



# Practice review report: Victoria Climbié

These case studies are intended to raise issues in a practical application; bringing together the critical factors, particularly around multi-agency working. They will help to contextualise risk factors and raise questions about prevention within situations of known abuse, neglect and harm. They have been summarised to assist in this process, but more information is available in the actual review reports.

## Context and background of review

Victoria Climbié died in the intensive care unit of St Mary's Hospital in Paddington on 25 February 2000, aged eight years and three months. Her death was caused by multiple injuries arising from months of ill-treatment and abuse by her great-aunt, Marie-Therese Kouao, and her great-aunt's partner, Carl John Manning.

Following their conviction for her murder, Lord Laming was appointed in April 2001 to chair an independent statutory inquiry into the circumstances leading to and surrounding the death of Victoria Climbié, and to make recommendations "as to how such an event may, as far as possible, be avoided in the future." The Report of the inquiry was published on 28 January 2003.

## Circumstances of, and challenges faced by, the individual

Victoria, who spoke no English, was brought to the UK from France by her great-aunt Marie-Therese Kouao in April 1999. Initially staying in a hostel, they moved in July to the north London home of Carl Manning with whom the great-aunt had formed a relationship.

## What happened?

**14 July 1999:** Victoria makes her first visit to the Central Middlesex Hospital after the daughter of her childminder suspects the girl has non-accidental injuries. The doctor accepts Kouao's story that Victoria has inflicted the wounds on herself by scratching at scabies sores. During this period, doctors alert child protection authorities as a precaution.

Haringey social worker Lisa Arthurworrey and PC Karen Jones are assigned to the case. They later cancel a home visit scheduled for 4 August after hearing about the scabies.

**24 July 1999:** Victoria is taken to North Middlesex Hospital's casualty department with scalding to her head and face. Doctors immediately suspect that the injuries have been deliberately inflicted. Kouao tells Lisa Arthurworrey and PC Jones that she poured hot water over Victoria to try and stop her scratching her scalp. She says that Victoria caused other injuries with utensils.

**6 August 1999:** Victoria is discharged from the hospital and is collected by Kouao after her explanation for the injuries is accepted by child protection authorities.

**1 November 1999:** Kouao tells social workers that Carl Manning has sexually assaulted Victoria. She withdraws the accusation the following day. PC Jones is asked to investigate why, but takes no further action after her letter to Kouao remains unanswered.



**24 February 2000:** Victoria is rushed to North Middlesex Hospital suffering from a combination of malnutrition and hypothermia. Doctors later transfer her to an intensive care ward at St Mary's Hospital in west London. Victoria dies the following day.

## Why it happened?

Dr Nathaniel Carey, the Home Office pathologist who examined her body, found 128 separate injuries and scars, many of them cigarette burns, and described them as "the worst case of child abuse I've encountered".

When consultant paediatrician Dr Mary Schwartz saw Victoria at the Central Middlesex Hospital, she decided her cuts were due to the skin disease scabies. Victoria was sent home to her abusers.

Dr Schwartz told the Laming inquiry she assumed social services would investigate further. Two weeks later, Victoria was back in hospital – this time the North Middlesex. Consultant Dr Mary Rossiter felt Victoria was being abused but she confused colleagues by writing "able to discharge" on her notes. Victoria was again sent home to her abusers.

The inquiry heard how PC Karen Jones failed to inspect Victoria's home for fear of catching scabies off the furniture. She said: "It might not be logical but I did not know anything about scabies."

Lisa Arthurworrey was Victoria's social worker and one of a number from Haringey Council blamed for failing her. Ms Arthurworrey felt she had been made a scapegoat. At the inquiry, she painted a picture of child protection in Haringey as chaotic, with workers in conflict. She attacked several colleagues and described supervisions with her manager Carole Baptiste. She said: "Ms Baptiste used most of the time to talk about her experiences as a black woman and her relationship with God."

Esther Ackha a distant relative of Victoria's great-aunt, Marie-Therese told the inquiry she made two anonymous calls to Brent council reporting fears for Victoria's safety. Nothing effective was done.

Priscilla Cameron was Victoria's childminder. It was Priscilla and her daughter Avril who had Victoria admitted to the Central Middlesex Hospital – only to get her wounds diagnosed as scabies.

"It seems that the basic discipline of medical evaluation, covering history-taking, examination, arriving at a differential diagnosis, and monitoring the outcome, was not put into practice in Victoria's case. I accept the evidence of Dr Peter Lachman, clinical director for Women and Children Services Directorate of North West London Hospitals NHS Trust, that paediatric doctors and nurses are highly trained in helping sick children get well.

"However, as he said, 'child abuse is one of the most complex areas of paediatrics and child health'. That being so, I found it hard to understand why established good medical practice, that would have undoubtedly helped clarify the complexities in Victoria's case, was not followed on the paediatric wards at the Central Middlesex Hospital and North Middlesex Hospital. Having considered the response to Victoria from each of the agencies, I am forced to conclude that the principal failure to protect her was the result of widespread organisational malaise. It is, however, instructive to contrast the inadequate response to safeguarding Victoria with the work of the health service in attempting to save her life at the end, and the professionalism of the police investigation after her death that led to the prosecution of Kouao and Manning. Alas, it was then too late for Victoria." Laming Report, 2003.



## Selected report recommendations

The report's key recommendations are:

- a new National Agency for Children and Families to ensure police, health and housing services can carry out their duties effectively and efficiently
- the chief executive of the agency could take on the functions of a children's commissioner for England and the agency should report to a ministerial committee for children's services
- the agency should scrutinise new laws, ensure policy is implemented and could carry out serious case reviews
- each local authority should have a committee for children and families with members from the police authority, council and health service trusts
- the committee would oversee the work of a management board for services to children and families, which would be made up of senior members of the police, social services, health, education, housing and probation services
- the management board must report to the committee and in turn the committee report to the national agency
- the Government should consider setting up a national children's database recording contact between a child under 16 and a member of the key services
- the Government needs to issue guidance on information sharing in relation to the Data Protection Act
- a single document outlining common language for all agencies gives a step-by-step guide on managing a case and replaces the current child protection register
- social services directors need to ensure staff have appropriate training and no case involving a vulnerable child should be closed until the youngster and his or her carer have been spoken to and seen
- senior managers should randomly inspect case files and social workers should check information from all child protection agencies before doing home visits
- allegations must be swiftly followed up and specialist services must be available 24 hours a day
- doctors who suspect a child is being harmed should consider taking an account from the youngster directly even without the carer's consent
- the police must ensure crimes against children are given as much importance as those against adults and child protection teams are fully integrated into the force
- chief constables should review police child protection units
- chief executives of local health services and local authorities should consider their duties towards vulnerable children
- new social work degrees should be introduced
- shorter, clearer guidance for one million professional staff dealing with protecting children
- police, health and social services have three-month deadlines to improve basic practice
- Children's Trusts to draw together local services for youngsters in a single organisation.

**Citation** Laming, L (2003) *The Victoria Climbié inquiry: report of an inquiry by Lord Laming*. Norwich: The Stationery Office (TSO).

**Citation** House of Commons. Health Committee (2003) *The Victoria Climbié Inquiry report. Sixth report of session 2002-03*. London: The Stationery Office (TSO).