The Climbié Inquiry:
what being 'mindful' really means in practice

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The long-awaited report of the inquiry into the death of Victoria Climbié was published on 28th January 2003. Lord Laming's report comes thirty years after the death of Maria Colwell, another child 'tortured to death by her carers'; and follows 70 previous public inquiries into 'child protection tragedies'.[1] It runs to over 400 pages and contains 108 recommendations. This article begins by looking at the focus of criticism in the report and Lord Laming's proposals for structural change. It then considers the implications for practice, in particular, what being 'mindful' in child protection actually means in practice for the staff themselves and for the organisations that employ them.

VICTORIA'S BRIEF HISTORY

Victoria Climbié came to England with her great-aunt, Marie-Therese Kouao in April 1999. Within a year, she was dead. On 25th February 2000, Victoria died of hypothermia at St Mary's Hospital, Paddington. She was just eight years old and had 128 separate injuries to her body. On 12th January 2001, her great-aunt Kouao and her boyfriend, Carl Manning, were convicted of her murder. The level of cruelty experienced by Victoria was truly horrific, with daily beatings using several different implements. Her final days were spent living and sleeping in an unheated bathroom in the middle of winter, where she was bound hand and foot, lying in her own urine and faeces in a bin bag in the bath. The Independent Statutory Inquiry into her death, under the Chairmanship of Lord Laming, was set up by the Secretary of State for Health and the Home Secretary in April 2001.

Whilst the appalling abuse she suffered was hidden from view, what makes the case quite remarkable was that Victoria was known to three housing authorities, four social services departments, two police child protection teams, an NSPCC family centre, and two hospitals. As Lord Laming's report says:

> '*The dreadful reality was that these services knew little or nothing more about Victoria at the end of the process than they did when she was first referred to Ealing Social Services by the Homeless Persons' Unit in April 1999. The final irony was that Haringey Social Services formally closed Victoria's case on the very day she died.*'

There were at least 12 key opportunities for the different agencies to intervene to prevent her maltreatment and death.

THE FOCUS OF CRITICISM AND KEY STRUCTURAL RECOMMENDATIONS

Several of the report's findings, especially around the lamentable way in which agencies failed to share their concerns about Victoria, and the recommendations are depressingly familiar. In chapter after chapter of the report, one gains an overwhelming sense of a vulnerable, isolated child, free-falling through professional system after professional system, all of which should have been able to assess her needs, and record and monitor them in order to protect her. Lord Laming attributes this failure to '*widespread organisational malaise*', and departs from the usual practice of child abuse inquiry reports that normally reserve their blame for the front-line workers and their individual failings. In contrast, he directs his main criticism at the managers and senior members of the authorities who should have ensured that the services for children, like Victoria, were able to operate effectively. He describes the agencies in which the staff operated as '*under-funded, inadequately staffed and poorly led.*'

In Lord Laming's opinion, the answer lies in:

> '…*a clear line of accountability from top to bottom, without doubt or ambiguity about who is responsible at every level for the well-being of vulnerable children*…[and] *managers with a clear set of values about the role of public services, particularly in addressing the needs of vulnerable people, combined with an ability to 'lead from the front'*.'

At the highest level, he proposes a Children and Families Board, chaired by a Cabinet minister and serviced by a national children and families agency, which will operate through a regional structure and be headed by a Children's Commissioner for England. Local authority chief executives will chair new management boards for services to children and families, which will comprise senior officers from social services, probation, the police, health and housing. These boards will:

- replace area child protection committees;
- appoint a director to oversee the development of effective inter-agency practice;
- advise on the development of services to meet local need; and
- identify the budget, contributed by each of the key agencies, to support vulnerable children and their families so that staff and resources can be used flexibly and effectively.

Boards will report to a Local Member Committee for Children and Families with lay members drawn from the management committees of each of the key services. These committees must ensure the effective inter-agency co-ordination of services for children and families. These recommendations will be given careful consideration as the Government prepares its response to the report in the form of the forthcoming green paper, *Children at risk*.

WHAT BEING 'MINDFUL' REALLY MEANS IN PRACTICE

Whilst clear accountability from top to bottom should go some way to tackling the 'organisational malaise' referred to by Lord Laming, there are other comments on practice in the report which merit closer scrutiny. Although the absence of a 'presence of mind' to follow straightforward procedures and the need for professionals to keep an 'open mind' in assessment are mentioned, the report fails to grasp the sheer complexity of practice: what it takes to demonstrate 'respectful uncertainty' with families, and, more importantly, to be inquisitive each and every day when dealing with chronic human suffering, grief and loss. Lord Laming's somewhat simplistic answer lies in '*doing the relatively straightforward things well*.' The report gets closer to the key issues when witnesses indicate their instinctive reactions to Kouao as '*forceful*' and '*manipulative*' and their observations of the relationship between Kouao and Victoria as lacking parental warmth. Intuitively, they were on the right lines and yet their feelings were rarely committed to paper, and, more crucially, were not tested out and followed through to a clear conclusion.

A more positive and interesting question to focus on is: faced with potentially devious and/or intimidating carers, what motivates staff to undertake skilled child-centred assessments, to liaise appropriately with other professionals, to record them fully and promptly, to follow up recommendations and monitor inconsistencies? The answer lies in using both sides of the brain and in having a clear appreciation of the influence of our feelings on reason.[2] This starts with reading through the file at the office, when the purpose of the visit is planned, and continues as you turn up smartly and on time so as not to be on the defensive. It remains with you as you park your car between two abandoned, wrecked vehicles; as you look at the boarded up windows of the flat you are about to visit; as the door is not answered on the first occasion and the light goes out in the stairwell, as it did to Victoria's social worker; and it ensures that you stay there and knock louder in order to gain access or pursue the referral back at the office with dogged determination. The point is that these feelings, perhaps of fear and/or intimidation, let you know that you have to fight your normal response to stressful, unpleasant situations every inch of the way. When you finally gain access to the child in the

home, if you feel intimidated, then the key question to ask is, '*if I feel like this, what is it like for this child living here?*'

The unequivocal focus on the child leads on to the next point, which is having a clear and enduring understanding of the seriousness of the job you and your agency are employed to do. This means ensuring that your recording is always up-to-date, and before you go home each night asking yourself the question of each and every child on your caseload, '*how would my practice be judged if X or Y or Z were to die tonight?*'

What was frightening about the majority of professionals who were involved in Victoria's case was that they simply did not appreciate the seriousness and responsibility of their jobs, whether they were senior managers or front-line staff. They went through the motions of responding to a referral, in several instances failing to make an adequate record or, indeed, any record at all. The over-stretched, stressful, and sometimes unhappy working conditions may explain why they chose to engage at such a superficial level or interpret the allegations of child maltreatment as a child in need referral. If staff feel unsupported and undervalued, they are much less likely to pursue a case in the rigorous and challenging manner that is necessary.

The next area to consider is that people lie and this capacity is not restricted to service users; some lies have very serious consequences. Indeed, during the Inquiry, significant inconsistencies developed in the course of some professionals giving their evidence. With regard to Kouao's deception, Victoria's social worker, did not believe she would harm Victoria:

> '*I am not a detective. I had no reason to question what I saw and what I was being told at that point.*'

This is to miss the point of what assessment is all about. There is a growing literature on reflection, reflexivity, and the generation of multiple hypotheses around a particular case[3], where a careful chronology is constructed and data are collected along different lines of inquiry, checked and corroborated if necessary, until one or two particular hypotheses win out. Research skills need to be learned or re-learned, but with the added 'feelings' dimension given careful consideration. All staff employed in child welfare/protection work need to understand the processes through which their brain, their reason and emotions acting together, have led them to a particular hypothesis and perhaps, more importantly, why others have been discounted. This is the meaning of 'mindful' practice.

CONCLUSION

Finally, as both carers and staff can lie, so can they under-perform, which was so tragically evident in Kouao and Manning's care of Victoria and the inability of several managers to deal with conflict and the under-performance of their staff. The workplace dynamics that Victoria's social worker experienced should not have been allowed:

> '*The basis of the split was the headmistress and the head girls against the social workers…It was very difficult to rebel among the schoolgirls because we were regarded as children who should be seen and not heard.*'

It is small wonder then that Victoria's lowly status and silencing mirrored that of her social worker.

Whilst Lord Laming's proposals for structural change can go so far, they will not achieve the desired changes for vulnerable children unless and until all staff appreciate the serious nature of the role that they are asked to fulfil on behalf of society. In this regard, one particular finding from the Phase Two seminars deserves closer attention: a healthy workplace culture where managers listen to the concerns facing front-line staff and staff are

encouraged to learn from their mistakes. What is needed is a much greater focus on the emotional health of organisations and the people within them such that people can learn from practice, and where conflict can be resolved constructively in the interests of better co-ordinated services for children and families. A healthy workplace will lead to staff feeling valued and supported so that they are able to work effectively, and, if necessary, assertively with other professionals. They will be able to demonstrate the 'inquisitiveness' and 'mindful' child-centred practice so lacking in Victoria's case.

The report identifies that:

> '*The future lies with those managers who can work effectively across organisational boundaries*.'

However, working in the new structures will be a considerable challenge to Committee and Board members as they deal with sharing budgets, conflict and change, and other senior managers and elected members who may be as self-interested and impervious to taking responsibility as those identified in the Inquiry report itself. These senior management teams, in the words of the Inquiry report, will need to 'walk the talk' and be in touch with the issues facing front-line staff. Their leadership and emotional health will be crucial to the development of positive workplace cultures which support staff in providing quality services for vulnerable children and their families.

The report of the Victoria Climbié Inquiry is available from www.victoria-climbie-inquiry.org.uk/finreport/finreport.htm

FOOTNOTES

1 The sixth sense, *The Guardian*, 30/01/03.

2 See Damasio, A., *Descartes' error: emotion, reason and the human brain* (1994).

3 Sheppard, M., Social work, social science and practice wisdom, *British Journal of Social Work*, 25, pp.265-293 (1995); Sheppard, M., Newstead, S., DiCaccavo, A., and Ryan, K., Reflexivity, and the development of process knowledge in social work: a classification and empirical study, *British Journal of Social Work*, 30, pp. 465-488 (2000); Sheppard, M., Newstead, S., DiCaccavo, A., and Ryan, K., Comparative hypothesis assessment and quasi triangulation as process knowledge in social work practice, *British Journal of Social Work,* 31, pp. 863-885 (2001); and Reder, P., and Duncan, S., *Lost innocents: a follow-up of fatal child abuse* (1999).