

The after-effects of Baby P

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Another dead baby, without even a proper name to call him by¹. When my children were little I used to wonder what they were going to look like when they were grown up. When I see the pictures of

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Baby P staring out from newspaper photos², and know that nobody will ever know the answer to that question, I react with feelings. Lots of conflicting feelings – sad for the child and the family members, (some responsible, others also victims); frustrated by procedures that should have protected that child but were routinely under resourced and sometimes ignored; angry at some of the facile media reporting and simplistic victim blaming; astonished by the clarity of the CGI images³ that showed all the bruising on the child's mouth and ears – surely that was obvious to anyone? Complacent and even smug that we always stick to the procedures where I work - don't we? Horrified at manipulative lies and misplaced trust as I read more and find that the parent spread chocolate on his face to hide the bruises; anxious as I discover that the paediatrician who saw baby P two days before he died was not seeing him under the procedures but to do a developmental assessment – how easy to slip under the radar if the parent says the child is 'unwell' and you find the child reluctant to be examined. The smugness evaporates and I remind myself of my mantra 'you're only as good as your last case'. I often tell myself and my trainees 'never rest on your reputation, it only takes one mistake to blow it all out of the water'. This is a timely reminder that the price of child protection is indeed eternal vigilance.

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So why are we back here with a dead child seen by health and social care professionals dozens of times shortly before his death? Didn't the Laming report⁴ sort all that out? Ed Balls⁵ has now asked Lord Laming to go back and see what has become of the 150 recommendations he made in 2003 after the death of Victoria Climbié, all of which were accepted by government, and should have been implemented. Yes we were all meant to have Designated and Named Doctors with identified sessions, yes everybody was meant to have training and yes, everybody should be following the procedures. But are we? Things move on, other pressures take over, and routine child protection goes out of focus for a while, until the shocking lens of a dead baby makes us look again.

What, then, can we learn and do differently following the Baby P case? First of all, awareness of the big picture of the 'child protection jigsaw' is vital. If Social Services have 'asked for a developmental assessment' what is the actual question, and is it being answered in the right way? In Child P's case a discussion between Social Worker and Paediatrician specifically addressing the question 'is this child developmentally delayed due to constitutional factors or due to

physical or emotional abuse?’ might have got everybody onto the same page, and made it easier for professionals to get it right. Good interagency work is about a shared collective understanding and purpose – and this can only happen when real people (the Doctor and Social Worker) have a real conversation with each other about the real facts of the case. And the medical model comes in handy when the issue is a diagnostic dilemma.

“ Courteous and respectful work with families who may be telling manipulative lies is challenging, but it comes with the turf ”

The horrific detail of Baby P’s injuries is instructive. I reflect on the significance of visible injuries to the fingers, mouth and ears. Injury in these areas would make me concerned. I would need to hear a full, corroborated story of how they came about. I’m glad of the fantastic resource of specialist evidence in the Core-info site⁶, the product of the Welsh Child Protection Systematic Review Group. I’ve taken part in some of the reviews so I know how much work they represent, and how solid an evidence base they provide for decision making. I make a mental note to look habitually at a child’s hands, mouth and ears at every consultation. Baby P’s vertebral and rib fractures would only have been detected on X-ray, but identification of other bruising might have led to that investigation.

What if I’m not sure? Well that’s the point of child protection procedures everywhere in the UK⁷ – I don’t have to be sure to start with; I just have to recognise when to be concerned. And if I’m not sure about whether to stay concerned- then I phone a friend (actually a child protection colleague) for advice. I also need to work with the views of other professionals, the child and the family, to listen and analyse as well as explain, negotiate and influence. These judgements about risk to the child take time and patience, especially in gathering information from the child’s family who may or may not be telling the truth about the injuries. Abusive families can be defensive, embarrassed, but also dishonest and threatening⁸. I need the courage of my professional convictions to challenge a parent⁹ about a child’s bruising.

My principle is to examine the child carefully and listen for the explanation that fits, rather than accept uncritically what I’m told - ‘believe your eyes not your ears’. Courteous and respectful work with families who may be telling manipulative lies is challenging, but it comes with the turf. Some parents up the ante by making a complaint about me – an effective way of muddying the water, only manageable by irreproachable adherence to process and note keeping, and support from a peer group of child protection paediatricians. My focus is always on the outcome for the child, which might be a ‘whole child transplant’ – removal from their family – and there is a narrow line between over and under protection. The consequence of my inaction might be what happened to Baby P. Either way, I worry about getting it wrong and its effect on me- will I be reported to the GMC? Will I be pilloried in the papers or suspended and unable to work? It has happened to others¹⁰ so it could happen to me, and it discourages paediatricians from doing this work¹¹.

How well does the child protection system work, and what risks remain? The process takes time, and I am acutely aware that for every child for whom I participate in planning meetings and

conferences there are dozens going through a similar child protection process who do not get my input. Does this matter? We don't currently know how to differentiate which few of the 35,000 children 'at risk' in the UK at any time¹² will turn up dead or severely injured despite being subject to a child protection plan. The 30 or so children every year who die in the UK from abuse are a small proportion of those going through child protection processes. They are, including Baby P, of course 30 or so deaths too many.

Getting it right for the child continues to be the challenge. The important difference in child protection work is that the parent is unwilling or unable to be an effective advocate for the child, so this becomes the role of the paediatrician and other child protection professionals. The potential for conflict is obvious, and although we are trained to deal with this, it is still too easy for a parent who dislikes the outcome (a child protected through removal) to complain about the process (criticise the Paediatrician)¹³. Of course parents must have a voice, but this must be heard and judged in the specific context of child protection¹⁴. We await Lord Laming's audit of his Climbié recommendations, and whether he will accept the view of a group of Paediatricians (myself included) that child protection reports made competently and in good faith should be legally exempted from disciplinary action (a form of 'Mandatory Reporting', used in many other countries¹⁵). Further exploration and debate is urgently needed on this to get the right balance that might have saved Baby P.

References

1. Baby P – [Haringey Council serious case review documents](#)
2. BBC News [17 Nov 2008](#)
3. BBC Panorama programme [17 Nov 2008](#)
4. [Laming Report 2003](#)
5. Terms of Reference for Laming review of Safeguarding [November 2008](#)
6. Core Info – [Welsh Child Protection Systematic Review Group](#)
7. [London Safeguarding Children Board procedures 2007](#)
8. Jenny C. [The Intimidation of British Paediatricians](#). Pediatrics 2007;119:797- 799
9. Southall DP, Plunkett, MCB, Banks MW, Falkov AF, Samuels MP. Covert Video Recordings of Life-threatening Child Abuse: Lessons for Child Protection. Pediatrics 1997; 100:735-760.
10. Chadwick DL, Krous HF, Runyan DK. [Meadow, Southall, and the General Medical Council of the United Kingdom](#). Pediatrics 2006;117:2247-2251

11. Haines L, Turton J. Complaints in Child Protection. Arch.Dis.Child. 2008;93:4-6
12. Point prevalence of children in England and Wales subject to a child protection plan at [31 March 2008](#)
13. Williams, C. [United Kingdom General Medical Council Fails Child Protection](#). Pediatrics 2007;119:800-802
14. McIntosh N, Mok JYQ, Margerison A. [Epidemiology of Oronasal Hemorrhage in the First 2 Years of Life: Implications for Child Protection](#). Pediatrics 2007;120:1074 - 1079
15. Mathews B. [Mandatory Reporting in the US](#). Canada and Australia Child Maltreatment 2008; 13(1): 50-63