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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 tragedy[3] 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.[3] 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, complex[5] 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 that that of a public inquiry into a child's death.

Lord Laming heard evidence that child protection is an unpopular specialty 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

BMJ 2003;326:293–4

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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Medical experts and the criminal courts

All relevant material must be disclosed, including facts detrimental to the opinion

The quashing of Sally Clark's conviction for the murder of her sons Christopher and Harry has inevitably been followed by questions about the role of the medical experts, in view of their failure to disclose key evidence and the role such evidence played in securing her conviction.[1] The debate has been played out across the media, not least in the pages of the *BMJ* and on its website.[2 3]

Medical experts are called on daily to deliver their opinions in both civil and criminal cases. Critics have focused their attention mostly on criminal trials. The initial involvement of an expert may be through professional duties, as in the case of the forensic pathologist who performs an autopsy and then finds that evidence from the autopsy report is being used by the prosecuting authorities in a criminal trial. Other experts may be called on by the police or by the Crown Prosecution Service.

In the adversarial systems of law in the United Kingdom the defence is also entitled to seek appropriate experts. Expert witnesses are in a very privileged position as they may give opinion as evidence, unlike other witnesses who can only give evidence of fact. Whichever side experts are called by, their duty is clear—to give impartial and objective evidence for the court and not for the side that has called them. The defence may ask for an expert opinion and then choose not to use such evidence. If an expert opinion is to be used it must be disclosed to the prosecution. The prosecution, however, is under an obligation to disclose all its evidence to the defence.

We live in an era of evidence based medicine, and experts should base their opinion on solid evidence and not on intuition. Alan Moritz discussed the problem of substituting intuition for scientifically defensible interpretation in 1956.[4] He said: "He [the pathologist] may be highly esteemed by the police and by prosecuting counsel because he is an emphatic and impressive witness. His prestige, together with exclusive access to original evidence, places him in an exceedingly powerful position in the courtroom." A defence expert may be viewed by the jury as hired to say something that would help the accused. Moritz concluded the passage by saying that the stakes are too high to play hunches in forensic pathology.

Experts should be appropriately qualified and remain in their field. Concerns have been raised where an expert only ever appears for the prosecution or the defence and about experts who seem to be pursuing a sociopolitical agenda not based on objective evidence.

One of the major criticisms in the Sally Clark case was the use of the statistic giving a one in 73 million chance of a woman with Sally Clark's background having two "cot deaths." This evidence was given by an eminent paediatrician but was roundly criticised by statisticians. Lord Justice Kay described the statistic as grossly misleading, although the first appeal court, aware of questions over the statistic, did not overturn the conviction. The main issue in the Sally Clark case was non-disclosure. The expert witness must include all relevant material, whether it supports or is detrimental to the opinion. The basic rule is that the prosecution must disclose its material to the defence. The microbiology results should have been in the pathologist's report, or their existence declared, whether they were felt to be important or not, so the defence could consider them.

The use of expert evidence in the legal system has been discussed in several reviews. Most recently Lord Justice Auld examined the role of experts.[5] At present it is for the trial judge to determine who is an expert. The possibility of using experts appointed by the court

BMJ 2003;326:294–5