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THE ATTACHED TRANSCRIPT WAS TYPED FROM A RECORDING AND NOT COPIED FROM AN ORIGINAL SCRIPT. BECAUSE OF THE RISK OF MISHEARING AND THE DIFFICULTY IN SOME CASES OF IDENTIFYING INDIVIDUAL SPEAKERS, THE BBC CANNOT VOUCH FOR ITS COMPLETE ACCURACY.

“FILE ON 4”

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HURLOW: This is where I come every day to see him, talk to him, tell him I love him, tell him I miss him. All I've got is this, just a little grave, that's all.

BOMFORD: On average, in England and Wales, one child dies every ten days at the hands of their parents or carers, sometimes in the most horrific circumstances.

BRIAN: He had bruising, he had a broken limb, had burns on him. Just thinking about it makes your stomach churn. Oh my God, it's frightening what had happened to that bairn.

BOMFORD: Next week it will be five years since the report into the murder of eight year old Victoria Climbié was published. It was supposed to change the child protection system for good. But the same mistakes keep happening, much to the frustration of the man who headed the inquiry.

LAMING: I despair, and I hope that captures what I feel. I despair about the organisations that have not put in place the recommendations which I judged to be little more than good basic practice.

BOMFORD: Tonight, File on Four asks what's going wrong with child protection?

#### SIGNATURE TUNE

OGUNKOYA: I went up to the house and I saw police everywhere. I went up the stairs, the police stopped me on the stairs, said I can't go any further. I explained to the police that my children were inside there, and the policeman looked at me and he said, 'Your children are dead.' That's pretty much all I can remember about that day.

MAN: Well that particular day was shocking because I was here in the house and I could hear a lot of noise and the police and all that sort of stuff, knocking on every door. As I opened the door the policeman said to me, 'Stay indoors.' I didn't know really what was happening until I heard Jimi saying, 'No, no, how could you do that to me? How could you do that to me?' He was going berserk really and police were trying to calm him down.

BOMFORD: Antoine, age ten, and three year old Kenniece, were killed by their mother, Vivian Gamor, a year ago on Sunday. They died in her flat in Hackney, east London. Antoine was beaten around the head with a hammer and strangled. Kenniece was suffocated with cling film and her body stuffed into a black bin liner. Their father, Jimi Ogunkoya, has still not come to terms with the loss of his children. His mother and father, Florence and Clement, lost their only grandchildren.

FLORENCE: The policeman said around nine o'clock that Vivian phoned them, phoned the police that she'd done something very bad and they should come round. When they went there, she refused to open the door and they had to force the door open. They see the two children lying in the passageway.

BOMFORD: For three years Vivian had been showing increasing signs of mental illness. She behaved strangely and hid herself away in her flat. Florence remembers how she said several times that the children weren't hers and they'd been swapped at birth.

FLORENCE: One day I went there to pick up Antoine and Kenniece. She said to me, 'These two kids, Mummy, they do not belong to me. I do not know where Jimi got them from.' She packed all their belongings in an Argos bag, a large one. She said, 'Mummy, I don't want to see them anymore.' I was crying. I said, 'What are you telling me, Vivian?' She said, 'Well I've told the children I am not their mother.'

BOMFORD: Vivian's condition deteriorated further, to the point that she was sectioned under the Mental Health Act and detained in hospital, where she was diagnosed as suffering from schizophrenia. But doctors felt they could successfully control the symptoms with drugs, and after 28 days she was released. The children were being brought up by Jimi and their grandparents, but when Vivian got out she started asking to see the children again. Jimi says he was pressed by Hackney Social Services to agree to a visit, supervised by a social worker, and he reluctantly agreed. After a single supervised visit, lasting just half an hour, Vivian asked for the children to begin unsupervised overnight stays. Social services backed her request, against the wishes of the children's father.

OGUNKOYA: I had reservations because this is someone that's just come out of hospital. I couldn't understand how someone could be in hospital for a month and then come out and be fine to look after children.

BOMFORD: But did you actually say to them that you were worried for the children's safety?

OGUNKOYA: I mentioned it on a number of occasions, will they be all right? But I was reassured by them, saying there's nothing wrong with her.

BOMFORD: Do you think there can be any doubt in their minds about your concerns? You made it very clear to them, did you?

OGUNKOYA: I don't know what more I could have said to them for them to have known that I wasn't happy about the situation. Don't get me wrong, I didn't think that she was going to kill them, but I thought she was unwell and I was concerned that the children were going round there and staying with an unwell person.

**BOMFORD:** But there was one vital piece of information that Jimi and his family had not been told, and they only found out when Vivian Gamor appeared before a judge at the Old Bailey in August last year to be sentenced. For the first time, Jimi heard exactly why, four months before killing her children, she was detained under the Mental Health Act. She'd attacked her half-sister with a knife.

**OGUNKOYA:** If I had known what I know now then, then there's no way that I would have ever agreed to any unsupervised overnight visits. I don't know why that wasn't disclosed, a violent person that can pick up a knife and attack somebody. For me, I think that information should have been shared with me also, because who in their right mind is going to send their children to sleep overnight with somebody who is violent and attacks their own family members with knives? Personally I think they were looking out for her and her rights as a mother and her rights as a patient. They didn't look at the bigger picture in this whole thing, which was the children. This didn't need to happen. I should have been going on the school run this morning, I should be taking my son to football on Saturday mornings. And my little girl, she was only three years old ... she was my little girl. I can only just try and take one day at a time and pray to God to get me through this.

**BOMFORD:** Vivian Gamor pleaded guilty to manslaughter due to diminished responsibility and is now being held in a secure mental hospital. One of the most important recommendations of Lord Laming's inquiry five years ago into the death of Victoria Climbié was the need for different agencies to share information. According to the Victoria Climbié Foundation, set up to campaign for changes to child protection, this is still not happening in many cases. Mor Dioum, the foundation's Director, believes this was a clear failure in the Hackney case.

**DIOUM:** Where I'm really concerned is the level of information-sharing between the mental health unit and social services. This is a woman with a history of ill mental health, who has been actually detained. You cannot, from a woman who has had this history of mental health, just have supervised contact for half an hour and based on that allow access to her children. The question we need to ask, how much information was shared and how much they have scrutinised the information received from the mental health unit, and I think this is what should have happened ...

BOMFORD: How significant do you think it was that she attacked her half sister with a knife?

DIOUM: I think it was extremely significant, and what is shocking about it is that this happened and yet the very people who were caring for the children weren't aware about it at all.

BOMFORD: A Serious Case Review was due to be published last September, but has been delayed while the inquiry team wait to see if they can speak to the family. The inquiry's been commissioned by Hackney's Safeguarding Children Board, headed by Fran Pearson.

One of the concerns that's been voiced by Mr Ogunkoya is that he knew nothing about a violent incident involving Vivian Gamor and her half sister. Why is it that important issues like that are not communicated to members of the immediate family?

PEARSON: I think that just underlines really how important it is for us to speak with Mr Ogunkoya and his parents and we really need to hear all about how they feel and how events felt to them at the time.

BOMFORD: In this particular case, were mental health services open with children's services about Vivan Gamor's mental condition?

PEARSON: I can't really comment on that in detail till we move to publish the findings of the report.

BOMFORD: It's an important issue though, isn't it? This is something that Lord Laming identified in terms of the way the different agencies work together. There was an issue of patient confidentiality, it seems, in this particular case, which may have outweighed the concerns for the safety of the children.

PEARSON: I think professionals work together very well in some instances in this situation and I think we'd be looking at good practice as well as the things we are more concerned about.

BOMFORD: The decision to give Vivan Gamor unsupervised access to the children came after one supervised visit, which was observed by the social worker concerned. Do you think that was enough?

PEARSON: I think we need to look at the findings of the report and, again, I'm in a position where it's quite difficult to say too much about that. But where we do need to learn, we will.

BOMFORD: There also appears to be a serious problem with the management and supervision of the social worker assigned to the case. In a statement to the court, the social services team leader admitted she'd been frequently absent from work, and due to what she described as 'poor management practices' she had little or no involvement in decision making. We can reveal that absenteeism is a significant problem at Hackney Children's Services.

The manager in this particular case referred to there being numerous absences from work for her, that she wasn't able to properly supervise this case or make decisions about this case, partly to do with what she described as poor management practices in Hackney. Is this something which has been addressed?

PEARSON: Where things need to be addressed, they were addressed some months ago. What this process is not about is about finding fault with individuals. It's about looking at how organisations work together.

BOMFORD: Is absenteeism an issue?

PEARSON: I think when we look at the report overall, there are a number of issues, but for me that wasn't one of the overriding ones.

BOMFORD: But if you've got a situation where the team leader is frequently absent and cannot supervise cases, how can it be that a social worker is left exposed?

PEARSON: I cannot comment on some of those aspects until we move to publish the report, but again, one always tries to realise the impact of absenteeism on the operational service.

BOMFORD: But it's not absenteeism in this case on the part of the social worker, it's the manager. I mean, surely it's important that social workers get the right sort of management support. If the manager isn't there to supervise or to help with the case, that's a problem.

PEARSON: It's exactly right that social workers need to be well supported and steps, you know, are certainly well underway in this borough to make sure that that is the case.

BOMFORD: In the inquiry report, Lord Laming described supervision by managers as the cornerstone of good social work practice, something which was 'woefully inadequate' in the Victoria Climbié case. Of 108 recommendations covering all agencies, 45 related specifically to social work, and almost all of those demanded better management and supervision. We asked Lord Laming for his views on the way the agencies worked together in the period before the killings of Antoine and Kenniece Ogunkoya.

LAMING: It seems to me that had the whole range of services been directed to supporting that mother, bringing to bear all their different resources, it may have been possible to prevent that mother doing what I don't imagine she ever intended to do, and the children paid the ultimate price for the failure of organisations to actually carry out their duty.

BOMFORD: Is it possible that in cases like that, it's not the children who are at the centre of this case, it's the concern for the mother, for her rights, for her confidentiality, for her right to spend time with her children, when surely this should be about child protection?

LAMING: Yes, the legislation makes it plain that it is the wellbeing of the child which should be the focus of all of the work by all of the agencies. That is clear in law. Too often agencies' attention is diverted onto the adult agenda. That happened in Victoria Climbié. And too often all the professions have a tendency to be too easily reassured, too optimistic, and they don't think how vulnerable a child can be in those particular circumstances. And if they kept their attention on what it is like in the day

LAMING cont: of a child, what it feels like to be a child in those circumstances, that would influence the way in which they react.

BOMFORD: One of Lord Laming's key recommendations, and the one which sets good practice off on the right track from the start, is for all agencies involved in child protection to get together and share information. Effective strategy meetings are essential, he said, to assemble all the fragments of information, establish an action plan, and decide who must do what and by when. Basic good practice, Lord Laming called it. One case in Newcastle shows that it doesn't always happen

#### ACTUALITY IN NEWCASTLE

BOMFORD: I'm outside a five-storey block of flats on a large housing estate in northern Newcastle. Jodie Taylor and Paul O'Neil lived on the top floor of these flats with their baby son, Aaron O'Neil. The child was just three months old when on 10<sup>th</sup> February 2005 Paul O'Neil murdered his son at a friend's house nearby. The baby's body was found with thirty-six different injuries. I'm going to knock on the neighbour's door and ask them if they remember that day.

#### ACTUALITY OF KNOCK

BOMFORD: Hi, I'm from File on 4. Can we talk to you ...

GLORIA: The police came in and said they'd like to talk about upstairs. They came in and I said, 'What's been happening?' They said, 'It's the baby,' and it was such a shock.

BRIAN: Even when the police came to interview us, you could tell they were sick with shock. What had happened and the amount of damage done to the child, because he had bruising, internal bruising, he had a broken limb, had burns on him. Just thinking about it makes your stomach churn. My God, it's frightening what had happened to that bairn.



DAVIES: That meeting never happened. If it had happened, it would have set arrangements for review. It's an ongoing process and it has to be continually reviewed until the point where you're sure the child is absolutely safe.

BOMFORD: The case was finally closed on January 13<sup>th</sup> 2005. Twenty-eight days later Aaron O'Neil was killed. The Serious Case Review was critical of the failure by the agencies involved to share what was known about Paul O'Neil and his violent past.

READER IN STUDIO: Information sharing was insufficient to provide a full picture of the history and risk to the child. Details were held on record by health and social services which identified the father as being a violent individual who presented a risk to women and children.

BOMFORD: After the Serious Case Review was published, Newcastle City Council carried out an Action Plan. It went right back to Lord Laming's report from two years earlier and restated his basic recommendations. I've got two documents in my hands – one is a copy of Lord Laming's report and his 108 recommendations, set out in January 2003, and the other is Newcastle's Action Plan, signed off in April 2007. The recommendations in both are uncannily similar. In 2003 Lord Laming said within six months:

READER IN STUDIO: Social workers must not undertake home visits without being clear about the purpose of the visit. No visits should be undertaken without the social worker concerned checking the information known about the child by other child protection agencies.

BOMFORD: And here, Newcastle's Action Plan, signed off April 2007, says:

READER 2 IN STUDIO: Before any home visit takes place, a check on all available information known about the child and their parents or carers should be carried out by the visiting social worker. This must include reading historical files and obtaining information held by other agencies.

BOMFORD: In 2003 Lord Laming said within three months:

READER IN STUDIO: No case opened in response to allegations of deliberate harm to a child is closed until ... the views of all the professionals involved have been sought and considered.

BOMFORD: And Newcastle's Action Plan, signed off April 2007, says:

READER 2 IN STUDIO: Social workers completing any assessment should have an ongoing dialogue with all the other professionals involved in the case ... it should be standard practice to hold a meeting, where all professionals could share information .... The case should not be closed until this has occurred.

BOMFORD: Nick Cott is Newcastle City Council's cabinet member responsible for children's services. He took over his post in May 2005, shortly after Aaron O'Neil's death, but he claims at the time internal audits showed that Laming recommendations were put in place in 2003.

COTT: My understanding of the situation was that we had been fully inspected and that the council at the time had no reason to believe that there were areas of weakness which needed to be focused on in particular.

BOMFORD: The information that we've been given is that while effectively there was a paper exercise to implement Lord Laming's recommendations, as far as the work on the ground affecting the individual social workers was concerned, very little had actually changed.

COTT: What I'd say to say is that at the time we were a three star social services authority and we'd put all the procedures into place. We had no reason to believe there were weaknesses, however when this was identified, the council then took swift action and the current administration put in place a number of measures, and subsequently we've invested heavily in children's social care. Safeguarding children is one of our top priorities for the council, so we were very very concerned that there were some areas that we needed to focus on, and we took swift action to address those issues.

BOMFORD: Why did it take the death of a child, Aaron O’Neil, for you to get round to fully implementing Lord Laming’s recommendations?

COTT: Well, the current administration wasn’t in power when the Laming recommendations were produced. When we recognised there were some issues which came out of the Serious Case Reviews, we immediately took action. The Serious Case Review, the executive summary was made public in I think February 2006. By the end of March all the recommendations had been implemented. I don’t see what else the current administration could have done in the circumstances.

BOMFORD: We asked Lord Laming what he thought of Newcastle’s failure to implement recommendations he said were so urgent they should be acted on within months of his inquiry.

LAMING: I am surprised, because one of the things that influenced the team that I worked with in the Victoria Climbié inquiry was that we wanted something to come out of this that would mean that Victoria had not suffered and died in vain. I reject the notion that any of this is rocket science. I believe this is about good practice, day by day good practice, about what happens at the front door of every agency and about a vision for children, and I am disappointed if there are organisations that took several years to address and put in place recommendations that I judged could be put in place within a matter of months.

BOMFORD: Is disappointed a sufficiently strong enough word, do you think?

LAMING: Of course, I despair, and I hope that that captures what I feel. I despair about the organisations that have not put in place the recommendations which I judged to be little more than good basic practice.

BOMFORD: And ‘good basic practice’, according to Lord Laming’s report, also includes a swift response to allegations of deliberate harm against a child – within 24 hours of an allegation being made.

## ACTUALITY ON SWANSEA SEAFRONT

BOMFORD: Decisions in child protection cases are often difficult and rely on fine judgements by the professionals concerned. Sometimes though, allegations of abuse are so clear and so unequivocal that it seems blindingly obvious that an immediate emergency response is needed. I've come here to Swansea to investigate the death of Aaron Gilbert, a 13 month old boy brutally killed by his mother's partner, Andrew Lloyd.

## ACTUALITY IN GRAVEYARD

HURLOW: This is where I come every day to see him. I talk to him and tell him I love him, tell him I miss him. It's just horrible. All I have got is this, just a little grave, that's all.

BOMFORD: Morryston Cemetery occupies a beautiful position on a hillside in Swansea. This is where the body of Aaron Gilbert is laid to rest. Family member Sharon Hurlow, who spent a lot of time looking after Aaron, is tending to his grave.

HURLOW: This is where my little boy is. This is his grave. This is where I come every day to do his grave.

BOMFORD: It's just a simple little cross, and you've got some toys down here and some flowers.

HURLOW: Yes, some flowers, few bits of toys. These are toys I bought him when he was alive. These little cars, his little fire engine.

BOMFORD: And Winnie the Pooh characters.

HURLOW: Yeah, he loved all them, he did.

Q: There are toys and flowers?

**BOMFORD:** Aaron Gilbert was beaten to death by his mother's boyfriend, Andrew Lloyd in May 2005. Fifty different injuries were found on the body of the thirteen month old baby. Aaron suffered several weeks of sustained abuse. Bruising to his face was so extensive that neighbours described him as the elephant man. Aaron's mother was Rebecca Lewis, Sharon's cousin.

**HURLOW:** She was a brilliant mother until she met a man called Andrew Lloyd. Becky moved in with this Andrew Lloyd. She came down, my front door was open, I was sitting in a chair. I seen my boy, I went down and gave him a kiss, I came back in. Andrew Lloyd had a can and he had a cannabis joint. Aaron was crying and he said to Aaron, 'Shut up.' I flew off my chair, I went to the front door and I said, 'No, you leave him alone.' I said, 'Becky, get that baby in, he needs a bath.' No, Becky drove up the road. Days went by, I never seen Aaron. I phoned Rebecca and said, 'Becky, will you fetch the baby down for me to see?' 'No, he's got a cold, he's got a sore throat, he's got an ear infection.' This is all excuses I was having every time I'd phone her. Couple of days went down, Becky come down the street again, I was out the front. He cried to come to me, called me Nana, so I took Aaron out of the pram. So she said, 'I'm going now,' so I gave Aaron a kiss and went to put him back in his pram and his trouser leg rolled up, and as I looked, baby Aaron had all bruises on his body. I said, 'Becky, how are they on his body?' She said, 'It's nothing to effing do with you.'

**BOMFORD:** The following day, Sharon made one of a number of anonymous calls to social services, alerting them to her concerns.

**HURLOW:** I just said, 'I'm not giving my name, but can you please act on it very urgent. There's a little boy, Aaron Gilbert, he's got bruises. Please can you act?' And the lady said to me that he wasn't the only child in the world for them to act on.

**BOMFORD:** Did you talk about your concerns about Andrew Lloyd?

HURLOW: Correct. I just said that he was a junkie. He liked his beer, he liked his drugs, and I was afraid that Aaron was beaten by him. Big bruises, that child was getting beat. And I said, 'They're not from a woman, it's a man's bruise,' because the fingerprints were so big on Aaron's body. I waited then and nothing was done, and that's when I phoned again.

BOMFORD: You made a second phone call?

HURLOW: Correct, yes.

BOMFORD: What did you say on the second phone call?

HURLOW: I said that I'd phoned up once, ... on this little boy, and I'm phoning again because I'm very concerned he's full of bruises, and they said, still said to me he's not the only child. I phoned a third time and I told them on the third time this child, we have not seen him, I was concerned he was getting beat and everything.

BOMFORD: There's a dispute over how many calls Sharon made warning social services that Aaron was being abused. The council says it received two calls, the first one coming eight days before the baby was admitted to hospital. The council also claims Andrew Lloyd was not named in the calls as Aaron's abuser. Whatever happened, they did not appear to take the warnings seriously. The council describes the calls as 'brief, jumbled, and judgemental' and social services responded by writing a letter to Aaron's mother inviting her in for a chat. By that time though Aaron was suffering head injuries from which he did not recover. Wendy Fitzgerald, the council's cabinet member responsible for social services, admits that was wrong.

FITZGERALD: In hindsight, it does seem inappropriate that when there was reference to a child with bruises, that this immediately wasn't taken on as a child in need of protection. But clearly this information was given in a much broader context of judgemental remarks about the mother of the child wearing short skirts and doing all sorts of other activities, out late at night and so on. It was an anonymous call and the caller hung up. Yes, there was clearly an error of judgement, but at that point in time there was a perception that this wasn't focused on an issue around child abuse.

BOMFORD: The response was actually judgemental. The comment was made that the caller was judgemental, whereas the response was judgemental.

FITZGERALD: You are putting words into my mouth now, but that is what you have to do, isn't it, as a professional? You know, you have to make judgements. I am not absolutely convinced that whatever you do, however many safeguards you put in place, that you can be absolutely confident that you will have a 100% failsafe system, because you are dealing with human beings.

BOMFORD: And human beings, when they're reporting something potentially very distressing like child abuse, won't necessarily use the right kind of language. It's not unusual, is it, for a call to be jumbled, you know, to have various allegations, to be emotional?

FITZGERALD: It wouldn't be unusual for that kind of call to come in, but quite clearly in this situation there was something in the way the call was made that didn't send alarm bells ringing, so to speak.

BOMFORD: We asked Lord Laming what he made of the decision to send a letter to Aaron Gilbert's mother after the allegation of abuse was made

LAMING: Well, my initial reaction would be that it is woefully inadequate, because what we know is that if, if there is any substance in these allegations, then it's highly unlikely that the adults in the child's life are going to respond quickly and positively to a letter of this kind. In other words, agencies have to be altogether more proactive in these circumstances. If there is a hint that a child is being deliberately harmed, then the first thing is to see the child. If the child is of an age to talk to, to talk to the child separate from the adults in the child's life, to make sure that there's a proper assessment made with any necessary forensic advice that may be needed.

BOMFORD: It's clear that problems have continued at Swansea since the death of Aaron Gilbert. Two years later, inspectors audited Swansea's children's services. They discovered that child protection services were still weak. They found:

- READER IN STUDIO: Significant delays in assessing children's needs.
- READER 2 IN STUDIO: Children not routinely seen or spoken to, even in alleged abuse cases.
- READER IN STUDIO: Investigations into allegations of serious harm not completed.
- READER 2 IN STUDIO: Poor understanding and implementation of national procedures.
- BOMFORD: If you get an allegation of abuse now, how quickly would you respond to that?
- FITZGERALD: Well, our aim is to respond with any incident of abuse within forty-eight hours. That is the maximum, and obviously we would want to respond much more quickly than that.
- BOMFORD: Why forty-eight hours? Lord Laming said twenty-four hours.
- FITZGERALD: Twenty-four? Okay. Well, I was reading the information which said that our response is within forty-eight hours, but twenty-four hours is obviously what we would hope to achieve.
- BOMFORD: So the response would be within twenty-four hours, not forty-eight hours?
- FITZGERALD: Well, I would hope so. My information is that we are required to respond within forty-eight hours, but obviously we would aim to respond much more quickly.

BOMFORD: Don't you think though that it's worrying that we're talking about a period two years after the death of Aaron Gilbert. Still there are these issues that are highlighted by the inspectors about children not being seen, even after allegations of serious abuse. This is still going on.

FITZGERALD: Well yes, you have picked out the most damning aspects of the report and I agree that okay, there are things that need to be done and it is, as you say, two years. But in that two years we have had some very difficult issues, and I will say that our loss of staff and the recruitment issues that we have experienced have impacted on what we have been able to do. We were running at about a 23% vacancy in children's services and clearly you can't operate a service with that level of vacancies. The average length of experience of our permanent social workers is around three years.

BOMFORD: Not very much at all.

FITZGERALD: No, it's not very much.

BOMFORD: Indeed, so great is the recruitment crisis that Swansea has been forced to import social workers from Eastern Europe, and also relies heavily on temporary agencies, simply to go some way towards easing the vacancy rate. Many social service departments face similar problems, but experts say despite this, practice has improved in many areas during the years since the Laming Report, but the fear is that the issues raised in Hackney, Newcastle and Swansea are all symptoms of a wider malaise. One person in particular has a unique insight. Ron Lock, an independent consultant, has carried out forty-five Serious Case Reviews in the last five years, analysing the mistakes agencies made in cases of child death or serious injury. He says there has been a failure to learn lessons and build on experience. Serious Case Reviews, he says, are always local in their scope and lessons are not applied more widely.

LOCK: That is an important point. They are only local, so each case review does relate to the particular locality that it happens in, so only the local teams and local professionals will hear the outcome of those reviews, and work to the recommendations of the Action Plans that I know a number of authorities do develop. The neighbouring authority may have very similar problems, very similar staff, very similar

LOCK cont: cases, but won't know what their neighbour's issues are. There's no way that that is transferred across, and you don't get a sense that the overall lessons that we learn in regions or parts of the country even are really disseminated in an effective way.

BOMFORD: The Government told us a process is now underway to summarise the central messages from Serious Case Reviews and publish them once every two years so that all child protection agencies learn the lessons from what goes wrong. Lord Laming's report five years ago said summaries should be published annually. But Lord Laming told us he's broadly happy with the way the Government has responded to his report, with important changes in policy, legislation and guidance. The failures, he says, are in the way policy and guidance are being carried out at the local level – the front line standing between abusers and their children  
Where did you think we would be five years on from your report, and is this the place that you wanted to be, because I can't imagine it is?

LAMING: Well yes and no. Where I remain unhappy is that I think the recommendations of Victoria Climbié have yet to be realised within the bloodstream, the life of every key agency, which is influencing the response to every child, however it is referred to the agencies, and we need to be absolutely intolerant of bad practice and be altogether more ambitious in our hopes for the future of children in our society. It is not about bureaucratic issues, it's not about organisational niceties, it's not about turf wars. It's about putting the child at the centre. If an agency puts the child at the centre of all that it does, then I think a great deal of good can come for children, beyond safeguarding. If the agencies don't, then I fear we'll go on having cases of this kind.

SIGNATURE TUNE