1

History and Background to Child Death Investigation

1.1 Introduction

Investigating child homicides and suspicious deaths necessitates a co-ordinated multi-agency response, and presents unique challenges for those tasked with this extremely complex, specialized, and sensitive crime area. These often protracted investigations, operating in what can be a highly emotive and distressing environment, require professionals from a number of disciplines to work together to safeguard the interests of the deceased child, their siblings, and any future children, whilst maintaining a supportive and empathetic position in relation to the child's parents, carers, and other family members. There are now well established policies, procedures, and statutory guidance in place to provide a framework for these professionals to operate, with the police being the lead agency in child homicides and suspicious deaths, eg Chapter 7 of *Working Together* (2010).

The current investigative environment has been influenced considerably by past failures in protecting the right to life of children and is still an area where controversy amongst different affected groups, eg in relation to the causation of the death, continues, with the arguments often being played out in courts and the media.

The processes of child homicide and suspicious deaths have evolved through episodes of history to their current position. However, before considering these it is important to examine the nature and extent of this tragic phenomenon, where vulnerable children are unlawfully killed, sometimes by those in the greatest position of trust and responsibility for their safety and wellbeing—their own parents and carers.

1.2 Facts and figures surrounding homicides

The latest figures published by the *Home Office Statistical Bulletin* in January 2011 for 2009/2010 showed that 52 child victims under the age of 16 years were victims of murder, manslaughter, or infanticide (the total number of victims including adults was 615), and a further two were victims of familial homicide (causing or allowing the death of a child or vulnerable adult). This equates to a child being unlawfully killed in England and Wales on average once a week. The most vulnerable age group was for those under one when figures for the period 2007/08 to 2009/10 were examined.

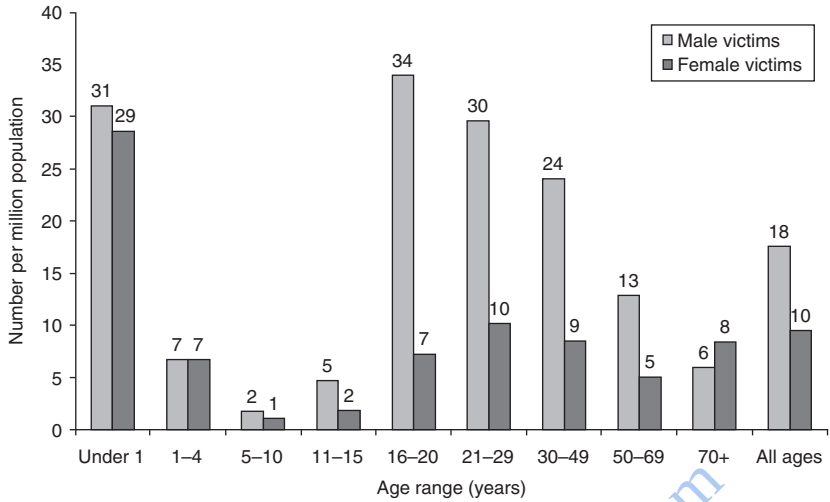

Figure 1.1 Offences currently recorded as homicide per million population by age of victim, combined years 2007/08 to 2009/10

Reproduced from Smith, et al, *Home Office Statistical Bulletin. Homicides, Firearm Offences and Intimate Violence 2009/10. Supplementary Volume 2 to Crime in England and Wales 2009/10* (London: Home Office) with permission.

As can be seen in Figure 1.2, these statistics also showed that in 69 per cent (36) of the cases recorded in these homicide figures for this period the perpetrator was a parent, in 19 per cent (10) of the cases at the time of recording there was no known suspect, in 6 per cent (3) of the cases a stranger had been responsible, and in the remaining 6 per cent (3) of cases the perpetrator was known, so that in 75 per cent (39) of the cases the victims had been acquainted with the main suspect. For these figures, the definition of 'suspect' refers to people who had been arrested and charged with a homicide offence or would have been if they had not died or committed suicide.

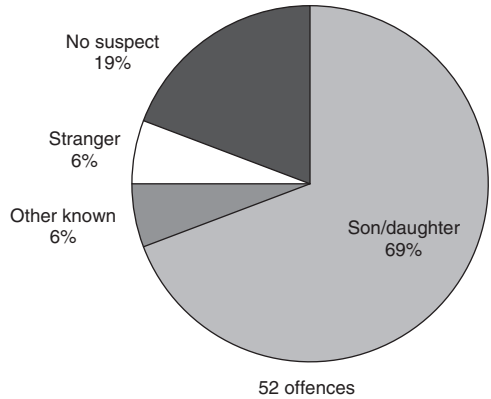

Figure 1.2 Victims under 16 years of age, by relationship of victim to principal suspect, 2009/10

Reproduced from Smith, et al, *Home Office Statistical Bulletin. Homicides, Firearm Offences and Intimate Violence 2009/10. Supplementary Volume 2 to Crime in England and Wales 2009/10* (London: Home Office) with permission.

These figures of recorded homicides, when combined with the following facts and figures for other measures in relation to childhood death, present a troubling picture in relation to the true scale of child homicide in England and Wales for whom the data is available, but with lessons for the UK as well.

Not all child deaths are homicides or suspicious; sadly many children die from natural causes, medical conditions, and accidents. The Foundation for the Study of Infant Death (FSID) has produced information on *Cot Death Facts and Figures* (last updated August 2010, available from their website <http://www.fsid.org.uk>), illustrating that over 300 babies still die every year as cot deaths in the UK.

Definition of 'cot death' by FSID

'Cot death is the sudden and unexpected death of a baby for no obvious reason. The post mortem examination may explain some deaths. Those that remain unexplained after post mortem examination may be registered as sudden infant death syndrome (SIDS), sudden infant death, sudden unexpected death in infancy, unascertained or cot death'.

The FSID figures cover the period 2000 to 2008 and include England and Wales, Scotland, and Northern Ireland. Figures are broken down for each individual year in this period, for each country, to include totals for children aged from birth to one year and also for babies over 12 months old.

The figures for children up to a year show a reduction in numbers from 2000 to 2008, from a UK total of 374 in 2000, with 334 in England in Wales, and an overall UK rate (per 1000 live births) of 0.55, down to a UK total of 312 in 2008, with 281 in England and Wales, and an overall UK rate (per 1000 live births) of 0.39.

The figures for cot deaths amongst babies aged over twelve months ranged from a UK total of 19 in 2000, with 17 in England and Wales, down to a UK total of 11 in 2008, with 8 in England and Wales, with only 3.4 per cent of cot deaths in the UK in 2008 being amongst babies over one year old.

FSID also point out that, since the launch of the Reduce the Risk campaign in England and Wales in 1991, with the positive encouragement of safer sleeping practices for babies, the sudden infant death number has fallen dramatically by around 70 per cent.

An article in the journal *Archives of Disease in Childhood* (Sidebotham, et al, 2011) looked at changes in rates of violent child deaths in England and Wales between 1974 and 2008, using an analysis of national mortality data (including data on causes of death from the Office of National Statistics (ONS) and on recorded homicides published by the Home Office). While explaining that, in the context of as many as 53,000 children dying worldwide each year through homicide, with the possibility that due to the nature of the crime there may be under-reporting including covert homicides, they concluded that, over the past 30 years in England and Wales, the rates of violent death in infancy (less than one year) and middle childhood (1 to 14 years) had fallen, but that, in contrast, rates in adolescence (15 to 19 years) had remained static or even risen over the same period. They suggest that 5 to 15 infants, 15 to 45 children, and 32 to 117 adolescents die violent deaths each year, with the true figures likely to be at the higher end of these ranges. The variation in numbers highlighted in the study results from different data sets, recording periods, age bands, registration criteria, and classifications within them. However, in the past three years absolute numbers of child deaths (0 to 19 years) from assault have varied from 48 to 58, which the authors argue represent a minimum estimate of the numbers of children dying violent deaths, as the true number of violent child deaths in England and Wales is not known.

To the figure of 54 child victims from the Home Office figures for 2009/10, consideration must also be given to the number of possible covert homicides. Researchers in another article in the journal *Archives of Disease in Childhood* (2004) (supported by Vaughan and Kautt, 2009), suggest that between five and ten per cent of the 300 sudden and unexpected deaths in infancy a year may be covert homicides.

This may suggest that the true figure for child homicides could have been between 69 and 84 victims for the year (2009/10). It is this possibility that makes child homicide investigation so difficult and different from other forms of homicide, where the cause of death is far more certain and clear from the outset. In a child-centred, victim-focused investigation, this possibility of a

covert homicide has to at least be considered, but in a very compassionate and sensitive manner, maintaining an open mind in the search for the truth.

Sidebotham, et al (2011) make a key point in their conclusion in relation to their research, suggesting a welcome reduction in violent child deaths that supports the other statistics cited and ethos running throughout this book, and is worth repeating here.

KEY POINT

'These reductions [in violent child deaths] ... appear to reflect real improvements in protecting children from severe abuse. However, there is no cause for complacency while at least one child or young person per week dies as a result of assault. Within this context, it is important that professionals, policy makers and the public continue to learn lessons from violent child deaths and to recognise that we all carry a responsibility to ensure children's safety.'

1.3 Important landmarks in child death investigation

The previous sections have explained that we now have specific guidance on investigating childhood death (to be covered in depth in subsequent chapters), and that the child death figures appear to be improving; but how have we arrived at this current position? The following section on the history of child death investigation illustrates how the current position evolved through a number of cases and issues over many years, showing that the timing and the sequence of events had a key impact on the continuing chronology, with many issues reoccurring and having a lasting effect on future childhood death investigations.

It is essential when examining any aspect of criminal investigation to look at the context in which the specified offence is committed, not only for that specific case but also the investigative context in more generic terms. A key feature or element of any context will be the history: what has occurred previously that has impacted on this particular area and, crucially, what lessons are to be learned from previous cases, to inform good practice but also to negate repeating previous errors? The history of childhood death investigation presents a very diverse and challenging picture with some disappointingly tragic cycles of failure. In some areas the investigative issues have moved on, although in others they have remained constant, with many continuing to present unique challenges to those tasked with the responsibility of determining how a child has died.

The period we will focus on in this chapter is between 1945 and 2010, examining the events and their position in the sequence of events of the overall chronology. It is essential to understand how the investigation of childhood death has developed and evolved over this key time frame. However, before looking at that key period in the history of childhood death investigation,

we will look at a story of a childhood death investigation from a much earlier period, that in a simple way will focus our minds on some key themes that are still central to today's investigations, but which are not unique, having been evident in society for over thousands of years.

This story is one of the earliest records of a childhood death investigation that can be dated to around 930 BC and has been the subject of paintings by famous artists including Raphael, William Blake, and Gustave Doré, as well as providing the basis for film and TV drama storylines, eg the BBC Soap drama, EastEnders.

Discussion point

As the following story unfolds what are the key issues or themes that are still evident today?

1.3.1 Early child death story

Now two prostitutes came to the king and stood before him. One of them said, 'My lord, this woman and I live in the same house. I had a baby while she was there with me. The third day after my child was born, this woman also had a baby. We were alone; there was no-one in the house but the two of us.

During the night this woman's son died because she lay on him. So she got up in the middle of the night and took my son from my side while I your servant was asleep. She put him by her breast and put her dead son by my breast. The next morning, I got up to nurse my son-and he was dead! But when I looked at him closely in the morning light, I saw that it wasn't the son I had borne.'

The other woman said, 'No! The living one is my son; the dead one is yours.'

But the first one insisted, 'No! The dead one is yours; the living one is mine.' And so they argued before the king.

The king said, 'This one says, "My son is alive and your son is dead," while that one says, "No! Your son is dead and mine is alive."'

Then the king said, 'Bring me a sword.' So they brought a sword for the king. He then gave an order: 'Cut the living child in two and give half to one and half to the other.'

The woman whose son was alive was filled with compassion for her son and said to the king, 'Please, my lord, give her the living baby! Don't kill him!'

But the other said, 'Neither I nor you shall have him. Cut him in two!'

Then the king gave his ruling: 'Give the living baby to the first woman. Do not kill him; she is his mother.'

When all Israel heard the verdict the king had given, they held the king in awe, because they saw that he had wisdom from God to administer justice. (© NIV)

This story contained in historic documents effectively illustrates the following key points for consideration.

KEY POINTS FOR CONSIDERATION

- How the elation of giving birth can be short lived and followed by the depths of grief at the loss of that newborn child—opposite ends of the emotional spectrum.
- The issues presented when there are a limited number of witnesses to the event and conflicting accounts—the 'Which of you did it?' scenario.
- Difficulty in establishing the cause of death.
- Death caused by a parent or carer overlaying a child and the challenging emotions that can pervade when there is the realization that the parent's actions may have contributed to the death.
- The different ways parties to the events can react to the death of a child.
- The extreme spectrum of emotions that can be experienced, from bitterness and resentment to compassion and empathy, by those directly and indirectly involved.
- Other opposites of deceit versus truthfulness in providing accounts and answering questions. The methods used to establish the truth.
- The difficult decisions that those investigating the circumstances of a death or administering justice have to make, as regards not only as to what has happened to the deceased child, but also as to how to deal with any surviving children. The resources deployed to answer these questions.
- The various methods that can be utilized to establish the truth.

Investigating childhood death continues to be extremely difficult and fraught with challenges that, as illustrated in this case, often require the 'wisdom of Solomon'—the king in this account—to arrive at a just outcome.

1.4 Chronology of child death investigation

Within more recent history there have been several key events that have come to be seen as defining moments in the investigation of child deaths and which have impacted on the investigative process. These will be briefly outlined in the following sections of this chapter, to give a fuller understanding of how the investigation of childhood death has developed. Some events will be discussed in greater detail in subsequent chapters. Generally, the events will follow a chronological order, but sometimes there is an overlap of events, with several key events occurring within the same time period. Hopefully, the outline of these important episodes in history will illustrate the developing background against which childhood deaths have been investigated and show how we have arrived in the current investigative environment, in which future deaths will be examined.

As will be clear from the chronology, these events are not limited solely to the police but cut across all those impacted by a child death, including the child victim, siblings, parents and carers, medical expert witnesses, and partner agencies, eg Social Services and healthcare.

Other cases and events may have occurred within this time period, but the events identified have been included as they illustrate the drivers for changes in perception and professional practice, as well as how issues can reoccur.

1.4.1 **Public Inquiries (1945–1999)**

Between 1945 and 1999, there were a large number of Public Inquiries into the deaths of children, where the actions of the carers and the professionals responsible for the welfare of the deceased children (often including their siblings) came under considerable scrutiny in a public forum. The findings of these inquiries would invariably lead to criticism of the various parties, and become the drivers for new or revised guidance, policies, and procedures, and even new legislation.

Case study—1945: Dennis O'Neill

Dennis O'Neill, aged 13 years, was starved and beaten to death by his foster father, Reginald Gough. Key issues at the Home Office inquiry included failures by agencies and staff, resourcing, and communication.

Case study—1973: Maria Colwell

Maria Colwell, aged seven years, was starved and beaten to death by her stepfather, William Kepple. Although having been fostered, she had been returned to her mother with insufficient evidence to justify this. All agencies were criticized in the inquiry, which ascertained that the family had been visited 50 times by social workers, police, health visitors, and housing officers.

The *Report of the Committee of Inquiry into the Care and Supervision Provided in Relation to Maria Colwell* published in 1974, and chaired by Judge Thomas Field-Fisher, QC, identified three key areas that would sadly continue to feature in subsequent enquiries.

- Lack of communication between those agencies involved
- Inadequate training for those involved, and
- Changes in the makeup of society and how children's place within it was perceived.

Case study—1984: Jasmine Beckford

Jasmine Beckford, aged four years, was starved and beaten to death by her stepfather, Maurice Beckford, who was convicted of manslaughter, and her mother, Beverley Lorrington, convicted of neglect. Despite Jasmine being known to Social Services for two and a half years and Beckford having been convicted of assaulting her younger sibling, she was seen only once in ten months by her social worker.

Case study—1984: Tyra Henry

Tyra Henry, aged 21 months, was beaten to death by her father after his release from prison for seriously assaulting her brother. Tyra's injuries included 50 bite marks on her body. The inquiry highlighted a lack of communication, training, resources, supervision, and experience, together with a failure to recognize and respond to the warning signs.

Mr Louis Blom-Cooper, the Jasmine Beckford Inquiry chairman, made some interesting comments, stating that, with the exception of the Tyra Henry Inquiry, to be held shortly, the Beckford Inquiry, which cost more than £300,000 'could well be the end of a series' which stretches back through more than 20 inquiries to the Maria Colwell case in 1973. He considered that 'We have got to the stage where the child abuse system has been sufficiently refined.' He explained that:

- a new code of practice for social workers was to be introduced,
- the child's interests must come first, and
- that the government was
  - consulting on how child abuse inquiries should be set up,
  - producing fresh guidance on the handling of child abuse cases and
  - that the issue of family courts was under review.

He said:

> 'I don't think we are going to see any major issues of principle in handling child abuse come up in the future. There will still be cases. This is a high risk game and there will be disasters. But I suspect they will be individual failures rather than something very fundamental.'

This is included as an appropriate challenge to our mind sets when we think we have identified and resolved all the key issues only to be met by a future case where, sadly, history is repeated, as will be evident from the following public inquiries in the 1980s and 90s, and more recent, current-day child deaths, eg Victoria Climbié, Baby P, and Kyra Ishaq.

Case study—1984: Heidi Koseda

Heidi Koseda, aged four years, was starved to death in a cupboard in a locked room by her stepfather and mother. A health visitor, despite having made 16 attempts to see Heidi at her home, never managed to actually see her in person.

Case study—1986: Kimberley Carlile

Kimberley Carlile, aged four years, was starved and beaten to death by her stepfather, Nigel Hall, and her mother. The Inquiry found that her death was avoidable and criticized social work and health staff.

Case study—1987: Doreen Mason

Doreen Mason, aged 16 months, who, despite being on the at risk register from birth, died from neglect having been beaten, burnt, and her leg fractured and received no treatment for her injuries. Her mother, Christine Mason, and her boyfriend, Roy Aston, were convicted of manslaughter and cruelty.

Case study—1992: Leanne White

Leanne White, aged three years, was beaten to death by her stepfather, Colin Sleate, who had inflicted over 100 injuries including repeated blows to the stomach that resulted in internal bleeding. Sleate was convicted of murder and her mother, Tina White, of manslaughter. The Inquiry considered that, if Social Services had responded appropriately to the concerns of her grandparents and neighbours, her death would have been preventable.

Case study—1994: Rikki Neave

Rikki Neave, aged six years, with two of his sisters, was beaten and burnt by his mother Ruth Neave, a drug addict. Despite his mother asking several social workers to take Rikki into care, he was left in her custody and found strangled in a wood.

Case study—1999: Chelsea Brown

Chelsea Brown, aged two years, was beaten to death by her father, Robert Brown, who had a history of violence against children. Despite numerous visits by her social worker and a paediatrician who examined her and found deliberately-inflicted injuries, no referral to police or case conference was held. Her father was convicted of murder and her mother of child cruelty.

This is just a snapshot from a number of inquiries, with over 70 since the introduction of the Children Act 1948. (See Hopkins (2007), 'What have we learned? Child death scandals since 1944', *Community Care*, 11 January, and Batty (2003), 'Catalogue of cruelty', *Society Guardian*, 27 January.)

As can be seen from the chronology of these highlighted public inquiries, the identification of key issues is essential, although only a part of the process; necessary safeguards have to be adopted, implemented, and adequately resourced to reduce the risk of similar circumstances reoccurring in the future. It would be impossible to totally eliminate the risk, as several of the contributing factors are outside of everyone but the perpetrator's control; the need for robust prevention and risk identification initiatives must be a priority.

Even though these inquiries were in relation to the deaths of the children, there were also far reaching implications for child protection and child abuse investigation that are inextricably linked. Children do not always die from abuse, but the investigative environment is identical in many ways, with only a fine line between survival and death distinguishing the two. Although this book's focus is on child homicide and suspicious deaths, it will, out of necessity, also include aspects of child abuse investigation, as unlawful child death is at the end of the spectrum of child abuse per se.

1.4.2 **The Children Act 1989**

This legislation, whilst not directly applicable to child deaths, as it is preventative legislation to protect and safeguard children, was a key milestone in child protection that is still central to that area today. It is clearly applicable and relevant for surviving siblings and future children of child homicide perpetrators. Its basis for introduction grew out of the startling findings from the above enquiries and also the 1988 *Cleveland Inquiry Report* by Dame Butler-Sloss, an inquiry into a complex child abuse investigation. A number of children had been taken into care in questionable circumstances, with many of their parents having been accused of child abuse, where a particular medical examination was utilized to detect sexual abuse. The issues that arose during the inquiry including the diagnosis of sexual abuse, the interviewing of children, and consideration of their views, as well as communication between different agencies, were considered in relation to proposed new legislation before Parliament and ultimately informed the 1989 Children Act.

The Children Act 1989 provided a primary legislative framework in relation to the prevention and investigation of child abuse and included the following key sections:

- **Section 17**—Identifies a child in need and the actions to be taken in relation to safeguarding and promoting their welfare.
- **Section 27**—Outlines the specific duty for services to co-operate in the interests of the child in need.

- **Section 44**—Emergency protection orders.
- **Section 46**—Police protection powers where otherwise a child is likely to suffer significant harm.
- **Section 47**—Identifies action to be taken if a child is suffering or is likely to suffer significant harm.
- **Section 53**—In relation to sections 17 and 47 emphasizes the need to take into account the child's wishes in relation to any suggested action to be taken in relation to them.

These procedures and legislation are important for child homicide and suspicious death investigations as in many cases the deceased child will have siblings. These may be witnesses, but in addition be subject to actions in relation to the above procedures. The two avenues of enquiry, childhood death and child protection procedures, as previously explained, will invariably run in parallel and often be inextricably linked.

1.4.3 Child death milestones

There then followed a number of milestones that all impacted in some way on the investigation of childhood death. They challenged society's perception regarding the extent and nature of the issues affecting it, including the inescapable fact that parents and carers were capable of killing children in their care. These milestones included the following:

Case study—1991: Beverley Allitt: 'The Angel of Death'

Between 21 February and 22 April 1991, a state-enrolled nurse at a Lincolnshire hospital, Beverley Allitt, murdered four children and injured nine children, whose ages ranged from seven weeks up to 11 years. She had killed the children by injecting them with potassium chloride or insulin. The term 'Munchausen syndrome by proxy' was a condition identified by Professor Sir Roy Meadow in 1977 as a form of child abuse and which describes the behaviour of this serial killer, who, whilst in a position of responsibility, betrayed that trust by killing or injuring children in her care. The many newspaper headlines describing her as 'the angel of death' perhaps illustrate the difficulty of society in accepting how a professional dedicated to saving lives could in reality be capable of destroying lives.

On another level, this level of unbelief that allowed Beverley Allitt to go undetected for some time is mirrored where friends and family do not believe that a family member would be capable of killing a child. There is a huge psychological barrier to be overcome, often requiring considerable evidence, before many people will accept the possibility that people do unlawfully kill children—and that the image of an evil monster is not the only one portrayed. (At the current

time the term 'fabricated or induced illness' is the preferred term to describe this offending behaviour and is covered in Chapter 6.)

Case study—1991: The 'Back to sleep campaign'

In the same year, 1991, the Department of Health's 'Back to sleep campaign' is credited with saving the lives of thousands of babies, who, prior to the campaign's launch, may have become victims of what was referred to at that time as 'cot death'—the sudden and unexplained death of a child, usually under the age of a year, and more commonly under six months.

The simple messages of the campaign in relation to the best way for your baby to sleep included:

- Lie your baby on his or her back.
- Use layers of sheets and blankets rather than a duvet.
- The best place is in a cot next to your bed.
- Cover just to the shoulders.
- Feet just touching the foot of the cot.
- Do not use a pillow.
- Offer a dummy.

This advice continues to be advocated and has resulted in the reduction in child deaths, continuing at the improved level. In this chronology where invariably the picture is very bleak and challenging, this is a 'good news' story that continues to have a positive impact on the rates of childhood death.

Case study—1986–1994: Professor David Southall: Covert Video Recordings of Life-threatening Child Abuse

Between 1986 and 1994, at hospitals in North Staffordshire and London, Professor Southall ran a research project in which children aged between two and 44 months' old, considered to be at risk from their parents, were covertly observed whilst in hospital. The patients were covertly monitored by hospital staff to establish the truth of the medical symptoms reported by their parents. Of the 39 children who were covertly observed, 33 were seen on camera to be intentionally suffocated, poisoned, or seriously assaulted (including a deliberate fracture) and this led to their parents being prosecuted for criminal offences. Also of interest is that the 39 patients undergoing covert surveillance had 41 siblings, 12 of whom had died suddenly and unexpectedly, 11 of which deaths had been classified as sudden infant death syndrome. However, following the surveillance, four parents admitted to suffocating eight of these siblings and another sibling was found to have been deliberately poisoned with salt. The project, despite its findings and staggering results, subsequently received some criticism from parents and other interested parties of the way it was managed, the methods it utilized, and in relation to issues of confidentiality.

Issues from this era still reverberate, with Professor David Southall continuing to be the subject of a campaign by parents who felt they were wrongly accused of child abuse wanting Professor Southall to be disciplined by the General Medical Council (GMC), charged with child abuse related offences in relation to the treatment of their children whilst in hospital under his care, and struck off the medical register. This campaign by the parents and other interested parties continues to this day and has impacted not only on their lives and their children's lives, but also on Professor Southall, who maintains his position that everything he did was, in his belief, in the best interests of the children in question. He is also limited in answering his critics, as much of the information on which decisions were made is confidential Family Court material that is against the law for him to disclose. It has also had a negative impact over the last 20 years on other paediatricians and medical experts' willingness to give evidence in similar cases, in view of the sensationalized media coverage that the ongoing actions have sometimes generated.

Case study—1997: Louise Woodward case in the USA and 'shaken baby syndrome'

1997 was the year that saw the issue of shaken baby syndrome come to the public notice with the prosecution of an English nanny, Louise Woodward, who was working in Boston and accused of killing the baby in her care by fatally shaking him. The case received considerable international media coverage and there was widespread support for Louise Woodward from friends and family, who did not accept that she was responsible for inflicting the fatal injuries referred to as 'the triad'. They, like the defence medical experts, believed there was an alternative causation for the injuries. Louise Woodward was convicted of killing the child in her care, Matthew Eappen, aged eight months. The original conviction of second degree murder was reduced on appeal to involuntary manslaughter.

There is still some debate over the causation of the triad of injuries, comprising retinal haemorrhages (bleeding into the linings of the eye), subdural haemorrhages (bleeding beneath the dural membrane covering the brain), and encephalopathy (damage to the brain affecting function) which, in the absence of any other evidence for an alternative plausible explanation, would be considered indicative of a non-accidental head injury. The issues surrounding 'shaken baby syndrome' continue to reverberate in the criminal justice and family court arenas. It is interesting to note that, whilst several still remember the name of the defendant, Louise Woodward, far fewer remember the name of the eight-month-old victim, Matty Eappen.

Case study—1991–2000: The legacy of Victoria Climbié

In 1998, for a better education, Victoria was flown from the Ivory Coast to France and then England where she lived for 11 months in the care of a great aunt and her boyfriend. On 25 February 2000, Victoria died in hospital from hypothermia, having suffered systematic abuse, where the perpetrator's belief in spirit possession was a factor, and at the time of her death she had 128 separate injuries.

On 12 January 2001, Victoria's carers were convicted of her murder, and on 20 April 2001 an Independent Inquiry was set up under the leadership of Lord Laming.

This was a real watershed case illustrating that, despite a considerable number of public inquiries, and changes in legislation and procedures, it was sadly still possible for history to repeat itself and for a child to die in horrific circumstances, where those who had the responsibility for safeguarding them failed in areas that had been highlighted in the Maria Colwell case of 1973.

The *Victoria Climbié Inquiry Report* was published in January 2003, and concluded that there had been 'a gross failure of the system' by the police, Social Services, and the health service. There were a total of 108 recommendations including a key one for the police, Recommendation Number 97, which stated:

> Chief Constables must ensure that the investigation of crime against children is as important as the investigation of any other form of serious crime. Any suggestion that child protection policing is of a lower status than other forms of policing must be eradicated.

This again illustrates the inseparability of child homicide and child abuse, which are just different points on the child abuse continuum.

1.4.4 High profile court cases reported miscarriages of justice—Clark, Cannings, and Patel (2003)

In 2003 there were successful Appeal Court judgments in the cases of Sally Clark and Angela Cannings, and a 'not guilty' verdict in the related trial of Trupti Patel. All three woman had more than one of their own children die in their care and been charged with their murder.

Case study—Sally Clark

Sally Clark, who had two children die, was convicted in 1999 of their murders but in a second Court of Appeal case hearing in 2003 had her conviction quashed, as the Court felt the conviction was unsafe. The two main issues in the second appeal centred on the discovery of previously undisclosed results of post mortem samples that suggested one of the deaths may have been from natural causes. The second was in relation to a statistic extrapolated by Professor Sir Roy Meadow from a 'Confidential Enquiry into

Sudden Death in Infancy' (CESDI) study entitled *Sudden Unexpected Deaths in Infancy* (SUDI), that made him come to the conclusion that the chances of two infant deaths within such a family being sudden infant death syndrome (SIDS) would be one in 73 million. The Court of Appeal thought that this statistic had misled the jury, although neither the prosecution nor the defence had suggested the deaths were as a result of SIDS. Injuries had been discovered on both children, some that were suggested to be the result of shaking and asphyxiation, and the prosecution had also suggested a number of similarities between the two deaths.

Case study—Angela Cannings

Angela Cannings had three children die and a fourth child suffer from an apparent life threatening event (ALTE). She was convicted in 2002 of two counts of murder in relation to two of the children's deaths. Her conviction was quashed in 2003 as the Appeal Court concluded that it was also unsafe. The Crown's case was that she had smothered her children resulting in either death or an ALTE. The defence case was that all the deaths were as a result of SIDS.

Case study—Trupti Patel

Trupti Patel, who had three children die and a fourth suffer from an ALTE, was charged in relation to their deaths, but after a six-week trial, the jury returned verdicts of 'not guilty'. There was significant media coverage of these three cases and some headlines even suggested 'Prosecution of mothers for baby deaths "will cease"'.

Personal criticisms of the eminent paediatricians Professor Sir Roy Meadow and Professor David Southall, including official complaints to the GMC in relation to the Sally Clark case, saw a change in the way medical experts were viewed and portrayed in the media. This often negative portrayal by the media became more pronounced over the following years and resulted in a detrimental impact on medical experts' willingness to give evidence at court in relation to child abuse and homicide cases.

At one stage both Professor Sir Roy Meadow and Professor David Southall were found guilty of serious professional misconduct and had their names erased from the register by the GMC. However, after many years and legal battles including in the Court of Appeal, both had the GMC's findings reversed and were reinstated to the register. Their cases were a protracted and complex process that it is not appropriate to cover in detail here, but they are succinctly explained in 'The Trouble with Paediatricians' by Catherine Williams (2010) in *Medical Law Review* (details in 'Further information and reading' at the end of this chapter).

Further information and reading

For free access to legal judgments like the Appeal Court cases cited go to <http://www.bailii.org>, the website for the British and Irish Legal Information Institute.

1.4.5 Which of you did it? (2003)

In 2003, following on from a seminar of the same title in 2000, the NSPCC, working with partner agencies, highlighted several issues related to the investigation of child death, including the 'Which of you did it?' scenario. This scenario related to the situation where a child had been unlawfully killed in a domestic environment and there were a limited number of suspects who could have been responsible for the death, usually the parents. However, neither parent would admit responsibility or apportion blame. Where both had previously been charged jointly with an offence of homicide, the prosecutions failed because of an Appeal Court judgment in the case of *R v Lane and Lane* (1987) 82 Cr App R 5. This judgment held that, in the 'Which of you did it?' scenario, if both suspects were charged, the circumstances could be such that it could result in the unfair conviction of an innocent person if there was uncertainty as to who was present and responsible for the fatal injuries. This had meant that there were cases where there was no dispute that a child had been unlawfully killed, but no one was prosecuted for the offence, albeit the Family Court may have taken action in relation to surviving siblings and future children born to the parents. The published findings of this multi-agency group advocated a new offence to cater for this lacuna in the law.

This theme was continued in April 2003 with the Law Commission (Law Com. No. 279), *Children: Their Non-accidental Death or Serious Injury (Criminal Trials). A Consultative Report*, and in September 2003 with the Law Commission (Law Com. No. 282) report of the same title with their recommendations.

1.4.6 Reports and Legislation—(2003/4)

Following on from the previously mentioned *Victoria Climbié Inquiry Report* published in 2003, there were a number of additional relevant documents and legislation published that added to the landscape of child death investigation and child protection. These included:

- A Green Paper—*Every Child Matters*—the government's response to the *Victoria Climbié Inquiry Report* (8 September 2003).
- The *Bichard Inquiry Report* (2004)—in relation to managing intelligence and sharing information following the murders in Soham of two schoolgirls, Holly Wells and Jessica Chapman, by Ian Huntley. The Inquiry examined the problems of not sharing information, managing intelligence, and poor

communication which wrongly allowed Ian Huntley to be employed in a post at a school.

- Legislation—The Children Act 2004—this would underpin the expectations of *Every Child Matters*, placing a statutory duty on local authorities and partner agencies to co-operate to improve the well being of children. Section 11 was central to this, placing a duty on both organizations and individuals to ensure functions are discharged with regard to the need to safeguard and promote the welfare of children.

1.4.7 Research—one in ten cot deaths may be murder or child neglect (2004)

In this highly emotive environment, with reported 'miscarriages of justice' and criticism of medical experts, two researchers, Dr Sarah Levene and Dr Christopher Bacon, from FSID, published an article in the journal *Archives of Disease in Childhood* suggesting that one in ten cot deaths may be murder or child neglect. This finding suggested that up to 30 to 40 cot deaths a year could in fact be covert homicides and accepted the fact that sometimes parents do kill their children. These findings are supported by other research (Vaughan and Kautt, 2009).

1.4.8 Sudden unexpected death in infancy—the report of a working group chaired by The Baroness Helena Kennedy QC (September 2004)

This seminal report was a multi-agency protocol for the care and investigation of sudden unexpected deaths in infancy. The eminent group of professionals who produced it was convened by The Royal College of Pathologists and The Royal College of Paediatrics and Child Health, initiated as a response to the acquittal of Sally Clark in January 2003. Members of the working group, in addition to representatives from the two colleges, also included representatives from FSID, the police, coroners, Department of Health, and Social Services. The multi-agency protocol advocated by this report has become the basis for current guidance on the investigation of sudden unexpected death in infancy and childhood.

1.4.9 The Attorney General's Review (2004)

Following the successful appeal of Angela Cannings, the Attorney General ordered a review of 297 cases from the previous ten years where children under two had died and a person had been convicted in relation to their death, especially where the conviction relied almost entirely on medical experts' evidence. Of the 297 cases reviewed, 28 were considered for referral to the Criminal Cases Review Commission and, where appropriate, referred to the Court of Appeal.

One of only two people to have their conviction for killing their children quashed after successful appeals as a result of this review was Donna Anthony who was convicted in 1998 in relation to the deaths of two of her children and was released from prison in 2005. It is interesting to see the comments from the Appeal Court judgment (*R v Anthony* [2005] EWCA Crim 952 (11 April 2005)) shown below:

> As the summary of events demonstrates, the conviction did not depend exclusively, or almost exclusively, on a disagreement between distinguished and reputable experts. There was indeed cogent and disturbing evidence, additional to the expert medical evidence, which supported the allegations made against the appellant and her own account of events was inconsistent and at times self-contradictory. (para.76)
>
> Notwithstanding the presence of disturbing features about the appellant's behaviour and her account of events, we have concluded that if the evidence available in the unchallenged form in which it is available to us had been available at trial, the decision of the jury might well have been different, and, in any event, if the judgment of the Court in *Cannings* had been available to the judge he would have ensured that the evidence given by the experts would have taken a different route, and would inevitably have summed the case up differently. In these circumstances, we are persuaded that the convictions are unsafe and must be quashed. (para. 97)

1.4.10 The Domestic Violence, Crime and Victims Act 2004

On 21 March 2005, section 5 of the above Act came into force, creating the new offence of 'Causing or allowing the death of a child or vulnerable adult'. This was in response to the issues raised in the NSPCC *Which of you did it?* report published in 2003, along with the Law Commission reports in the same year. This legislation is discussed in more detail in Chapter 3. The new offence recognized the special relationship and responsibility that carers and household members had to their children, introducing special procedural measures in support of this. In specific circumstances, it allowed the prosecution of both the person suspected of 'causing' the unlawful death of a child, together with any person who recognized that there was a risk of significant harm to a child, failed to take reasonable steps to protect the child from the risk, and the child died from an unlawful act in circumstances that they should have reasonably foreseen, and so 'allowed' the death to occur.

1.4.11 Appeal Court cases —issue of 'shaken baby syndrome' and 'the triad' (2005)

The Appeal Court ruling in the combined cases of *R v Harris, Rock, Cherry, and Faulder* examined in detail the medical evidence relating to the triad of injuries and, in particular, a defence theory for their causation described as the 'unified

hypothesis theory'—Geddes et al, 2003—which suggested that the injuries of the triad could be caused by a severe lack of oxygen which led to brain swelling rather than inflicted trauma. This theory, that in the court proceedings was accepted to be only a hypothesis by Dr Geddes, was not endorsed by the Court of Appeal which stated (para. 69):

> In our judgement, it follows that that the unified hypothesis can no longer be regarded as a credible or alternative cause of the triad of injuries.

However, whilst accepting that the triad did exist, the conclusion regarding future prosecutions was that it would be considered unlikely to mount a prosecution based solely on the presence of the triad of injuries without any other supporting evidence. Guidance was also given in relation to medical expert evidence and in the Criminal Procedure Rules regarding case management.

1.4.12 Working Together to Safeguard Children (2006, superseded) (2010)

This multi-agency guidance, deriving its statutory basis for several chapters from the Children Acts of 1989 and 2004, included Chapters 7 and 8 which relate directly to child deaths. **Chapter 7** outlines two related child death review processes that became compulsory on 1 April 2008 and were to be followed when a child died in the Local Safeguarding Children Board's area. The first process relates to a rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child. The second involves an overview of all child deaths in the area and is undertaken by a multi-agency Child Death Overview Panel (CDOP).

Chapter 8 related to Serious Case Reviews—a multi-agency review on lessons to be learned where abuse or neglect of a child is known or suspected and either the child has died or the child has been seriously harmed, and there is cause for concern as to the way in which the authority, their Board partners, or other relevant persons have worked together to safeguard the child. The guidance was updated in 2010.

1.4.13 The death of Baby Peter Connelly (2007–2009)

Peter Connelly, aged 17 months, who had been on the child protection register for eight months, was unlawfully killed in August 2007 and found to have sustained over 50 injuries including a broken back. This death received unprecedented publicity and occurred in Haringey, London, the same area as the death of Victoria Climbié in 2000, with several of the same issues including communication, training, and the way society perceives children being identified again. The child's mother, Tracey Connelly, her boyfriend, Steven Barker, and his brother, Jason Owen, were all convicted in 2009 of 'Causing or allowing the death of a child or vulnerable adult' receiving indeterminate sentences.

Haringey Council's leader and a cabinet member resigned whilst the Director of Children's services was dismissed in the aftermath of public scrutiny and uproar. (In August 2011, the Supreme Court upheld an earlier Appeal Court judgment that they had been unfairly dismissed.)

1.4.14 The Protection of Children in England: A Progress Report (2009)

In 2009, following on from the death of Peter Connolly, Lord Laming, who had conducted the Victoria Climbié Inquiry, was asked to prepare a progress report into the protection of children in England. His report, *The Protection of Children in England: A Progress Report*, was published in March 2009, and one quote in particular perhaps provides an explanation as to why the lessons identified in the Maria Colwell Inquiry in 1973 were tragically repeating themselves.

He stated that policies, procedures, and structures are important 'but more so the robust and consistent implementation of these policies and procedures which keeps children and young people safe'.

He also stated that 'managers must lead by example by taking a personal and visible interest in frontline delivery'.

These statements are not, in my view, limited to child protection but also are equally valid to all those tasked with investigating child homicides and suspicious deaths, when sadly those child protection policies, procedures, and structures have failed. They have the duty and responsibility of implementing the child death policies and procedures to establish the circumstances of the death and, if any criminal offences are disclosed, establishing who was responsible. Investigations will be far more effective when managers, the investigating officers, and especially the Senior Investigating Officer (SIO) lead by example, taking a personal and visible interest in frontline delivery and a determination to succeed that the death of any child deserves. The responsibility also extends further as the consequences for other siblings or children yet to be born, of an inadequate or ineffective investigation, are potentially catastrophic.

1.4.15 Further issues with 'the triad'—appeals of *R v Henderson and others* (2010)

The issue of the triad and expert medical evidence again became the focus of a number of appeals that were heard together. One of these cases concerned Keran Henderson who was convicted in 2007 of the manslaughter of Maeve Sheppard, aged 11 months. Like the Louise Woodward case ten years earlier, there was considerable media coverage of the support she was receiving from her friends and family who just could not accept that she would be capable of inflicting the fatal injuries that resulted in the death of Maeve. However, the Court of Appeal upheld the conviction and commented unfavourably on the

conduct of some of the defence medical experts. These Appeal Court cases are included in this chronology as they:

- Highlight the circular way in which history can repeat itself;
- Demonstrate the reliance placed on expert medical evidence;
- Illustrate the psychological impact of these types of cases;
- Reveal the varying levels of acceptance of the possible causes of death; and
- Show the relevance of the surrounding circumstances in child deaths.

There are also lessons to be learned by both the prosecution and defence in the management of these cases for future trials: we must learn from history and be open to alternative explanations, recognizing that all the genuine evidential jigsaw pieces do fit into the true picture.

1.5 Investigative features—and how they differ from other homicide investigations

Having explained the evolving history of childhood death investigation, this section will consider how there are a number of features which are sometimes unique and not apparent in other homicide investigations. However, whilst there will be many aspects of the investigation that will be the same and be covered in the standard guidance in the ACPO *Murder Investigation Manual* (MIM), this book will seek to identify those areas where child homicide investigation presents unique or different challenges and develop the guidance to cater for these investigative challenges. However, the 'five building block principles' will continue to underpin the investigative processes.

KEY POINTS

The Five Building Block Principles of Investigations

- Preservation of life;
- Preserve scenes;
- Secure evidence;
- Identify victim/witnesses, and;
- Identify suspects.

1.5.1 Investigative differentials

The investigative process and how it sometimes differs from other homicide investigations will be examined in detail in subsequent chapters, and in particular Chapters 4, 5, and 6. However, it will be useful here in a checklist to just identify from the outset several areas for future consideration where the investigation of child homicide is different to that of adult homicides.

Checklist—Key areas for consideration where child homicide investigations differ from adult homicides

1. **Less attributable as a homicide from outset**—Where the initial circumstances show no obvious cause of death being immediately apparent or even after post-mortem.
2. **Hidden nature of child homicide**—Due to the vulnerability of very young children it is possible to obscure the cause of death and the circumstances, eg asphyxiation in young children as tell tale signs visible in adult cases are sometimes absent.
3. **Sensitive management**—Due to the tragic nature of child death and period of uncertainty in establishing cause of death and circumstances.
4. **Specialist knowledge**—Serious crime area in an unique investigative environment.
5. **Natural death v crime?**—This is not always obvious from the outset and may take some time to establish.
6. **Paediatric pathologist**—Specialized post-mortem procedures.
7. **Dealing with and access to body**—Issues of parents handling the deceased child if any suspicions in relation to circumstances and cause of death that would not arise in adult cases.
8. **Faith and child rearing practices**—For example, belief in spirit possession, bed sharing practices.
9. **Highly emotional nature of child deaths**.
10. **Risk for siblings if child is unlawfully killed by carer.**
11. **Multi-agency response**—This is essential and advantageous but there can be issues in relation to conflicting priorities, sharing of information, and communication.
12. **Suspect within the family**—This can present real issues for family liaison strategy.
13. **Reliance on experts**—Particularly medical experts where limited witnesses to circumstances surrounding the death, eg inflicted injury versus accidental.
14. **Special offences**—Serious crime area with criminal offences relating solely to children.
15. **Parallel proceedings in the Criminal and Family Courts**—May create issues, eg in relation to disclosure and access to siblings who may be witnesses.
16. **Limited forensic opportunities**—For example, closed circuit television (CCTV) or DNA comparisons that are so useful in adult homicide cases but are sometimes of limited value when a family member is responsible for the death.
17. **Media reporting**—Can impact on the investigation, eg timing of enquiries, reluctance of medical experts to give evidence.

As the book progresses other differences may become evident but these examples are included to stimulate consideration of these identified areas and where this differential may impact on the investigation. These specific areas will be examined in more detail in subsequent chapters.

1.5.2 **Investigative perceptions**

A useful way to perhaps consider the various perceptions of the different groups of people impacted by childhood death is to answer the following question.

Question: Rank in order of seriousness the following offences:

(a) A gang related murder.
(b) A domestic murder, eg husband kills his wife.
(c) A child murdered by their carer.
(d) A child murdered by a stranger.
(e) A terrorist-related murder.
(f) A rape or serious sexual assault of a child.
(g) A cat thrown into a wheelie bin.
(h) A dog kicked by its owner.

But then consider how they may be ranked by different groups who would consider the offences from varying perspectives. Consider the following groups:

1. Police
2. Public
3. Partner Agencies
4. Press
5. Parents and family
6. Judicial system including CPS, lawyers, barristers, and judiciary

What factors would be appropriate to consider when trying to determine the respective ranking results for each group to the question?

No definitive answer will be given to the question but just completing the exercise will hopefully illustrate yet another facet of childhood death investigation and the environment in which investigations are conducted. A few comments may assist with the exercise and show how the question may be answered by the different groups.

KEY POINTS TO CONSIDER WHEN ANSWERING THE QUESTION

- What level of resources do the police deploy to the respective investigations?
- What level of media coverage do the respective offences receive?
- What sentences do the respective perpetrators receive when convicted?
- Is the sentence commensurate with the level of seriousness?
- How highly is the life of a child victim valued and is that reflected in the sentences received?
- What emphasis should be placed on the behaviour and motivation of the offender?
- Is there more empathy shown to people who kill their own children as opposed to strangers who kill a child?
- What place should the special position of responsibility a parent has for their child have in this process?
- Should the vulnerability of the victim be a factor?
- Does the fact that older victims have more of a 'life story' and an 'identity' affect how their loss is perceived?
- Should a distinction be drawn between a parent who, under a number of stressors, 'cracks' and fatally assaults their child compared to someone who derives a sadistic pleasure from inflicting injuries on a child?
- Are animals viewed in a similar way to children or do they receive preferential consideration?
- Where is the focus when cases are reported—is it on the victim or someone else, eg parents?

In concluding this chapter, perhaps the answer to where child homicide ranks on the seriousness rankings could incorporate features from the following:

- Each case is unique and, although there may be common themes, each should be considered on a case by case basis;
- Different groups may have a different perspective that will affect their response to childhood death; and
- There may be no definitive answer as to whether or not a child murder is the most serious offence but, even if child homicide is not considered the most serious, it could still be argued undoubtedly that it was equally as serious and, therefore, deserved a similar priority and allocation of resources, whether human or physical, to investigate it.

KEY POINT

It is essential to remember and emphasize that any investigation into a childhood death involves professionals from many different agencies who all have distinct roles but who complement each other by working together to establish how and why the child died, most crucially by sharing information and professional knowledge.

The majority of childhood deaths will not result in criminal proceedings as there will be other natural and medical explanations for the deaths, which are equally as important outcomes, eg establishing a natural cause of death from a health perspective or other factors for social care when considering options in relation to any siblings and Family Court proceedings.

Childhood death investigation operates in a very challenging and thought provoking environment—one that needs very careful consideration, sensitivity, management, and professional knowledge-based judgements that hopefully this book will help inform.

This brief history of childhood death, and consideration of how it differs from other forms of homicide investigation, provides the background and signposts key areas for the subsequent chapters that will develop some of these issues in more detail. It will examine the continuum of child death investigation from the non-suspicious sudden unexpected death in infancy (SUDI), through suspicious child deaths to child homicide at the other end of the spectrum. These chapters will also consider legislation and guidance, case management, and future considerations.

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