, usually with a project in mind—"Can we turn this stretch of empty green space into a community allotment?" or, "Is there a way of us, as young people, helping you, as older people, to keep the war memorial up to date and clean and tidy?" or, "Can we work together on community programmes that are about learning about each other and learning together?" That is what they are asking for. We are in a moment of opportunity. If you cannot afford both a community centre and a youth club and a this and a that and the other, and you can only have one of those, you're all going to have to use it together, so how about we run some properly structured programmes? There are organisations that can help you do it—from the voluntary sector, from academia and from the schools in our communities—and who will help to bring those generations together. It is happening already in many parts of the country, and it does bear fruit. It is very important, because the two ends of the age scale characterise each other as not understanding each other. Actually, it is about bringing them into spaces where they learn to speak each other's language, and that is what children are consistently asking for.

***Professor Frank Furedi:*** Unfortunately, the generations will not come together as long as we believe that child protection is based upon the vetting, monitoring and surveying of adults. As long as adults feel that they are being viewed as potential criminals they will feel estranged, and in many cases will feel very awkward about physically coming near children. It is a very big problem, particularly for the older generation. When you talk to them they often feel very uncomfortable about being with children not because they do not want to be, but because they are worried about how their behaviour will be interpreted by other people. This is where politicians and people like ourselves have a very important role to play in encouraging some kind of cultural change so that the default position is that we think adults are responsible, decent people, rather than potential paedophiles. I think we need to establish that, and we need to act on that basis.

**Q43 Chair:** The culture change that has taken us in that direction, about which there may or may not be a consensus that it is the wrong one, was based on a series of legislative and administrative process-based actions, which tipped things that way. I think Damian is trying to ask—rather than wishing a culture change, which I don't think we will effect from this room, however persuasively we talk—what actions need to be taken. It is like anything to do with health and safety, where people say, "Tell us the specific ones you want to withdraw, where you will accept the increased risk by removing them," when it sounds as if it is there to protect small children, for instance. You have to remove that and take it away, and accept it in order to change the culture. Is that true, and if so what should we do?

***Professor Frank Furedi:*** We should take away the vetting and barring scheme straight away, because it creates more problems than it solves. We need a sensible system for monitoring people who either work full-time with children—teachers, social workers and people of that sort—or who are consistently exposed to them in specific areas of volunteering. The inappropriate extension of the scheme into other areas, which has happened in recent years, is really where the problem is. We need very specific forms of monitoring where this is really explained. We also need to have somebody, either in social services or elsewhere, whose job it is to police the bureaucratic mechanisms that have been established and keep them from getting out of hand in the way that they have. Yesterday, for example, one local government wrote a letter to parents because they allowed their kids to walk to school. In that instance, it would be their job to reprimand that local authority for causing harm and creating difficulties for the individuals concerned. We need to bend the stick in the opposite direction.

***Colin Green:*** I am afraid—

**Chair:** Colin, your body language is showing that you fiercely disagree with that. We must move on or we will not deal with other issues. I hate to cut you off, especially when you have so obviously been severely provoked.

**Q44 Nic Dakin:** I was provoked as well, but I will move on. Is the publication of Serious Case Reviews the right thing to do? Does it in itself bring about the accountability that is desired, and how do we make sure in those cases that surviving children are not harmed by that publication?

***Colin Green:*** First of all, it is important that there is accountability, but I do not think that full publication of Serious Case Reviews will achieve accountability. The primary problem with this is that—I am just trying to make sure I state this clearly—what we have had, and the move towards publication means that the focus of the Serious Case Review will become on preparing a document for publication, or preparing a document that will get full marks from Ofsted. It will not be on learning, it will not be on organisational change and it will not be about what we really need to do differently in those cases. I feel that publication is a costly exercise that will not contribute either towards better accountability or towards keeping children safer.

***Dr Maggie Atkinson:*** I would add to that, and again I am on public record as having already said this. If it becomes an extremely process-driven and document-driven and get-the-ticks-in-the-boxes-driven exercise, how is it supposed to continue to help to keep children safe, whether they are surviving siblings or not? For me as Commissioner, the big issue—because we see all of them—is the quality, honesty, robustness and detail in the executive summaries of Serious Case Reviews. To come back to an issue raised earlier in this conversation, there are partner agencies whose members would, I think,

stand back from even allowing their documentation to be used as part of a Serious Case Review if the Damocles sword of potential publication and pillory in the press was held over their heads. It is not an aid to co-operation between agencies. The biggest insult as far as children and young people who are surviving siblings and have talked to us as an agency are concerned is, "You are about to publish this, but you have not talked to me about it. When were you going to ask my opinion as a 13-year-old surviving sibling in a desperately awful case? If you're not going to ask for my opinion, how do I respect you as professionals in the system? Why would I want to? All right then, I won't tell my story." How safe are they if they are not going to tell their story because of their fear of publication? If you are child B and child A was the subject of a Serious Case Review and you live in a tiny village in the back end of a dale in north Yorkshire, everybody at your school is going to know that you are child B even if your material is redacted. It's not a means of keeping children safe and it won't be a means of entirely assuring the system that it will learn. If you want to make them trials, then call them trials; Serious Case Reviews are supposed to be learning exercises.

***Colin Green:*** I would just add that in terms of the issue of learning, the biennial reviews, where research teams looked at all this, have been a very powerful learning tool. That is the way to get the learning out to a wider community in a systematic way that has been synthesised and can give people a focus on what they need to understand has gone wrong and what we need to do differently.

**Q45 Nic Dakin:** Moving on from Serious Case Reviews, has the abolition of the National Safeguarding Delivery Unit, which Laming asked for, been a loss to the promotion of good practice? You might want to take that first, Colin.

***Colin Green:*** I would say yes, because all the National Safeguarding Delivery Unit did was bring together the civil servants from across government who had leads on safeguarding. I worked as a civil servant on safeguarding for three years in the then DfES, and one of the perennial issues was ensuring that government departments worked together on safeguarding, particularly the Home Office and the Department of Health, but not just them. The Safeguarding Delivery Unit brought those people together and co-located them with some clarity of common leadership. I thought that was potentially really beneficial. It didn't add anything to cost and it wasn't a quango—it was simply about bringing people together so they could do their policy work more effectively.

**Q46 Nic Dakin:** What should replace ContactPoint?

***Dr Maggie Atkinson:*** In my last job in Gateshead, we were a pilot area for ContactPoint and we saw that it made a difference. Let's just be clear what ContactPoint is not: it is not a database full of case records, case conference minutes or whatever. For most children in this country, what ContactPoint did was tell you who they were, when they were born, where they lived, their GP reference number and where they went to school. For most children, it was simply one simple, central national record of where they were. For those children who needed additional services, it enabled me as, for example, an Educational Welfare Officer, to get into the system with three or four passwords to work out who else had contact with that child. Children and young people tell me, "I'm sick of telling my story five times over. I need all these extra services, and I need to tell my story once. Whoever's doing it then needs to work out who else needs to work in the team around me." If we are going to have a database only for the vulnerable, I would like somebody somewhere to sit me down and define "the vulnerable." Do you mean all four million in poverty? Do you mean all 1 million with a disability? Do you mean all however many with a special need? Do you mean anybody who comes home from work and suddenly their dad's not got a job and they're about to be thrown out of their house? Do you mean somebody whose family has suddenly broken up? Define me "the vulnerable" and where one is not and one is vulnerable and I'll tell you that we can only have a database for the vulnerable. It is really important that we have something simple, clear and fast.

**Q47 Nic Dakin:** Are you essentially saying that ContactPoint was that something, or were people right to be critical of it and do we need something else?

***Dr Maggie Atkinson:*** For us in Gateshead, it was that something and I could show you concrete proof of finding a child who had gone missing in another borough, because they came in to us and we knew what their national health number was and we found them within 48 hours. And they were in danger.

***Colin Green:*** I was more sceptical about whether ContactPoint would ever work quite in the way that Maggie has described. I am more sceptical about whether we can construct something else that is somewhere between the list of children who have a child protection plan and all children, for the reasons Maggie has very briefly outlined. It is also for me, in what are going to be hard times, about the opportunity cost of trying to create yet another technical system. My concern with ContactPoint is and always was that it was yet another technical fix for what I see as essentially a human problem, which is about people recognising they have information that needs to be shared and that they need to go and talk to other people to whom that might be useful, and vice versa. That really is my concern. The effort needs to go into the training and development of the work force, so that they understand who they need to talk to and do that in a proactive way.

***Professor Frank Furedi:*** In addition, from a sociological point of view, there are a number of other reasons why it is a really horrible idea. One is that it tends to fossilise identity and leads to a situation where what is on the screen is the child, rather than the living creature that is out there. That often tells us that random databases are a very illusory way of dealing with child protection, or for any social problem for that matter. It is a lazy way of going about the whole process.

***Dr Maggie Atkinson:*** Chair, I have to come back.
***Professor Frank Furedi:*** Secondly, there is a tendency, when you have databases, to invite more information and other people's suspicions, and notes also get on it. So databases very rarely stay still. They tend to expand with the passing of time until you get to the point where, especially when you come to more subtle nuance issues, they become a little bit unreliable. That seems to me to be a danger. From a non-sociological point of view, it is a civil liberty issue. A society that has to put all the children on a database is basically saying that we are a sick society—that this is the only way we can proceed. That is a form of self-condemnation that I am really surprised that enlightened practitioners are comfortable living with.

**Q48 Nic Dakin:** May I move on to one last area, which is the Munro review? There has been review upon review upon review in this area. Do we need another review and, if we do, has this got the right remit?
***Dr Maggie Atkinson:*** We do need another review and this builds on what Moira Gibb's Social Work Taskforce did in such sterling fashion, but what Moira and her team were looking at was the structure of the profession. The really positive thing that Eileen has been asked to look at is the nature of front-line practice. What that then enables you to do is to listen to the voice of the client of that front-line practice. That enables you to then re-shape the front-line practice to tackle exactly what Frank raised, which is too much time away from the client transforming into better time with the client—staff who do not know what the profile of a social worker should look like being told from the horse's mouth of the client's experience what a social worker should look like. Eileen has been asked to do it in a very short period of time. She has been asked to give concrete recommendations on how the profession ought to move into the 21st century. This is the finishing point of the work that Moira Gibb did leading up to this.
***Colin Green:*** I would agree with all of that. It is a very wide remit, so there are some concerns about whether there is the time to cover such an enormous scope. I feel that it is more practice-focused. Also, given the direction she comes from with her academic research and interest, we know it will be focused on practice and be a systematic and human look at what actually happens and why things go wrong. We will not get 100 recommendations about process and procedure.
***Professor Frank Furedi:*** She is unusually sensible for an academic, so I completely agree with the two comments.

**Q49 Chair:** Are the current levels of safeguarding activity—as we know, it has gone up a great deal since 2008, for whatever reason—sustainable, given what we know about local authority budgets? Is it reasonable for us to expect that funding for preventive and early intervention services might suffer as a result of the expected reductions?
***Colin Green:*** To put it another way round, the activity is there; the question is, can local government and the partners sustainably respond to that level of activity? The answer at the moment is that it is proving very challenging to respond to that level of activity and do it to a reasonable standard. That is really the crux, because a lot of the issue is that where things get into serious difficulties, there are often problems about the sheer capacity of the system and of people to do the work, and to do the work well. If you're looking at social worker case loads, health visitor work loads or work loads in police public protection units, all those are up, and that leads to compromises on quality. One of the quality issues, of course, is about the quality of recording. Although I agree that people spend too much time at their desks, this is an area that requires very careful recording. These are children's lives. There may be critical decisions made, on the basis of records, on whether children may be separated from parents, and so on. It's a real concern. I think it is quite possible we will be in a scenario where preventive services will go, because of the need to maintain the child protection services and services to look after the children who are already in our care. Once you have a child in your care, you have got to provide a service. That is a very costly service, and it may well squeeze out other services for children and young people.
***Dr Maggie Atkinson:*** My warning to the system has been consistent since I took up office: be careful what you wish for when you start to cut preventive and early intervention services. The very services Colin has just carefully and eloquently described will then be even more swamped than they are now, because there is no diversion or dilution of behaviours and no early intervention in families who, if you got in early enough, would recover. I recognise that every public service, my own organisation included, is having to face some very tough decisions about what we spend and how we spend it. If you simply take the easy way of cutting the discretionary and the universal, you will live to regret the day you did it.

**Q50 Ian Mearns:** I have often been made aware of the tension between the levels of need driving the service and the resources available. We've been through some very difficult times recently in children's services—Sharon's still sitting there listening to all this. We have heard about the recent history of demands on services and the breadth of the role of Director of Children's Services within a local authority—I think it was John Bangs from the NUT who described it as "undoable" in evidence to this Committee in its previous life. Given all these tensions between resources and needs and the times that we're in, is it going to become more difficult to recruit people who are capable of fulfilling the duty of a Director of Children's Services into the future? Are you finding any sort of wastage in the system where people are bailing out because of the demands on them as individuals?

***Colin Green:*** There has certainly been, I would say in the last year, a change in about 40 local authorities in Directors of Children's Services. That was a full mix of retirements, people moving between authorities and so on, so it is quite a high rate of churn. To be frank, I don't know how hard it is to recruit. I certainly know a number of authorities have had to look pretty hard, and maybe go out a couple of times, so I think the demands of the job are reflected in that way, but the National College for Leadership of Schools and Children's Services, or whatever it's now called, is doing a lot of work to try to ensure that there are people coming through who have been prepared for the role.

***Dr Maggie Atkinson:*** I'd add to that that there is certainly a breadth and depth of talent in the system. It is about the current generation of directors not portraying the sense of hero leadership. I come back to what Colin said earlier: this is a team effort. You can't keep the whole of the job in your head. Somebody else has to step up in very senior roles and have exposure to elected members, partners and other things, so that they are ready to take it on and can see it as a possible next step. There is a vast array of talent out there, and I come back to what I said earlier. That's why most children's services departments are extremely good.

**Q51 Ian Mearns:** Given the collegiate approach that is necessary, and the requirement to fulfil the role and provide the services adequately, you would need different agencies to work together. Given all of that, do you think it's therefore reasonable that a Director of Children's Services is ultimately accountable for everything that happens on their patch?

***Dr Maggie Atkinson:*** I'd say an unequivocal yes. I always saw myself as being absolutely where the buck stopped.

**Chair:** I think we will bring this session to a close. Thank you all very much for giving evidence to us this morning.

---

*Witnesses:* **Tim Loughton MP,** Parliamentary Under-Secretary of State for Children and Families, and **Dr Jeanette Pugh,** Director, Safeguarding Group, Department for Education, gave evidence.

**Q52 Chair:** Thank you both for joining us this morning, Dr Jeanette Pugh and Tim Loughton MP. It is a pleasure, Minister, to have you here for your first appearance before us after taking office. Lord Laming said that what was required now was to—I think he said—"Just do it", echoing Nike or whatever. Why, after Lord Laming's Social Work Taskforce and all the other reviews and efforts, have you decided to have another review instead of just getting on with it?

***Tim Loughton:*** Perhaps I can make three introductory remarks, and then address that entirely. Thank you, Chair, for introducing Jeanette Pugh, who is here as my minder. She is the director of safeguarding at the Department for Education, and a very excellent one at that. First, I really welcome the review that the Committee is doing. It is a really important issue. Child safeguarding and the protection of vulnerable families is a very important part of the work of the Department. It does not get the recognition it deserves in Parliament more generally, and I think the Committee's work will help to resolve that. Secondly, this is a very important issue for me and for our part of the coalition, in particular. For several years before the election, we did a lot of work around social workers and child protection. The commission on the future of children's social workers, which I chaired back in 2007, produced a report, *No More Blame Game*, and a second report in response to the Laming inquiry in 2009, and we then produced a document called *Back to the Frontline* in February this year, ahead of the election, so there is quite a lot of form in this area—it isn't something that's just happened. Why I think it is particularly good this inquiry is happening now is that it's not a knee-jerk reaction to another tragedy that has just happened, which is usually the only time we get a focus on this particular area. On the third thing—and then responding to your question about why don't we just do it—I think we've done an awful lot in the first four months of this Government. Within the first 100 days, we had set up the Eileen Munro review—no doubt we'll have more questions on that—which I think is absolutely crucial. We had established the new regulations for publication in full of serious case reviews, and the first of those was published retrospectively at the end of July with the Khyra Ishaq case, and I think that that was a very positive and widely welcomed move. And, on 6 August, I gave the order to switch off ContactPoint—again something that was a clear undertaking in the coalition agreement and in the manifesto commitments of the two coalition parties. Added to that, the vetting and barring review is under way, which is very germane to safeguarding; I've been doing various things around fostering regulations; there is the family law review, which is essential for CAFCASS, which is very much a part of this area—and so on and so forth. So there is an awful lot we have done at a very early stage in this new Government.

**Q53 Chair:** What will the review cover that Lord Laming didn't?

***Tim Loughton:*** What is different about Eileen Munro's review? The first reaction to it was twofold: first, "Oh no, not another review" and, secondly, "Does that mean that all the very good work done by Moira Gibb and the Social Work Taskforce is going to be junked?" My response to that is no, this is complementary to the work of the Social Work Reform Board and all the excellent work that Moira Gibb has done. The very first person that Eileen Munro went to see was Moira Gibb, and one of the people from her reform board is serving on the

reference group. Secondly, on why it's different, so many reviews in the past have been knee-jerk reactions—a disaster has happened and something must be done about it. There's a big review, and the result of that is usually several hundred extra pages of regulations added to the rulebook. I believe those regulations have added to the problem and resulted in social workers and other key professionals spending up to 80% of their time attending to processes, usually in front of their computer. What I think Eileen Munro will come up with—I am in the slightly difficult position of not wanting to prejudge her final report, let alone her initial scoping report, which is due out on 1 October—will, I hope, be to get rid of a lot of those regulations, or to say that, actually, this stuff is standing in the way of better child protection and we can do it better with fewer regulations, relying on the common sense, the good training, good practice and professionalism of social workers and other professionals, if we just allow them to get on with the job of being social workers.

**Q54 Chair:** Is the brief that Professor Munro has had from Ministers such that she will feel constrained by the financial circumstances we're in, or does she have carte blanche to recommend those things, however expensive, that she feels need to be put in place to protect children?

***Tim Loughton:*** I made it absolutely clear, as did the Secretary of State when he wrote to Eileen Munro confirming her appointment, that she has absolutely carte blanche. There are two things we've given her, effectively. One is a destination, and that destination is to come up with a system that protects children better by freeing up social workers and other professionals to spend more of their time eyeballing the people they are there to protect at the front line, and able to make well informed value judgments, some of which will be wrong, but they will be better informed value judgments that their professional training leads them to be able to make. That's the destination point. We gave her a couple of landmarks, if you will, and that is that we are scrapping—have scrapped—ContactPoint, and secondly, that we will publish, and are publishing, serious case reviews. As to where she goes from there, it's entirely up to her. There will be areas that she feels the need to look at in terms of inspection and training, what other professionals are doing and so on, and it's entirely up to her to do that.

**Q55 Nic Dakin:** We have just heard from the professionals about the publication of serious case reviews and the concern about going down exactly the legalistic line that you've described previous initiatives doing. How can we be confident that that won't be the case?

***Tim Loughton:*** I entirely disagree with that sentiment. If the contention is that it would all be about preparing for the serious case review, up to now it's been all about preparing for the executive summary of the serious case review, which is the only public face of that investigation. As we have seen, very manifestly in the case of the Edlington Serious Case Review, where the leaked full report to "Newsnight" showed that there was very little, if any, relationship between the 150-page full serious case overview and the 12-page executive summary, it absolutely showed that there was no confidence in serious case reviews really being a learning exercise, as they should be. I believe we've got to the stage where public confidence in child protection in this country is so completely shot, and the ramification of that is that confidence in the profession and on the part of the profession in itself is at an all-time low, which I think is a really very serious matter that we need to address and what Munro is really going to address. Only full transparency of serious case reviews will start to rehabilitate the image of child protection in the eyes of the public, and therefore start to rehabilitate the reputation of those involved in doing something about it, particularly social workers. I think those who will benefit most from the full publication of serious case reviews will be social workers. Let's face it, whether they are published or not, most of the details of the high-profile cases appear on the front page of the tabloids or on the internet. The full details are actually there. When you see the full serious case review—I have now been able to read some, and every executive summary of a serious case review now comes via my desk for me to look at them, and there are 130 of those a year at the moment—you will see that, actually, okay, there were some problems and mistakes made by social workers, but actually the police didn't do a very good job, or the school was at fault, or the GP or the paediatrician in the A and E department mucked up. I am not looking at pointing blame. I am looking for a fairer apportionment of responsibilities, so that all the partners know that they have to pull their socks up too.

**Q56 Nic Dakin:** We are also aware that there is a lot of pressure on funding and resources. How can we be confident that the capacity will remain in the system for effective early intervention, so that we get less of these things happening?

***Tim Loughton:*** I entirely agree with the comments that Maggie Atkinson made in terms of the good investment that early intervention is about. One of my jobs in our Department is to ensure that we make that strong case in our discussions with the Treasury and to say that it is a false economy not to intervene early. That is also what the Munro review is about—to ensure that social workers can intervene early, so that the first knock on the door by the social worker is not signalling the initiation of care proceedings but actually saying, "We're here to help. How can we work with you supportively and bring in additional services?" We want to ensure, as much as possible, that families can stay together, rather than the children having to be taken into care because it has all gone pear-shaped and we are intervening too late in the day. A lot of money is being wasted at the moment, though, because of the high vacancy rates and the high absentee rates of social workers, due to sickness and everything. We are paying a huge premium for the turnover in social workers, for the cover provided by agency social workers and for the fact that so much money is being spent on processes

and paperwork. If we get rid of a lot of that so much more time can be spent at the sharp end and hopefully social workers will feel rather more invigorated and confident in their job, and more people will want to come into the job and stay in it.

**Q57 Nic Dakin:** So what practical steps are the Government proposing to improve the capacity of the front line, in a context in which there will be no more money?

***Tim Loughton:*** First, we released £23 million of social work reform money, which is all about improving training and retention of staff at the sharp end. That has been absolutely welcome. I need to argue, and I have been arguing, the case that we need to have some resources available for what Eileen Munro comes up with, particularly in the early stages. Otherwise it would be a meaningless review, if she came up with lots of what I think are lots of practical and whizzy ideas only to be told, "Well, that's all very nice, but actually there's no money in the pot." As I say, though, I think that actually there is a financial gain to be made here in quite short order, whereby if we get it right in social work we instantly get rid of a lot of the waste. We speed up the courts system, where there are delays because a social worker is not available to turn up in court, because the paperwork has gone missing, or because it is a new social worker assigned to the case so they have to go back to first base. That is where so much money is wasted, and while that time delay exists the problem is being exacerbated such that a more expensive permanent care option may be the only solution by the end of the day.

**Q58 Nic Dakin:** So you are very clear that resources will be there to fund what comes out of the Munro report, to ensure that the problems with vacancies, management and so on and so forth, which you very clearly described, will be addressed in short order?

***Tim Loughton:*** I am very clear that I am making that case to the Treasury. As for whether or not the Treasury has completely taken that case on board, that will become clearer after 20 October.

**Q59 Tessa Munt:** Can I pick up on some of the issues related to serious case reviews? In Maggie's comments—I know you were here then for them—she talked about the impact on the survivors, if you like, and the siblings of such a situation. How do you answer that potential criticism, that it is not very effective to publish? Secondly, why do you choose to publish serious case reviews? I ask because, as you have identified, if those case reviews come across your desk and you can see that the executive summary is different from the content of the report, it strikes me that it is possible for you to instruct that the executive summary be written accurately and the executive summary could be published without the content of the document itself, because of the implications that publishing the content has. We have heard already about the potential fear among the people who are involved of the impact of publication. I just want to explore that a little more, if I may.

***Tim Loughton:*** I will take that second part first, Tessa. It is the role of Ofsted to inspect the serious case reviews, both the executive summary and the full overviews in any case. It can obviously rate one as unsatisfactory and then it would have to be done again. There is the whole question—this is something that the Munro review will look at—about the capacity of Ofsted to inspect serious case reviews, which came up in the Haringey case. The first executive summary was deemed to be okay until all the subsequent information came out, and then it wasn't worth the paper that it was written on. I see all the executive summaries at the moment. For some serious case reviews, where there are wider implications, I will ask to look at the full review as well. All of them, apart from the four cases that we said should be published retrospectively, were initiated pre-10 June, which is the date that we announced that future serious case reviews should be published. I go back to the point that I made to Nic Dakin earlier that the credibility of the child protection system requires greater publication transparency to the public in the future. I want to get to a stage where the public are not interested in the latest baby death tragedy because they are confident that a serious case review is there, warts and all, available for all those professionals at the sharp end and for others who are interested to take a real interest in, and that things have not somehow been swept under the carpet. There is a fear about the culture of secrecy, which surrounds a lot of serious case reviews, that has led people to be entirely cynical that any lessons will be learned and to believe that it is another whitewash, that there are the same old regular suspects and that nothing ever happens about it. We need to improve serious case reviews. Eileen Munro will be looking at whether the format of serious case reviews is the right one. Can we learn from either the different models that the SCIE is looking at at the moment or the way in which they do it in America—the different narrative to the serious case reviews? I don't think the reviews are the best way of doing it anyway. They were introduced in 1988 as a replacement for having a full inquiry into every suspicious child death. We also need to consider the way in which they are audited. Should we go back in a year's time to do a checklist to see whether things that were suggested in the recommendations have been done? The authorship of serious case reviews needs to be looked at. How can we be guaranteed that the quality, independence and arm's-length position of the author from the LSCB is guaranteed? We need to look at all those things, and Eileen Munro will be looking at them. Your first point, which is a very valid point, is that we did not just say that every serious case review will be published and bulldoze that through regardless, and we certainly did not say that retrospectively every one will now be published. There would have been no time for any social workers in any local authority children's department in the country to do any social work if they had had to go retrospectively through all those reports. We chose instead to highlight four high-profile cases that had very wide ramifications for the way in which we are doing child

protection in this country and say that they should be published, of which one has been published already. We said that they should be published subject to anonymisation, to appropriate redaction and, crucially, to there being no threat to the welfare of a surviving child or siblings. There may well be future cases in which the LSCB can make out a special case for why the full publication of that serious case review could go against that third criteria. Indeed, one of the retrospective reports that we are considering having published may come under that bracket. If it does, it won't be published. However, I would say that, if you look at the model of mental health homicide reports, which have been published in full for many years, there hasn't been a problem. They refer to Dr A, Nurse B and Patient C or whatever, and are a very thorough and transparent learning tool. If we can do it for mental health homicides, why can we not do something similar for child deaths and child harm?

**Q60 Lisa Nandy:** I want to return to the question of resources. The Government spend an enormous amount of money each year on locking up children in immigration detention. It has been documented beyond any doubt that that horrific practice causes long-lasting harm to children and cannot be justified. Your Government made a very welcome commitment in May that that practice would end. That was May and this is September. Five months later, why is this horrific practice still going on?
***Tim Loughton:*** First, it is not a matter for me. There was a clear commitment in the coalition agreement, and the progress on that has been outlined by Damian Green as the responsible Minister. Absolutely, it is the intention to bring that practice to an end as quickly as possible. I entirely agree with your sentiments. As for the exact mechanics about the timing, that is a matter for the Home Office and the Immigration Minister.

**Q61 Lisa Nandy:** I am a little concerned about that answer, because one of the key things that the creation of the Department for Children, Schools and Families did was bring together under one roof responsibility for all children. For some children left out of that equation alternative arrangements were made, but for others no arrangements were made, including this group of children in particular. Are you telling the Committee that this group of children is not a priority for your Department?
***Tim Loughton:*** Absolutely not. I am saying that the mechanics of bringing that practice to an end, the timing and the practicalities are a direct responsibility of the Home Office and the Minister for Immigration, with whom I have had conversations. He is entirely aware of my sentiments, which are the sentiments of my Department and which coincide with your own feelings, as you expressed. So absolutely, we have serious concern about the future of that group of children and want to see the situation brought to an end as quickly as possible.

**Q62 Lisa Nandy:** Can you tell the Committee when the practice will end?
***Tim Loughton:*** I can't, because it won't be me signing it off. However, I am putting as much pressure as I can from my Department on to the Home Office to bring it to an end as quickly as possible.

**Q63 Lisa Nandy:** Are you concerned about your lack of ability as a Minister who is responsible for children to influence what is happening to that group of children right now?
***Tim Loughton:*** No, I don't think so. I have every confidence that the Minister for Immigration is absolutely committed to bring the practice to an end as soon as possible. I don't think there is a conflict of policy here at all. It was a clear coalition agreement. It remains a clear coalition undertaking. It remains a clear obligation of the Minister for Immigration, as the front-line Minister responsible, to do that as soon as possible, in full measure.
***Dr Jeanette Pugh:*** If I may say, to reassure the Committee, I have been working closely with a ministerial colleague, Sarah Teather, on this—indeed, were it not for this Select Committee this morning, at this very moment I would be at a senior programme board dealing with this issue at the Home Office. Unfortunately, I had to give my apologies because I am here, but the very first e-mail that I sent this morning was to my opposite number at the Home Office, arranging for a further meeting with him about the matter next week. We are working very closely with colleagues in UKBA and the Home Office to deliver this commitment, on which we are absolutely determined to make the most progress possible, through the review and by working with UKBA and a range of NGOs. I can certainly give you my absolute assurance on that.

**Q64 Lisa Nandy:** What concerns me about your answers is that this very specific practice raises wider questions about the commitment to safeguarding children. Essentially, we have a group of children, today, who are being harmed at the hands of the state. My question for you is, if safeguarding is top priority for this Department, why has that practice not been ended?
***Tim Loughton:*** Lisa, I think you're looking for a problem that's not there. There is no suggestion of any demurring about that commitment. All the things that I have outlined so far express in tangible terms a huge undertaking of child protection and safeguarding vulnerable families that we initiated in the Department for Education in our first 100 days. Absolutely, we hit the ground running. The first visit the Secretary of State paid on becoming Secretary of State was to a group of child protection social workers in Hammersmith, for example. Having been quite a cynic in opposition about how government works, I have been absolutely amazed at just how quickly we have been able to bring about some of these things that we were committed to in opposition, and at how we have already set a very tight timetable for Professor Munro, the family law review and some of the other reviews. We don't want

to kick them into the long grass. I want to make these changes because I don't think that vulnerable children in this country are any safer now than they were on 25 February 2000, when Victoria Climbié lost her life in tragic circumstances. Despite an enormous amount of good will and good intentions on the part of the previous Government and all parties, and a huge amount of legislation concerning children—every piece of which I served on in opposition since 2001—we are not getting it right, and I want to get it right. It is a priority of my Department that we get it right.

**Q65 Lisa Nandy:** I simply put it to you that you will be judged on the record of how you protect the most vulnerable, and I haven't heard anything yet about that particular group of children, of whom Victoria Climbié was one—a child brought into this country from abroad—to suggest that your Department is sufficiently involved with that issue. It was an unequivocal commitment in May that the detention of children must end. Yet five months later, there is no clear rationale for why that practice continues. There are children in immigration detention now. I put it to you that that is a problem that really does exist.

***Tim Loughton:*** And it existed in the previous 13 years of the last Government, when no action took place. It will happen, but in the first 100 days, the clear coalition agreement commitments—to abolish ContactPoint, to publish Serious Case Reviews and to get under way a serious review of child protection—have already happened. I think that that is pretty impressive, and absolutely shows the commitment in our Department to getting on with it.

**Q66 Damian Hinds:** There has been something threading through all three evidence sessions we've had this morning, which is very important, about inter-agency working, joined-up thinking, collaboration, computer systems that let people see what notes other people have taken, and all the rest of it. One thing I don't think we have heard much about at all is the individual ownership of cases—responsibility. It strikes me that in most organisations if you really want something to happen you don't give it to a group or a committee. You may involve lots of people. You may want people working across departments; you probably even want them working outside the organisation, with other organisations; but ultimately one person owns the problem or issue. I wonder, Minister, if you might say a few words on your thinking on that.

***Tim Loughton:*** I absolutely agree. At the end of the day, it is not a computer database, however elaborate and, in the cast of ContactPoint, very expensive, that rescues vulnerable children. It is key professionals, at the sharp end—well trained, well intentioned, and confident about their job—who will make the appropriate judgment calls and intervene. My criticism of what has happened in the past is this: here is a problem; we all know what the problem is and agree something urgently needs to be done, so, "Let's set up a database"—that becomes an end in itself. That has done more harm than good. There was the, "Let's set up a new database" approach, and the previous Government came up with the Integrated Children's System. I think that did more harm than any other single IT approach to child protection, because it meant that social workers had to spend hours of their time filling in the equivalent of 50 pages per child, in a very un-user-friendly system, when a lot more of that time could have been spent more profitably actually speaking to the child, as Maggie Atkinson quite rightly would like, or speaking to the child's parents, or visiting the home, etc. The other approach was, "We need to restructure everything." Children's services went through so many restructurings. So much was wasted on that; so many new committees have been set up. Now we have Children's Trusts. I think the principle of Children's Trusts and greater agency working is right, but Children's Trusts have become a huge great body. With Local Safeguarding Children's Boards the solution was, "Let's add more people." The previous Government said, "We're now going to have two lay people on the Local Safeguarding Children's Boards." We therefore have a lot of time spent with an increasing cast of thousands round an increasingly large table, talking about the problem, when what is needed is one, two or three key individuals to identify the problem, pick it up and run with it and knock on the door. Too much of what has happened is preventing that and putting so many obstacles in the way: there are so many boxes to tick, so many processes to go through before somebody can actually get up and do something practical.

**Q67 Damian Hinds:** This might be a point for Dr Pugh as well: I think a lot of people felt that putting all 11 million-odd children and youngsters in the country on a database was slightly disproportionate to what we are trying to achieve, but on the other hand you want the right IT systems and support to make sure that people are well informed and able to work together and so on. What do you see as the right balance to be struck, and what should be the entry criteria for how someone gets on to such a database?

***Tim Loughton:*** I shall start, and then perhaps Jeanette can answer. A database is not an end in itself. We need to identify the problem and then we need to find solutions, which may be IT based, in order to address that problem. Too often it has been the other way round. So the key feature of everything we do, and the destination of Eileen Munro, must be to free up that professional's time to deal with the case at the sharp end and have the space to make those well informed judgment calls. Everything must be predicated on that. What we want to see as an alternative to ContactPoint, which we are investigating at the moment, is a system that concentrates resource on genuinely vulnerable children. Absolutely a key question, which Maggie Atkinson raised, is how you define those vulnerable children. That is the work that we are doing at the moment. It makes much more sense than thinly spreading resource across 11.5 million children in

ContactPoint, which did not do an awful lot of what people said it would do. It still had serious security flaws, such that the last Government would not publish the security review they commissioned into the security behind it. It had access to 390,000 professionals and goodness knows who else and did not really tackle the problem. I want a system that enables us to identify those kids who are genuinely vulnerable and makes sure that they are on the radar of those people who are in a position to do something about it, and to build some other checks into the system. I had a very interesting conversation last week in my constituency. I met a group of doctors. I asked them all what they thought about ContactPoint. Only one had ever heard of it. These GPs who are supposed to be part of that system, who are part of the weak link between child protection and health, had not even heard of it except for the one senior doctor who had heard of it because her daughter goes to an independent school and the independent schools waged a very aggressive letter-writing campaign to all their parents saying, "ContactPoint is terrible. You must do something about it." I thought that spoke volumes. I also asked her, "If you had a child in your surgery with Mum and there was some suspicious bruising on that child and you had doubts, what would you do?" Her reaction was, "I think I'd ring up the school and have a chat with a responsible teacher there. If that teacher said, 'Well, it's funny you should mention that because we have been a bit worried about little Johnny', that should trigger an intervention. It would then go to children's services and a responsible social worker would be asked to look at it." ContactPoint never did that. I want to see some trigger points in the system so that if a professional got on to the database to see whether there was any form about that child and whether that child was deemed to be vulnerable and was told no, then a few weeks later another professional got on to that system about the same child, it triggered someone to ask why they were getting those inquiries. ContactPoint would not have done that, so I want a system that works and brings in interventions when they are required for those children we know are genuinely vulnerable. We also need to know about those children who are just under the radar. We can spend our resources more effectively on achieving that sort of solution.

***Dr Jeanette Pugh:*** I simply want to broaden out the point into what is different about Professor Munro's review. It very much starts with what happens in that living room between that social worker and that child or that family. What is it in that moment that prevents that social worker, if that is the case, from doing the right thing? It could be a whole range of things to do with an intimidating family or a lack of confidence. It might be something that another agency has failed to do or has not done adequately. What is different, and leads to optimism and a wider welcome for Professor Munro's review, is that it starts from that point, works outwards and looks at the system, which is not just IT systems and processes, but the people and how they interact and whether we can make them interact better to create a virtuous cycle of behaviour rather than a vicious circle, which leads to risk aversion and poor judgment.

**Q68 Damian Hinds:** On the IT aspect, we all recognise that the way you outlined it is the way it must be. But these systems and processes are there as back-up. The trigger points have to happen. You need to make sure that the trigger points have been activated. There are all those sorts of things. Can the pipework—the infrastructure—of ContactPoint be recycled into this new purpose, or is it a new spec that you are having to put out? What progress has been made thus far?

***Tim Loughton:*** One criticism that we received was that we did not turn off ContactPoint the day after the general election. One reason I did not do that immediately was precisely because I wanted to see what we could cannibalise from it to be available for any new systems. Secondly, there are all sorts of penalty clauses around switching off that contract early, which I wanted to be able to—I hope that I have—avoid successfully. There were financial reasons and some IT development reasons behind that decision. We are taking all that into account in the scoping that we are now doing, to see whether we can have a system that does what we want it to do. It may be that we cannot make the case for that system. What I will not say is that we will have a computer system whether it does what it says on the tin or not, which, I think, is partly what ContactPoint turned out to be. If the Munro report comes up with all sorts of other solutions that are not IT based, we may not end up with what we have called a national signposting database of generally vulnerable children. I have no hard and fast criteria there. It is a question of what works to make children safer at the end of the day, and I'll look at any range of things. At the end of the day, however, it is the professionals who rescue vulnerable children, not technology.

**Q69 Charlotte Leslie:** Lord Laming's report was unequivocal in its view on safeguarding. It stated that you needed an independent cross-departmental perspective for improvement. Given that, why has the National Safeguarding Delivery Unit been abolished?

***Tim Loughton:*** We opposed the NSDU when it was set up, because my response was, "Here's yet another structure being set up to tick the box 'We're doing something about safeguarding children'." Roger Singleton has done a very good job in contributing to the whole area of child safeguarding, and continues to do so in other areas and be available to the Department. The NSDU was created to improve front-line practice, but its establishment was based on certain assumptions about how the system should work. I think that we have moved on from there, and Eileen Munro's review will create a completely different route ahead. Having said that, it is not as though we have lost that resource, because some of the people who were working in the NSDU are now working on the Munro review. What it comes back to is the culture and approach from the past of,

"Let's set up another committee, let's set up another unit, let's set up a database to address the problem", rather than getting to grips with the problem at the sharp end, which is what we are now trying to do.

**Q70 Liz Kendall:** I have just one quick question, as people may be wanting to move on to Prime Minister's questions. You discussed GPs being a weak link in the child protection system, so how do you think the NHS will be better engaged in child protection when primary care trusts are abolished and GPs are given responsibility for the NHS?

***Tim Loughton:*** That is a very good question, and it is certainly an issue that I have been discussing with colleagues in the Department of Health. With all the proposed changes to the NHS, the issue of who has responsibility for safeguarding children absolutely needs to be factored into those considerations. I think that that is a fair point, which has not been reflected in some of the headlines about the changes in the health service, but goodness knows that it is my primary focus. There is a problem, which was identified particularly when the high profile cases came out, with how A and E departments deal with child protection—for example, the child who turns up at 9 o'clock on a Friday night with some suspicious unexplained injuries. Just over a year ago, we did a Freedom of Information survey of all hospitals on how they would handle that, and they would handle it in very different ways. In many cases, they had not even fulfilled the obligations that came out of the Victoria Climbié case from Lord Laming's report. That absolutely needs to be overhauled with what we are doing in the Munro review. We need to go to Health and say, "This is the way we need to do it." That needs to apply to GPs as well, because GPs were some of the most reluctant engagers in ContactPoint in the first place, and they raised all sorts of problems about client confidentiality and things like that. So they've slightly distanced themselves from the whole process. The evidence for that, colloquially, was my meeting last week. They have to be absolutely fully engaged in the process, because it is GPs and teachers who probably see those vulnerable children in the right context. They're in a position to say, "Hold on a minute. We need to do so something about that." We need to make sure that they are absolutely integrated into the preventive systems—or the intervention systems, rather—that we need to bring into play.

**Chair:** Minister and Dr Pugh, thank you both very much for coming along and giving evidence to us this morning.

Printed in the United Kingdom by The Stationery Office Limited
11/2010 005661 19585