

Child protection—lessons from Victoria Climbié

Recommendations will work only with professional and managerial commitment

In his report on the torture, starvation, and eventual murder of Victoria Climbié, Lord Laming noted that any case of deliberate harm to a child is a serious and potentially fatal condition that deserves the same quality of diagnosis and treatment as a brain tumour or heart disease.¹ His report includes a long list of recommendations. He stresses the importance of accurate written records, discharge plans, and better information systems. His support for a “commissioner for children” is welcome.² The proposed new national and local managerial structures should improve supervision, coordination, and accountability. But the key question is not who will be accountable for the next child abuse tragedy³ but how much the better reporting arrangements will contribute to preventing one.

The answer is, probably not a lot, unless there is also professional and managerial commitment to other, and arguably more important, changes. Prevention depends on collaboration, as emphasised in the publication *Working Together* from the Department of Health.⁴ But it is not just organisations, committees, and boards that must work together. Children like Victoria die when individual professionals do not work together. Often the reasons lie in failures of systems rather than individual shortcomings. Within hospitals, changed working practices threaten continuity of care in clinical teams. Different geographical boundaries between agencies, high staff turnover, workload pressures, and indifferent managerial support make it increasingly difficult for health professionals, social workers, and police officers to train together and manage cases together. This in turn prevents the development of the mutual trust and respect that are gained only through regular collaboration and an understanding of each other’s perspectives and organisational cultures.

Lord Laming rightly emphasised the importance of better education, training, and quality monitoring. This is no small task. All general practitioners treat children and have a duty to be aware of the many different manifestations of child abuse and to respond by seeking advice. A higher level of knowledge and competence is expected of paediatricians, whether generalists or specialists—they have a duty of care to any child in whom abuse is being suspected, unless or until they have formally transferred responsibility to someone else. The syllabus for all paediatric trainees must include patterns of abuse, legal and ethical issues, and an understanding of social and cultural factors and of the motivation for

abuse.⁴ Clinical training should cover multiprofessional teamwork, interviewing and consultation skills with children and parents (particularly those who are hostile, aggressive, violent, or mentally ill), physical examination, preparing reports, and giving evidence.

Specialised help must be available for the investigation of suspected sexual abuse and for advice in unusual, complex⁵ or contentious cases.⁶ Doctors who take on these tasks need additional opportunities for training and professional development and a means of accreditation that confirms their expertise to clinical and forensic colleagues and to the judiciary.

As with any difficult clinical situation, consultation with colleagues is important. Local support should be available from the designated and named doctor and nurse, whose roles are defined in Department of Health guidance. Every chief executive must ensure that these individuals have enough time and resources to do their jobs properly. This must include opportunities to form continuing education and support networks with others in similar posts. A process of audit should be in place in each department of the hospital to monitor adherence to local and national statements of good practice.⁷

The designated and named professionals would have a leading role in the local implementation of Lord Laming’s most ambitious proposal—for regular revalidation in child protection of every consultant paediatrician and general practitioner. This might best be achieved by a standardised package and process, which would be equally relevant for trainees. The model could be based on that already established for resuscitation training, as in the advanced paediatric life support course. This is taught largely by consultants, and in doing so they also maintain their own expertise. The cost of developing and maintaining a similar system for child protection will be substantial—although probably less than that of a public inquiry into a child’s death.

Lord Laming heard evidence that child protection is an unpopular speciality of paediatrics. He chose not to address the reasons in detail. There are many,⁸ but one issue that increasingly inhibits high quality child protection work is the fear of complaints and litigation. No one condones poor clinical practice, but some complaints are malicious and are intended to obstruct social work and police investigations, and some arise from orchestrated campaigns.⁹ The NHS complaints system was not designed to deal with such situations.

Amid the justifiable horror at the death of Victoria Climbié and the focus on violent physical abuse, we

must not neglect the opportunities for prevention.¹⁰ This too is the responsibility of all who work with children,¹¹ but in the health service it particularly falls on primary care staff, including midwives, health visitors, school nurses,¹² and on those working with mentally ill adults and drug misusers. These teams naturally focus on the needs of their adult patients and are at risk of forgetting the child or children at home.

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Competing interests: The College is seeking funds to extend a training scheme in child protection in collaboration with NSPCC and Johnson and Johnson Pediatric Institute.

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