ASSOCIATION OF CHIEF POLICE OFFICERS

A Guide to Investigating Child Deaths

The Association of Chief Police Officers have agreed to this guidance being circulated to, and adopted by, Police Forces in England and Wales.

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Document information

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This Guidance has been produced by the ACPO Crime Business Area and has been endorsed by the Gateway group on [type date]. ACPO has agreed to this guidance being circulated to and adopted by Police Forces in England and Wales. It will be updated according to legislative and policy changes and re-published as required.

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1. Introduction

1.1 The investigation of the death of a child is an extremely complex area of police work; and is also very demanding for investigators in terms of emotional pressure. Children are not meant to die, and the police investigation into the sudden death of a child must be influenced by this basic fact. This means that even when there are no apparent suspicious factors, the police contribution to the investigation must be detailed and thorough.

1.2 For the purposes of this guide all references to Investigating Officer/ Lead Police Investigator is understood to be a member of staff who has attained a national standard in the field of investigating Child Death and therefore is qualified to perform the role of lead investigator.

1.3 The purpose of this guidance is to assist investigating officers in all cases of Sudden Unexpected Death in Children (SUDC) whether or not there are any suspicious factors. In cases where there is suspicion that a crime may have been committed, this guidance is not to be used instead of the ACPO (2006) *Murder Investigation Manual* (MIM), but rather as a supplement to that guidance.

1.4 The three distinct strategic phases of investigating deaths still need to be carried out:

- Instigation and Initial Response - this involves the deployment of officers to the report of an incident, which may be a homicide, and the action they take to secure the scene, identify suspects and locate evidence, in essence carry out fast track actions and the 'Golden Hour' principles.
- The Investigation - this involves developing investigative strategies for establishing cause of death and who, if anyone is responsible for the death.
- Case Management - pre and post charge or inquest.

1.5 The main difference when investigating the death of a child, as opposed to an adult, is that all three of the phases are carried out jointly, to varying degrees, with multi-agency partners. A sensitive yet controlled approach to scene preservation is crucial. A delicate balance often has to be adopted between what could prove to be a natural death whilst minimising potential evidence loss if subsequently found to be suspicious.

1.6 There has been a huge reduction in unexpected infant deaths (children under one year old) in recent years. This has largely been brought about by education campaigns for new parents, such as, the 'Back to Sleep' campaign. Despite this reduction, every year in England and Wales, several hundred children will die before they reach the age of one. The majority of these deaths occur as a result of natural causes, such as disease, physical defects or deaths caused by accidents. A small proportion of deaths are, however, caused deliberately by violence, by maliciously administered substances or by the careless use of drugs. Research suggests that as many as 5-10% of sudden

unexpected deaths in infancy (SUDI) might be covert homicides[1]. In other cases even where there is an identified natural cause of death there will be a proportion where neglect and or maltreatment by carers may have been a contributory factor.

1.7 Investigating officers must be aware that as the number of genuine unexpected deaths decreases, the proportion of all deaths which could be attributed to homicide is likely to increase; education campaigns will not impact on all people who kill children. Although high profile cases capture a lot of media and public attention, the true scale of child homicide is unknown. It is widely stated that one or two children die each week in the UK at the hands of their carers[2]. One of the greatest challenges for investigating officers dealing with these suspicious deaths, particularly those occurring in infancy, is often their covert nature. Smothering, particularly when using a soft object may leave no external signs of injury and post-mortem findings are typically non-specific so that it may be difficult to distinguish homicides from other SUDC[3]. It is therefore, extremely important that any peripheral or environmental factors which may indicate homicide are discovered by a thorough investigation.

1.8 Every child who dies deserves the right to have their sudden and unexpected death fully investigated in order that homicide can be excluded and a cause of death identified[4]. Article 2 of the Human Rights Act (1998) states that everyone's right to life shall be protected by law. This requires public authorities to establish the cause of death. Apart from anything else, this will help to support the grieving parents and relatives of the child. It is also important to enable medical services to understand the cause of death and, if necessary, create interventions to prevent future deaths in children. The police have a key role in the investigation of infant and child deaths, and their prime responsibility is to the child, as well as to siblings and any future children who may be born into the family concerned.

1.9 A definitive cause of death cannot always be established. Pathologists or Coroners tend to classify such cases as 'unascertained'. Most paediatric pathologists use the term 'unascertained' to describe the cause of death when no definite conclusions can be drawn from the post mortem (PM) findings[5]. All this means is that NO CAUSE OF DEATH HAS BEEN FOUND**.** Coroners may also use a narrative verdict to supplement this and require a thorough investigation to provide them with the relevant information. Sudden Infant Death Syndrome (SIDS) is described as the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation,

[1] J Vaughan, *Infanticide: The effects of miscarriages of justice*, University of Cambridge, 2007, p.2
[2] P Sidebotham, 'Fatal Child Maltreatment' in P Sidebotham & P Fleming, *Unexpected Death in Childhood A handbook for Practitioners*, John Wiley and sons, Ltd, Chichester, 2007, p. 75

[3] ibid., pg 77

[4] Kennedy Working Group, *Sudden unexpected death in infancy,* 2004, p. 66

[5] SJ Gould, MA Weber & NJ Sebire, 'Variation and uncertainties in the classification of sudden unexpected infant deaths among paediatric pathologists in the UK: findings of a National Delphi Study', *Journal of Clinical Pathology*, vol. 63, no. 9, Sep 2010, pp. 796-799

including performance of a complete autopsy, examination of the death scene and review of the clinical history[6].

1.10 There are a number of guiding principles that must underpin the work of all relevant professionals dealing with a SUDC.

1.11 When dealing with SUDCs all agencies need to follow five common principles, especially when having contact with family members. These are listed below:

- Balanced approach between sensitivity and the investigative mindset;
- A multi agency response;
- Sharing of information;
- Appropriate response to the circumstances;
- Preservation of evidence.

1.12 In applying the above principles individuals and agencies should ensure that their actions are legal, necessary, relevant and proportionate in order to comply with The Human Rights Act 1998.

1.13 As a result of a series of high profile appeal court acquittals Baroness Helena Kennedy QC chaired a working group to look at 'sudden unexpected death in infancy' with its object to suggest best practice in the investigations of infant deaths by introducing a multi-agency protocol. There is little doubt that a multi-agency approach is the best way forward to investigate child deaths, as recommended by Baroness Kennedy. All Local Safeguarding Children Boards (LSCB) have developed protocols to ensure that such investigations do have a multi-agency approach to them, as this is the best way to determine the cause of death and to assist in any future prosecutions.

1.14 In April 2013, HM Government issued updated guidance titled 'Working Together to Safeguard Children 2013'. Within this document, Chapter 5 provides overarching guidance for Police and constituent agencies of LSCBs on how they collectively should investigate child deaths. This is statutory guidance and should be adhered to. See extract from Chapter 5.

1.15 The chapter sets out the processes to be followed when a child dies in the LSCB area(s) covered by a Child Death Overview Panel (CDOP). There are two interrelated processes for reviewing child deaths, either of which can trigger a Serious Case Review (SCR):

- 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;

[6] M Willinger, LS James & Catz C, 'Defining the sudden infant death syndrome (SIDS): deliberations of an expert panel convened by the National Institute of Child Health and Human Development', *Journal of Pediatric Pathology*, Sep-Oct 1991, pp. 677-684

- An overview of all child deaths up to the age of 18 years (excluding both babies who are stillborn and planned terminations of pregnancy carried out within the law) in the LSCB area(s), undertaken by a panel.

1.16 In this guidance an unexpected death is defined as the death of an infant or child (less than 18 years old) which:

- Was not anticipated as a significant possibility, for example, 24 hours before the death; or
- Where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

1.17 When a child dies unexpectedly, particularly when abuse or neglect is a factor, several investigative processes may be instigated. The Working Together guidance intends that the relevant professionals and organisations work together in a coordinated way, in order to minimise duplication and ensure that the lessons learnt contribute to safeguarding and promoting the welfare of children in the future.

1.18 It is intended that those professionals involved, before and/or after the death, with a child who dies unexpectedly, should come together to respond to the child's death.

The joint responsibilities of these professionals include:

- Responding quickly to the unexpected death of a child;
- Making immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the Coroner;
- Undertaking the types of enquiries/investigations that relate to the current responsibilities of their respective organisations when a child dies unexpectedly. This includes liaising with those who have ongoing responsibilities for other family members;
- Collecting information in a standard, nationally agreed manner;
- Providing support to the bereaved family, and where appropriate referring on to specialist bereavement services; and
- Following the death through and maintaining contact at regular intervals with family members and other professionals who have ongoing responsibilities for other family members, to ensure they are informed and kept up-to-date with information about the child's death.

1.19 Where there is a review process parallel to the criminal investigation, the investigating officer and the Crown Prosecution Service (CPS) should be involved in a discussion about the terms of reference and scope of the review in order to avoid prejudicing any criminal proceedings.

1.20 The police will be the lead agency for any criminal investigation. They should be informed immediately whenever there is a suspicion of a crime to ensure that the evidence is properly secured and that any further interviews with family members and other relevant people accord with the requirements of *Achieving Best Evidence in Criminal Proceedings Guidance on Interviewing Victims and Witnesses and Using Special Measures MoJ* (2011) [7]and the Police and Criminal Evidence Act 1984. The police will begin an investigation into the sudden or unexpected death of a child on behalf of the Coroner. They will carry this out in accordance with this ACPO Guidance.

1.21 Unless there are clear indications of maltreatment, and there is no opportunity for an attempted resuscitation, children who die suddenly and unexpectedly at home or in the community will normally be removed by the Ambulance Service and taken to an Emergency Department at a hospital (rather than a mortuary).

1.22 It is good practice to obtain as much information as possible in respect of the history of the child and the circumstances leading up to the child being found dead. This will help to inform the decision making that should be taken ahead of the interviewing process. It is beneficial for this account (sometimes referred to as the history taking) to be conducted jointly by a police officer and a paediatrician, preferably the SUDC paediatrician for the area.

Consideration should be given to whether or not carers are interviewed together or separately. Relevant factors will include:

- Helping to corroborate respective accounts;
- Preventing a dominant carer from controlling the conversation;
- The need for carers to be supported by each other.

1.23 A standard set of samples should be routinely taken by the hospital staff in the Emergency Department after the death is confirmed. This is normally done in accordance with a protocol agreed in advance with the relevant Coroner, and is based on the sample set recommended in the Baroness Kennedy report. It is an integral part of the entire process to help establish the cause of death and any contributory factors. The police are not responsible for securing or packaging the samples and these will normally be processed through hospital laboratory procedures. However, consideration should be given to situations where it is important to maintain a chain of evidence, for example, for toxicology samples. Whereas the police are not responsible for the retention of these samples the investigating officer should be aware of their existence to cater for the eventuality that the pathologist may be unable to extract sufficient material, for example, histology.

[7] http://www.justice.gov.uk/guidance/docs/achieving-best-evidence-criminal-proceedings.pdf

2. Instigation

WHO SHOULD ATTEND A SUDDEN UNEXPECTED DEATH OF A CHILD?

2.1 If the police are the first professionals to attend the scene then urgent medical assistance should be requested as the first priority. Police attendance should be kept to a minimum. Several police officers arriving at a house can be distressing especially if they are uniformed officers in marked police cars. The first responder should be a detective officer in plain clothes and use an unmarked police car.

2.2 In all cases of SUDC, whether or not there are any obvious suspicious circumstances, a Lead Investigator should be tasked to immediately take charge of the investigation. It is recommended that the lead police investigator attends the location of the body to liaise with the lead clinician and other medical practitioners. This is dealt with more in more detail in Section 4 of this document.

2.3 It is important that the environment where the child died is sensitively and carefully secured, pending the joint scene assessment.

2.4 If there is any reason to believe the death may be suspicious, an accredited SIO should lead the investigation.

2.5 Early effective cooperation and liaison between police and paediatricians is very important. The detection of child abuse is part of the standard training of paediatricians, which should equip them to carry out an external examination and to arrange the relevant investigations such as a skeletal survey and tests for abnormal bruising. The paediatrician may also assist the investigating officer by collating relevant information from medical records, preparing reports for pathologists and convening a meeting among all medical professionals involved with the family.

2.6 It is recommended that the investigating officer is present when the external examination by the paediatrician of the child is carried out. Should any marks of interest or possible significance be noted these should be recorded in detail by the lead clinician and photographed by the police.

2.7 The Kennedy Report and Working Together 2013 highlight that it is best practice to carry out joint police/health professionals' home visits. It is highly recommended all forces adopt this model.

2.8 The investing officer should ensure that the Coroner is notified as soon as possible. The Coroner will make use of their officer and their experience in dealing with sudden deaths and bereaved families will be invaluable in explaining to the parent/carer what will happen to their child's body and why. The investigating officer and the Coroner's Officer should continue to liaise closely throughout the investigation. The Foundation for the Study of Infant Deaths has compiled a leaflet as a guide for both parents and carers.

3. PRELIMINARY ASSESSMENT

3.1 It is important that an early view is taken by the investigating officer as to whether or not there are suspicious factors. The following will be useful in making this judgement.

FACTORS WHICH MAY INCREASE SUSPICION

3.2 The key information from '*Risk Factors for intra-familial unlawful and suspicious child deaths*[8]' is shown below. Read the full article

3.3 The authors have endeavoured to advance what is sometimes referred to as the 'detective's gut instinct' based on their assimilation of psychological factors and anecdotal information by providing a research based list of factors. This list is not exclusive to unlawful deaths, but if some of the factors are present it may justify a more comprehensive examination of the circumstances surrounding a death.

3.4 This paper reports the findings of an analysis of 282 consecutive cases from the London metropolitan area which have all been investigated by the Metropolitan Police Service (MPS) and had specialist post-mortem examinations performed according to the standard protocol. The aim of the study was to determine whether certain features are disproportionately associated with unnatural suspicious deaths. The findings are of potential benefit to the police, paediatricians, pathologists and others involved in child abuse investigation work. There were 54 suspicious deaths and 228 non-suspicious deaths during the study period. This dataset does not include children who died as a result of peer-on-peer murders, stranger murders, suicides or road traffic collisions.

3.5 Risk factors for suspicious child death (these are in priority of suspicion):

- History of violence to children;
- Inconsistent account;
- Mental health issues;
- Previous atypical hospital visits;

[8] J mayes, A brown & D Marshall, 'Risk Factors for intra-familial unlawful and suspicious child deaths', *Journal of Homicide and Major Incident Investigation*, vol. 6, no. 1, Spring 2010, pp. 77-96

- History of alcohol abuse;
- Child over one year old;
- On child protection plan;
- Known to social services;
- History of drug abuse;
- History of domestic violence;
- Criminal record;
- Previous sibling dead.

3.6 The following features were found at autopsy to be significantly associated with suspicious deaths:

- Presence of features of the RADI (rotational acceleration deceleration impact injuries sometimes referred to as the triad which is subdural haemorrhages, brain swelling and retinal haemorrhages);
- Toxicological detection of drugs of abuse;
- Presence of fractures;
- Bruising at unusual sites, for example, torso;
- Post-mortem features indicating that the interval since death was significantly longer than stated by parents or carers.

3.7 In particular, suspicious child deaths were often associated with significant social issues for parents or carers, such as previous history of violence to children, mental health issues, alcohol and or drug abuse, or domestic abuse. Learning from serious case reviews into the deaths of children who die where abuse or neglect is a factor support these findings.

3.8 The data from the present study indicate that an inconsistent history of events provided by parents or carers is significantly more frequent in the suspicious death group and should therefore be regarded as one of the indicators of possible suspicious death. However, as with all the possible indicators they must be regarded as an indication or factor that merits further investigation. People react in different ways to death and may behave 'suspiciously' but after questioning, their rationale may provide an explanation which removes the suspicion and can negate an arrest[9]. (*Wate and Marshall,* 2009).

3.9 SOCA are collecting details of all suspicious child deaths with a view to carrying out analysis which will both assist investigators and help with prevention strategies. These details are captured on a Operation Marshall Form

[9] R Wate & D Marshall, 'Effective Investigation of Intra-familial Child Homicide and Suspicious Death', *Journal of Homicide and Major Incident Investigation*, vol. 5, no. 2, Autumn 2009, pp. 17-38

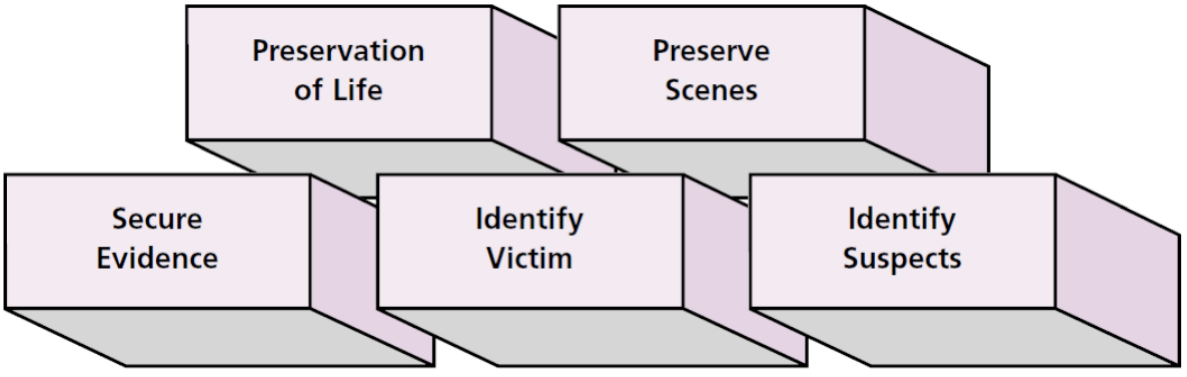
4. INVESTIGATION

INITIAL ACTION

4.1 The thorough investigation of an unexpected child death cannot be carried out by a single investigator. Even when there are no apparent suspicions, as a minimum it is suggested that a team of three investigators will be required to assess and manage scenes, carry out interviews and follow lines of enquiry. The Lead Investigator of this team should have the experience necessary to manage enquiries of this complexity. If at any stage the inquiry indicates that the death of the child is suspicious a PIP level 3 SIO should be deployed to take command of the investigation. When conducting interviews in relation to a suspicious death with either a suspect or a significant witness, the SIO should always consider using the services of a tier 5 interview adviser.

4.2 Investigating officers should always adopt an investigative mindset, using investigative evaluations and developing hypotheses where necessary will help detectives to establish what has occurred.

4.3 The five investigative building blocks should be considered:



4.4 The following elements should be considered in developing an investigative strategy:

- Crime Scene;
- Forensic;
- Pathology;
- Witness;
- Family Liaison;
- Suspect;
- Elimination Enquires;
- Media;
- Community;
- Passive Data;
- House–to-House;
- Search;
- Reconstructions;
- Covert.

4.5 The Lead Investigator should initially attend the location of the body, usually at the Emergency Department, but occasionally at the scene of the death if the body has not been removed. In the later case, they should make a visual check of the child and its surroundings, noting any factors as described above as suspicious. It must be established whether the body has been moved and the current position of the child should be recorded. They should identify potential scenes, and preserve evidence but it is not usually appropriate at this stage to seize bedding from, for example, cots.

4.6 In cases where the child has been removed to the Emergency Department, the Lead Investigator should deploy an experienced investigator to the premises where the death occurred. This officer should conduct a basic assessment of the type of premises involved and whether there is any likelihood that potential evidence may be removed or destroyed. In many cases scene security can be achieved by a low key discreet presence, but if there is any danger that potential evidence might be lost, more robust scene preservation may be necessary. It is crucial that the death scene, and all items therein when the child died, is maintained as closely as possible in its original state pending a full scene assessment

4.7 The Lead Investigator should meet the parents, preferably with a paediatrician, and explain the process of the investigation. The role of the police, and the purpose of a post mortem (this may determine the cause of death or help in giving reasons for the death should be covered). They may also find it useful to refer parents to the FSID 'The Child Death Review' leaflet.[10]

[10] Available at http://fsid.org.uk/Page.aspx?pid=780

4.8 Where the death of a child is considered suspicious, the SIO should consider the best way of obtaining an account from the carers of the child. If they are suspects, then any decisions concerning the topic of voluntary attendance or arrest in order to interview under caution needs to be considered and balanced. If there are no clear suspects, yet the death is considered suspicious, the carers, and people in the premises when the child died may well be significant witnesses and where possible, their account should be recorded. All decisions about the status of carers and other people present when the child died should be recorded in the SIO Policy file.

4.9 In planning the interview the relevant information which will be required from the initial account will depend upon the age of the child, but where applicable should at least include:

- Who saw the child last?
- What condition was the child in?
- When the child was last fed, with what, and by whom? (Locate and preserve any bottles etc.)
- Who put the child to bed and how?
- Who found the child to be dead?
- How did the child look when found (blue, pink, stiff etc.)?
- Who else was in the house at the time of discovery?
- Where was the child sleeping in relation to the parents/carers and in what?
- Who was in the child's room/bed?
- Who else was in the child's bed?
- What was the sleeping position of the child?
- Detailed account of child's behaviour 48-72 hours prior to death, i.e. health of the child the day before.
- Do the parents, other members of the household or carers smoke? If so, was the child in a smoke free environment or not?
- Has any carer had any alcohol whilst caring for the child?
- How much clothing or wrapping was used on the child and what was the room temperature where the child was found?
- Was bedding over/under the child?
- Was bedding tucked?
- Was an electric blanket used?
- Was there heating in the house?
- Was there heating in the child's room?
- What type of heating?

Investigative Areas

- Was the child breast fed?

- What was the child's routine breast feeding pattern?
- Who was there/with the child in preceding 24 hours?
- Detailed account of child's behaviour 48-72 hours prior to death, i.e. health of the child the day before.
- What was the sleeping position of the child?
- Do the parents, other members of the household or carers smoke? If so, was the child in a smoke free environment or not?
- Has any carer had any alcohol whilst caring for the child?
- Have there been any previous child deaths in that or extended family? If so full details.
- Has either of the carers been involved in earlier relationships where they have had children? If so, obtain full details of any significant events in the lives of those children.
- Who is the child's GP?
- Has the child had any illness since birth or been seen by a Doctor for a health problem?
- Has child received injections? If so, for what and when?
- Has the child attended clinic or been medically examined? If so, date and venue.
- Has the child been admitted or taken to a hospital or clinic? If so, which hospital/clinic, when, what for?
- Were they furnished with a booklet detailing medical checks, examinations, dates etc.? (The parent-held Child Health Record often known as the Red Book). If so, where is that?
- Full details of parents/carers contact addresses, telephone numbers etc. (Furnish with your contact details).
- What guidance have the parents received with regard to SIDs from the medical profession or children's centres prior or since the birth of the child?
- Was an infant intercom in place?
- Was the child born prematurely and what was his/her weight at birth?
- What type of delivery?
- Did the child require special treatment after birth?
- Was child discharged from hospital with mother? If not, did he/she require special treatment?
- Has anyone new been visiting the household?
- If with a carer are they accredited?
- A detailed description concerning the history of the child's general behaviour and well being
- Any relevant personal issues that exist within the family/ carer relationships.
- A profile of the parents/carers which may assist in the investigation

4.10 Clearly, someone who has knowingly killed a child is likely to lie to cover up their actions, so any conflicting accounts should raise suspicion. It must not be forgotten, however, that any bereaved person is likely to be in a state of shock and possibly confused. Repeat questioning of the parent/carer by different police officers should be avoided at this stage if at all possible. However, officers should always consider the behavioural response of the parents and take particular note of

inappropriate or unusual response to child death, for example, remoteness, insensitivity to circumstances, indifference to the death, and disposal of articles. It is important to record accurately any conversations.

4.11 In all cases the Lead Investigator should also ensure the following is done:

- Check police records for all family members including PND, Force Intelligence System, INI, Crime Recording System, Incident Logs, Command & Control Records, and Domestic Violence Logs.
- Contact the Child Abuse Investigation Unit (CAIU) to check their database, and consideration should be given to involving CAIU officers on any investigation.
- Arrange for interviews to be conducted with and full statements taken from the ambulance crews and the paediatrician who received the child into the Emergency Room for attempted resuscitation. These statements should particularly focus on the actions and words spoken by carers or other people present at the death scene, as well as the visual presentation of the child and any medical procedures and techniques carried out. Secure any notes made by these professional witnesses.
- Liaise with the relevant Children's Social Care Department to ensure their records are checked, including whether the child is the subject of a Child Protection Plan or a statutory order e.g. care order (and previous history of a plan or statutory order if possible), and ensure they are involved in a strategy discussion.
- Obtain all details of family members such as siblings and any foster children, history of illness. Obtain medical records including Red Book, and if nursery or school age those records.
- It is best practice to interview other children in the family, both as potential sources of information and as an indicator of standards of care given by the parents. It is also important to check on the siblings' welfare and whether any child protection procedures need to take place in relation to them.

4.12 The preservation of the death scene and the level of investigation should be proportionate and appropriate to the presenting factors. This should include children with end of life plans that may be in place for those with life limiting medical conditions/terminal illness. Forces with hospices in their areas should have an advanced protocol in place.

4.13 In cases where there is no apparent suspicion, consideration should be given to the following:

- Ensure everything is done with sensitivity and if possible in collaboration and cooperation with parents and carers

- Try and ensure a low key presence at the premises, ideally with no marked vehicles or uniforms. Ensure police staff avoid use of potentially emotive jargon such as "crime scene investigator", "exhibit bag" etc.
- Preservation of the scene. Including recording room temperature, plus a thermometer reading taken amongst, for example, clothing in a drawer. Orientation of room is it south facing with the sun coming in overheating is a factor in SUDC and the heating arrangements such as thermostat settings and timers.
- Arranging for photographs and video of, for example, the scene/other rooms, by a CSI/police photographer.
- If there are signs of forensic value such as blood, vomit or other residues on bedding and clothing, then these should be secured. The child's nappy and clothing should remain on the child but arrangements should be made for them to be secured at the hospital. Ensure continuity of exhibits is always completed.
- Secure items such as the child's used bottles, cups, food, medication which may have been administered.

The above is NOT an exhaustive list of actions and should be treated only as a guide. They will not be necessary in every case.

4.14 If the death is clearly suspicious then full scene security should be implemented under the guidance of a Crime Scene Manager.

5. CASE MANAGEMENT – In cases where there is no apparent suspicion:

5.1 If police are aware of the case before the child has been taken to a hospital, then the child's body must be accompanied to the hospital for the purpose of continuity of identification. It is recommended that the body should be taken to a hospital Emergency Department rather than a mortuary, firstly to enable any chance of resuscitation and secondly to make it easier to get an early expert physical examination by a paediatrician. This should be done appropriately and sensitively. The body will normally be transported by ambulance but it may be appropriate to use the services of an undertaker.

5.2 Often medical staff interview parents before the police arrive at hospital in an effort to establish the circumstances surrounding the child's collapse. This account should be sought by investigators as it may prove useful should a different version be provided later, or forensic evidence not support the account given.

5.3 Often the first notification to the police occurs when the child is already at hospital. In such cases consideration should be given to designating scenes, both at the hospital and at the location where the child was first discovered to be unwell.

5.4 Details of death must be notified to the Coroner. It may be appropriate for an officer who has already built a rapport with the parent/carer to obtain details on the appropriate form. A copy should be sent to the CAIU in order to update child protection (CP) records.

5.5 Consideration must be given to evidencing any factors of neglect which may be apparent, such as temperature of scene, condition of accommodation, general hygiene and the availability of

food/drink.

5.6 If articles have been kept for a while, try to ensure they are presentable and that any official labels or wrappings are removed before being returned. Return any items as soon as possible after the Coroner's verdict or the conclusion of the investigation. The term investigation will include any possible trial or appeal process.

5.7 If it is considered necessary to remove items from the house, do so with consideration for the parents. Explain that it may help to find out the cause of their child's death. Before returning the items, the parents must be asked if they actually want them back.

5.8 A physical external examination should be undertaken by medical staff and police at the earliest possible stage in order to record any suspicious or unidentifiable marks. Any such marks should be recorded by a trained police photographer.

5.9 If the death occurs in a hospital setting consideration should be given to securing all relevant medical equipment.

5.10 It is entirely natural for a parent/carer to want to hold or touch the dead child. Providing this is done with a professional (such as a police officer, nurse or social worker), present, it should be allowed in most cases, as it is highly unlikely that forensic evidence will be lost. If however, the death has by this time been considered suspicious, the SIO MUST, where possible, be consulted before a parent/carer is allowed to hold the child. If the carer wishes to hold the child during the process of taking an account, the welfare of the police investigator needs to be considered as it could be very distracting and therefore less conducive to a careful and detailed conversation.

5.11 If the parents/carers wish to accompany their child to the mortuary, then this should normally be facilitated, ensuring that they are accompanied by a police officer. A Family Liaison Officer (FLO) or Coroner's Officer may be appropriate for this role.

5.12 Hospitals often wish to supply bereaved parents with a lock of hair, or foot or hand prints. Police should only refuse these considerations if there is good reason to believe it would jeopardise the investigation, and it is highly unlikely that this would be the case. This is often best completed after the PM.

5.13 If there is any lack of agreement between medical staff and police about the handling of the body then the Coroner's Officer must be informed at once in order that the Coroner can decide on the appropriate course of action.

5.14 In all cases, the police should request that a post mortem examination is carried out by a paediatric pathologist or a pathologist with paediatric expertise. A full skeletal survey should always be requested and also, where possible, an MRI scan. In cases where there are suspected head injuries, advice should be sought from a neuroradiologist on the additional benefits of carrying out a CT scan before the post mortem examination takes place. These should be carried out and interpreted by a paediatric radiologist, or radiologist with paediatric expertise to maximise the opportunity for the recovery and interpretation of the evidence. It is important that the skeletal survey includes the whole body. The Lead Investigator must offer to give a full briefing to the pathologist(s), including showing of the video and photographs of the scene, and to sharing of all information gathered thus far. Good practice is that a written record of the briefing is maintained. Also good practice for the Lead Investigator to attend the PM.

5.15 Whether or not the post mortem examination reveals physical signs of injury it is important that extensive toxicological tests are carried out. This should be intelligence led and any medicines or drugs found within the death scene should be included in the screening. Investigators need to be aware that a basic toxicology screen may only test for common drugs of abuse and so they should provide the toxicologist with a list of all drugs found and any others that may be implicated in the death.

5.16 When the Lead Investigator is obtaining authority from the Coroner for a post mortem examination it is good practice to clarify which powers the post mortem samples are being taken under, i.e. under the Coroners Rules to enable the Coroner to establish the cause of death (subject to the Human Tissue Act 2004 regarding retention/disposal) and/or under PACE 1984 to progress a police investigation into a suspicious death.

Where the death is considered suspicious:

5.17 The investigative guidance contained in the *Murder Investigation Manual* should be adhered to and the SIO must consider how to manage the information that the investigation generates. Good practice is to ensure that *Major Investigation Room Standardised Administrative Procedures* (MIRSAP) is adhered to and the enquiry is managed on HOLMES.

5.18 Unlike many adult homicides where the cause of death is obvious and there are independent witnesses, in the majority of child homicides great reliance is placed on circumstantial and expert medical evidence. The suspect is also invariably in or closely connected to the family as opposed to being a stranger. These investigations often take months to resolve due to the specialised nature of the forensic and medical tests. It is crucial to keep an FLO involved throughout this period, as there is a high degree of uncertainty for all of those involved. An abstract from '*Child Homicides: A suspect in the family. Issues for the Family Liaison Strategy'* the NPIA SIO Journal Spring 2008 is

available here.

5.19 It is good practice for an FLO to be deployed in every case that is deemed suspicious to assist the SIO. The role of the FLO is outlined fully in the ACPO (2008) *Family Liaison Officer Guidance*. The aims of an FLO are: to analyse the needs, concerns and expectations of the family in order to identify all the relevant and realistic action that should be taken in the context of their human rights and obligations. Also to work with the family in order to comply with their right to receive all relevant information connected with the enquiry, subject to the needs of the investigation, while gathering material from them that assists the investigation in a way that is proportionate to their fundamental right to privacy and family life. However, their role is also that of an investigator and they should not be involved in counselling or bereavement support to the family[11]. This should be provided by social services/health or through voluntary organisations like FSID.

5.20 A key consideration for SIOs is that this deployment should be undertaken as one that has a suspect in the family. Where there may be a suspect in the family group, a risk assessment must be carried out prior to deploying the FLO. The following issues should be taken into consideration:

- FLOs are overt investigators;
- Enhanced monitoring of the work and interaction with the families include FLO's welfare and safety;
- The level of information disclosure to the FLOs and in turn the family;
- How any intelligence that arises from the FLO's contact with the family is to be managed;
- In view of the potential for intelligence and evidence gathering, the need for the FLO to be clear concerning his or her interaction with the family;
- The importance of fully documenting all contact and interactions with the family;
- The deployment of new FLOs when a suspect is arrested;
- Investigative and/or evidential impact of deployment.

5.21 It is best practice for the FLO to be trained in or have an awareness of Child Protection. Their role would include, obtaining full history of the child as well as details of, for example, existing siblings and carers.

Keeping parents/carers informed

5.22 Wherever possible, bereaved parents/carers should be kept up to date with all progress made during the investigation, unless this could compromise any intended police action. Care should be taken to avoid any duplication of effort, particularly in regard to any direct contact with the parents/carers. The communication strategy for parents/carers should be an agenda item at the

[11] Family Liaison Officer Guidance 2008,NPIA, 2008, p.30

rapid response meetings. Also forming part of the FLO strategy.

5.23 Important information should only be withheld from parents/carers, if absolutely necessary. In such circumstances honesty and transparency about police actions and intentions form a critical part of gaining the respect and cooperation of parents/carers without which an effective and comprehensive investigation may not be possible.

5.24 In 'non-suspicious' cases, the Coroner's Officer should be specifically responsible for informing parents/carers of any movements in the location of the child's body up until the point of release to the family undertaker. In 'suspicious' cases, the FLO should obtain this information from the Coroner's Officer and promptly pass it to the parents/carers.

5.25 In any case where the death is suspicious, a forensic post mortem must take place if ordered by HM Coroner. If the Home Office Pathologist does not have paediatric experience, they must work alongside a paediatric pathologist or pathologist with paediatric expertise to maximise the opportunity for the recovery and interpretation of evidence. Good practice is a Joint Home Office and paediatric pathologist post mortem. It is good practice for the Lead Investigator/SIO to attend the PM and not to delegate this task, due to the relevant medical information that will be considered.

Obtaining blood and/or urine samples

5.26 In many investigations into childhood death, any drug/alcohol content in the carer's blood may be significant when trying to determine the cause of death or any contributing factors. If a carer's ability to properly look after a child is impaired, this needs to be taken into consideration, and if there is evidence that a carer has taken illegal drugs this should be considered when an intelligence led toxicology screen is requested for the child.

5.27 Some children die when sharing a bed or sofa with a parent, and in cases where overlaying seems to be the cause of death it is important to request that the carers supply a blood sample for analysis. This is entirely voluntary on their part but can of course rule out any suggestion that alcohol or drugs may have impaired their ability to care for the child.

Obtaining blood and urine samples from suspects[12]

5.28 Section 62 of the Police and Criminal Evidence Act (PACE) 1984 creates a power to request intimate (blood and urine) samples from a person in police detention. If you suspect that someone who has

[12] This section is taken from the paper written by Dave Law. Greater Manchester Police Chief Constable's Order 2008/52 Appendix B GMP guidance on investigating unexplained and unexpected deaths in childhood.

been arrested was adversely under the influence of alcohol or drugs whilst caring for the child or young person leading up to the time of death, you should give the earliest possible consideration to requesting and obtaining blood and urine samples. Drug and/or alcohol levels may prove highly relevant in any later criminal proceedings, coroner's investigation or care proceedings.

Obtaining drug and alcohol samples without making an arrest

5.29 The exercise of a power of arrest is a discretionary one. Chapter 5 of *Working Together* sets out that families and carers should be treated with sensitivity, discretion and respect at all times.

5.30 Where you have grounds to arrest but decide that this should, if possible, be avoided on compassionate grounds, you should still consider (where applicable) requesting and obtaining 'voluntary' samples of preserved and unpreserved urine and blood.

5.31 One very important sample, which should be taken as a matter of routine, is plucked hair from the head of the child victim and also the suspect(s), if appropriate. The child's hair sample should be taken at the PM prior to any incisions of the child's body to prevent any suggestion of contamination.

5.32 In all cases where blood samples are requested (either under PACE or as a voluntary request) it is not appropriate for hospital staff to take the samples, and a Forensic Medical Examiner or forensically trained nurse should be deployed to obtain the sample.

Other Investigative Considerations

5.33 The SIO should consider making use of an analyst to analyse all information; in particular the comparing of the various accounts.

5.34 It is good practice for the SIO to call upon the services of SOCA Crime Operational Support desk, which can provide an up to date list of experts as well as knowledge of the latest investigative techniques, and access to the National Injuries Database.

6 TYPES OF OFFENCES

6.1 This area is such a specific area that the law recognises it with specific offences.

6.2 Child homicide

- Murder;
- Manslaughter;
- Familial homicide - causing or allowing the death of a child; Section 5 of the Domestic Violence Crime and Victims Act 2004, and also now includes Serious injury by virtue of Domestic Violence Crime & Victims (Amendment) Act 2012.
- Infanticide.

6.3 Other related offences

- Child destruction;
- Administering drugs and/or using instruments to procure an abortion (miscarriage);
- Unlawfully exposing and/or abandoning a child under the age of 2 years, where life is endangered;
- Concealing a birth;
- Neglect – death of an infant under the age of 3 years, caused by suffocation while the infant is in bed with person(s) 16 years old or over and person(s) who went to bed under the influence of alcohol;
- Maliciously administering poison or noxious thing so as to endanger life.
- Child Cruelty

7 ABUSIVE HEAD TRAUMA

7.1 Some children die, or are seriously injured, as a result of a violent shaking incident. From an investigative point of view it is relatively straightforward to ascertain that the death should be considered suspicious. Expert paediatric / ophthalmological assessment should quickly reveal the presence of retinal and subdural haemorrhages, bruising or other head injuries.

7.2 Abusive Head Trauma is also sometimes referred to as shaken baby syndrome. The triad of injuries most commonly found, and known to be consistent with shaking, are subdural haemorrhages (bleeding around the surface of the brain), brain encephalopathy (brain swelling) and retinal bleeding. These Rotational Acceleration Deceleration Injuries (RADI) are quite different from those acquired from a short fall and point strongly towards non-accidental causes. The triad of injuries are caused when the brain moves inside the skull, damaging the brain and shearing the bridging veins. Infants are particularly susceptible because of their relatively large heads, heavy brains and weak neck muscles. These injuries can also be caused by a sudden violent throw, which causes the head to jolt backwards and forward and undergo rotational forces[13].

7.3 Medical opinion for these forms of injuries is that a 'Triad' of injuries is a strong indicator of Rotational Acceleration Deceleration (RAD). This is not the opinion of all paediatric specialists. In R v Pink the court of appeal stated:

[13] *R v Harris, Rock, Cherry and Faulder* [2005] EWCA Crim 1980

'The classic picture of what has become known as non-accidental head injury to an infant caused by mis-handling by an adult is that there should be present three particular features. First sub-dural haemorrhage; secondly, encephalopathy (damage to the brain structure itself); and retinal haemorrhages. This has become known as the 'Triad' of injuries the coincidence of which is considered to be the hallmark of non-accidental injury[14]*.*

7.4 It takes a significant force to cause head injuries severe enough to kill a child, and although feelings of sympathy for the carers may well manifest themselves, it is crucial that a detailed and professional homicide investigation is commenced as soon as police become aware of the case. An SIO should therefore take control from the outset and the guidance contained throughout the *Murder Investigation Manual* should be applied in the same way as if the victim was an adult.

7.5 These are invariably difficult investigations that need to involve highly specialised techniques for evidence gathering in addition to the advice given above in respect of all infant deaths.

7.6 As a guide, some of the specialised techniques which should be employed include:

- Full skeletal survey, from head to finger and toe tips, properly interpreted by a paediatric radiologist;
- Ultra violet photography;
- Thorough ophthalmologic examination including specialised retinal photography, examination of eyes as soon as possible (whilst the child is still in the Emergency Department) as the picture will deteriorate and the timing of when things are observed is very relevant;
- MRI and CT scans - ensuring that the machine is set up for brain matter and a child sized brain;
- Full post mortem ophthalmologic examination - carried out in a specialised laboratory;
- Full post mortem examination of the brain - carried out in a specialised laboratory;
- The services of a forensic analyst to provide a detailed timeline of all significant events in the child's life.

This is not an exhaustive list, and techniques change and improve regularly, hence the need to get advice from SOCA list of experts in every case.

7.7 A great deal of the evidence used in any prosecution will be from medical and scientific experts. SIOs must, however, guard against assuming paediatricians and other medical personnel will automatically carry out the appropriate tests, because whilst they are expert at healing sick children, they are not necessarily expert in gathering evidence for a homicide investigation. Investigating police officers must maintain a clear dialogue with medical professionals, and ensure

[14] *R v Pink* [2006] EWCA Crim 2094

each party understands exactly what is needed and why it is needed. They should challenge if appropriate any hypothesis that the medical profession put up.

7.8 Where there is serious disagreement between reputable prosecution and defence experts, the prosecution should not be continued without other supporting evidence. The best way forward as dictated in the judgement of the Angela Cannings case and recommended in the Kennedy Protocol is for the Prosecution and Defence Medical Experts managed by Counsel from both sides to get together at an 'Experts meeting' to iron out what the areas of serious disagreement actually are. The trial Judge should then hold a pre trial hearing in order to decide if the case should proceed.

7.9 Baroness Kennedy remarked that '*It is also important that the courtroom is not a place used by doctors to fly their personal kites or push a theory from the far end of the medical spectrum. The expert should have recent clinical experience, peer reviewed research and should not roam outside of his or her area of expertise*.'[15]

7.10 The approved judgement in R v Henderson[16], Butler & Oyediran emphasises the importance of Part 33 of the Criminal Procedure Rules 2010. These Rules need to be deployed to ensure that the overriding objective to deal with criminal cases justly is achieved. The rules are designed to ensure that the expert opinion is unbiased (33.2.1) and in particular, by virtue of 33.3(1) that an expert provides evidence of relevant experience and accreditation (a) details of any literature relied upon (b) that any range of opinion should be summarised and reasons given before the opinion of the expert (f) and that any qualifications to that opinion should be stated.

7.11 Generally it will be necessary that the court directs a meeting of experts so that a statement can be prepared of areas of agreement and disagreement. Such a meeting will not achieve its purpose unless it takes place well in advance of the trial, and is attended by all significant experts including defence experts and a careful and detailed minute is prepared and signed by all participants.

7.12 CPS has compiled guidance that can be found at www.cps.gov.uk/legal/l_to_o/non_accidental_head_injury_cases/ and which should be considered in all such cases.

[15] Kennedy Working Group, op.cit., p. 5.

[16] Henderson v R [2010] EWCA CRIM 1269

8 PARALLEL PROCEEDINGS

8.1 Whilst police are investigating the death of a child there may be a number of additional proceedings being carried out at the same time. The protection of other siblings is paramount and there maybe proceedings being carried out in the Family Court making use of the same witnesses that could be subsequently required in the criminal court. Albeit this maybe extremely concerning to an SIO, it can also be a positive situation, with for example the medical evidence being rehearsed in a court setting. Use of this material can take place with the permission of the Family Court Judge.[17]

8.2 In many cases of child homicide it is likely that the LSCB will commission a Serious Case Review in accordance with Chapter 4 of Working Together 2013.

8.3 The prime purpose of a Serious Case Review (SCR) is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children. The lessons learned should be disseminated effectively, and the recommendations should be implemented in a timely manner so that the changes required result, wherever possible, in children being protected from suffering or being likely to suffer harm in the future.

[17] The Family Proceedings Rules 2011

8.4 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires LSCBs to undertake reviews of serious cases.

8.5 The SCRs carried out under this guidance are one's where:

(a) Abuse or neglect of a child is known or suspected; and
(b) Either- (i) the child has died; or (ii) 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.

LSCB's will also consider conducting reviews on cases which do not meet the SCR criteria but feel that lessons can be learned by partners and also where good practice has been identified.

SCRs are not inquiries into how a child died or was seriously harmed, or into who is culpable. These are matters for coroners and criminal courts, respectively, to determine as appropriate.

8.6 The SCR is an important process that will not necessarily be delayed by ongoing criminal proceedings unless compelling reasons to do so can be given by police or the CPS. It is important that the SIO makes contact with the police representative on their LSCB to ascertain whether a SCR has been instigated, and if so discussions can be held about any potential implications for prosecution witnesses or the criminal court proceedings.

8.7 In the article on 'Statutory reviews and the Homicide Investigation' in the Journal of Homicide and Major Incident Investigation, published in November 2011 the author Dr John Fox outlines advice which is detailed below in the next few paragraphs. Many police officers carrying out homicide investigations understandably start from a position whereby they would prefer that any external review should not go ahead at all if there is a criminal investigation, because it does mean that along with their many other responsibilities, SIO"s need to consider whether a simultaneous statutory review could taint witnesses or lead to disclosure problems. Such a position is not supported by Government statutory guidance (DfE, 2013 and for DHR's Home Office, 2011) and would in any case be an over-reaction because much useful learning can still be established without compromising the investigation.

8.8 In 2011 A guide was published for the police, the crown prosecution service, and local safeguarding children boards, to assist with liaison and the exchange of information when there are simultaneous Chapter 4 WT 2013 serious case reviews and criminal proceedings.

8.9 At the Royal Courts of Justice, on 20th July 2011, this guide was subject to challenge by a Local Safeguarding Children Board (LSCB) in a case where the police, whilst investigating the suspicious death/neglect of a child, had followed it in seeking to view potentially relevant SCR material. The

LSCB Chair had refused and, in line with the guidance, a witness summons was obtained by the CPS and a Public Interest Immunity hearing was held.

8.10 In his Judgement, Mr Justice Maddison referred to several sections of the Guidance and commented, "In my view, the Guide is a helpful document" with "eminently sensible" suggestions (R v Rees and others, Bristol Crown Court – Pre Trial Hearing relating to third party disclosure).

8.11 Criminal investigations and SCR/DHR"s can work alongside each other without too much hindrance, and information from one process might, in fact, help the other achieve its aims. A police investigation, particularly concerning homicide, will be extremely thorough and this will result in the gathering of a great deal of material. Some of this material may, for example, be of value to those seeking to learn lessons about how a child was maltreated or how agencies could have better worked together to prevent maltreatment.

8.12 There is a real need for dialogue between the SIO and the Review Panel Chair because it is unlikely that both will fully understand the working procedures and requirements the respective processes they are leading on. With greater understanding between the parties, there is more likely to be respect for what each is trying to achieve[18].

8.13 In respect of family court proceedings in relation to any siblings, it is important that any information held by for example children's social care is obtained at the earliest opportunity. Once this information is filed within the family proceedings (whether in the form of a statement or otherwise) it is then subject to the rule that papers within the court proceedings are protected by confidentiality and the courts permission will need to be sought. This does not affect the provision of the Family Procedure Rules 2010; that information within proceedings can be disclosed to a number of professional's including police officers acting in the furtherance of the protection of children[19].

8.14 This does not mean that papers can be disclosed into criminal proceedings without the permission of the Judge in the family court but they can be used as information to assist as part of the criminal investigation. The Judge has to decide upon the release of the papers and it is advisable for officers to be specific in their requests, factors that the Judge will consider include 1) The interests of the administration of justice, including the need to ensure a fair trial in criminal proceedings. 2) The interests of children generally, including those perpetrators of child abuse is brought to Justice.

[18]The Journal of Homicide and Major Incident Investigation, Volume 7, Issue 2, November 2011
[19] Family Procedure rules 2010 rule 12.73 & 14.14

8.15 Section 98 of the Children's Act of 1989 prevents any admission or statement of liability by a parent in the family court being used as the basis of a criminal prosecution. There is however nothing to prevent this admission or statement being put to an alleged perpetrator in interview or put to a defendant in cross examination. Note however that if subsequently the family court were to refuse permission to disclose that admission, it would affect the admissibility of the interview into any criminal proceedings (see for example re EC (Disclosure of material) [1996] 2 FLR 725

8.16 On the other hand it may be necessary for the criminal investigation to disclose documents and information to the Local Authority and into family proceedings prior to their obligations to disclose material to the defence under the Criminal Procedure and Investigations Act 1996. In cases where it may prejudice the investigation the court can be asked to consider the issue of disclosure in the context of public interest immunity issues.

8.17 It is important to consider disclosure at an early opportunity before papers are required to be filed in the care proceedings. Although there are regional and local variations the ACPO/Family Disclosure protocol is helpful in describing the way forward in these cases. It must be remembered though that the interests of the child are paramount and the first investigative building block is the preservation of life, so the protection of sibling(s) is a crucial duty that the police are party to. CPS guidance on disclosure states*. 'Because of the overriding interest in the welfare of the child it will not be possible to delay disclosure until the criminal proceedings are complete but in cases where there is a danger that disclosure will prejudice police inquiries it is important to hold a conference with the police and local authority to discuss what can safely be disclosed to serve the purposes of a the local authority without hindering the police investigation.'*

8.18 However there are judgements that set a high hurdle for non-disclosure once care proceedings have commenced and it is for the criminal investigation to be clear on what documents or class of documents they require to withhold. This is regarded as of a very high standard and the test will be on of necessity and with short timescales attached.

8.19 Issues of public interest immunity (PII) arise most often in the context of a pending criminal trial or where there is on-going investigation (eg covert) where disclosure of material into the family proceedings may affect the trial or investigation. The balancing exercise carried out by the court can be summarised as:

Balancing or reconciling two kinds of public interest which may conflict
(i) the public interest that the investigation or criminal trial should not be damaged by the disclosure of certain documents;

(ii) the public interest that the administration of justice (within the family proceedings and their aim of child protection) should not be frustrated by the withholding of documents which are of material relevance to the issues in that case.

Where public interest immunity is raised, it is important to detail the reasons why the balance falls against disclosure, with specific reference to the documents involved.

9 TRAINING

9.1 Investigating Officers, Lead Investigators and SIOs who respond to unexpected deaths of children should receive appropriate training.

9.2 A variety of training programmes exist in various aspects of the response to childhood death; for instance, LSCBs might provide training based on the *Responding When a Child Dies*[20] programme, a resource pack from the Department for Education[21].

9.3 An e-learning package for all frontline officers has been developed by NPIA on behalf of ACPO to assist them in managing cases until a Lead Investigator arrives to take command. This is available on NCALT. For those required to progress the investigation thereafter, this ACPO Guidance recommends the modular *Investigating Sudden Childhood Death* programme produced by the NPIA. This programme is comprised of two modules, each targeted at a different aspect of the investigation of childhood death and at two categories of investigator.

[20] Available at: http://www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/childdeathreviewprocedures/trainingmaterials/trainingmaterials/

[21] Further materials available at: http://www.dcsf.gov.uk/everychildmatters/safeguardingandsocialcare/safeguardingchildren/childdeathreviewprocedures/childdeathreviewprocess/

9.4 Module 1 is aimed at those who provide the initial senior lead investigator response to childhood death in accordance with local protocols derived from chapter 5 of Working Together 2013 and this guidance where the child's death initially presents as non-suspicious. The module provides students with the knowledge, understanding and skill required to enable them to effectively respond to incidents of childhood death, thereby improving their ability to determine whether a crime might have been committed, and to secure an effective foundation for any potential homicide investigation.

9.5 Module 2 is targeted specifically at SIOs and provides additional capability, over and above their capability at Level 3 of the Professionalising Investigations Programme, to comprehensively investigate those cases of childhood death that are unexplained from the outset but believed to be suspicious. Both modules examine the investigator's decision making ability using developing case-studies. Each module can be delivered individually as two-day stand alone training courses or together as a complete four-day package.

10 FURTHER READING

Association of Chief Police Officers (2006) *Murder Investigation Manual*. London, ACPO

Association of Chief Police Officers (2008) *Family Liaison Officer Guidance*. London, ACPO

Association of Chief Police Officers (2009) *Guidance on investigating Child Abuse and Safeguarding 2nd Edition*. London, ACPO

Cook, T & Tattersall, A (2010) *Senior Investigating Officers' Handbook 2nd Edition.* Oxford, Oxford University Press

Department for Education (2013) *Working Together to Safeguard Children.* London

Fox, J, (2008) Briefing Paper. *A Contribution to the Evaluation of Recent Developments in the Investigation of Sudden Unexpected Death in Infancy.* Department of Sociology, University of Surrey in association with the NPIA

Kennedy, Baroness H. (2004) *Sudden Unexpected Death in Infancy: A Multi-Agency Protocol for Care and Investigation.*

Marshall D (2012) *The Effective investigation of child homicide and suspicious child deaths.* Oxford, Oxford University Press

Sidebotham, P & Fleming, P (2007) *Unexpected Death in Childhood A Handbook for Practitioners*. Chichester, John Wiley and Sons, Ltd

Vaughan, J (2007) *Infanticide: The Effects of Miscarriages of Justice.* Cambridge, University of Cambridge

Working Together to Safeguard Children: March 2013

Chapter 5

The Regulations relating to child death reviews

The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

a) collecting and analysing information about each death with a view to identifying-

(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);

(ii) any matters of concern affecting the safety and welfare of children in the area of the authority;

(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

(b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

1. Each death of a child is a tragedy and enquiries should keep an appropriate balance between forensic and medical requirements and supporting the family at a difficult time. Professionals supporting parents and family members should assure them that the objective of the child death review process is not to allocate blame, but to learn lessons. The Review will help to prevent further such child deaths.[35]

2. The responsibility for determining the cause of death rests with the coroner or the doctor who signs the medical certificate of the cause of death (and therefore is not the responsibility of the Child Death Overview Panel (CDOP)).

Responsibilities of Local Safeguarding Children Boards (LSCBs)

3. The LSCB is responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by a Child Death Overview Panel (CDOP). The Panel will have a fixed core membership drawn from organisations represented on the LSCB with flexibility to co-opt other relevant professionals to discuss certain types of death as and when appropriate. The Panel should include a professional from public health as well as child health. It

[35] Department for Education leaflet that can be given to parents, carers and family members to explain the child death review process.

should be chaired by the LSCB Chair's representative. That individual should not be involved directly in providing services to children and families in the area. One or more LSCBs can choose to share a CDOP. CDOPs responsible for reviewing deaths from larger populations are better able to identify significant recurrent contributory factors.

4. LSCBs should be informed of the deaths of all children normally resident in their geographical area. The LSCB Chair should decide who will be the designated person to whom the death notification and other data on each death should be sent.[36] LSCBs should use sources available, such as professional contacts or the media, to find out about cases when a child who is normally resident in their area dies abroad. The LSCB should inform the CDOP of such cases so that the deaths of these children can be reviewed.

5. In cases where organisations in more than one LSCB area have known about or have had contact with the child, lead responsibility should sit with the LSCB for the area in which the child was normally resident at the time of death. Other LSCBs or local organisations which have had involvement in the case should cooperate in jointly planning and undertaking the child death review. In the case of a looked after child, the LSCB for the area of the local authority looking after the child should exercise lead responsibility for conducting the child death review, involving other LSCBs with an interest or whose lead agencies have had involvement as appropriate.

[36] Department for Education: list of people designated by the CDOP to receive notifications of child death information.

Specific responsibilities of relevant bodies in relation to child deaths	
Registrars of Births and Deaths (Children & Young Persons Act 2008)	Requirement to supply the LSCB with information which they have about the death of persons under 18 they have registered or re-registered. Notify LSCBs if they issue a *Certificate of No Liability to Register* where it appears that the deceased was or may have been under the age of 18 at the time of death. Requirement to send the information to the appropriate LSCB (the one which covers the sub-district in which the register is kept) no later than seven days from the date of registration.
Coroners (Coroners Rules 1984 (as amended by the Coroners (Amendment) Rules 2008)	Duty to inquire and may require evidence. Duty to inform the LSCB for the area in which the child died within three working days of the fact of an inquest or post mortem. Powers to share information with LSCBs for the purposes of carrying out their functions, including reviewing child deaths and undertaking SCRs.
Registrar General (section 32 of the Children and Young Persons Act 2008)	Power to share child death information with the Secretary of State, including about children who die abroad.

Medical Examiners (Coroners and Justice Act 2009)	It is anticipated that from 2014 Medical Examiners will be required to share information with LSCBs about child deaths that are not investigated by a coroner.
Clinical Commissioning Groups (Health and Social Care Act 2012)	Employ, or have arrangements in place to secure the expertise of, consultant paediatricians whose designated responsibilities are to provide advice on: • commissioning paediatric services from paediatricians with expertise in undertaking enquiries into unexpected deaths in childhood, and from medical investigative services; and • the organisation of such services.

6. A summary of the child death processes to be followed when reviewing all child deaths is set out in Flowchart 6 on page 83.. The processes for undertaking a rapid response when a child dies unexpectedly are set out in Flowchart 7 on page 84.

Providing information to the Department for Education

7. Every LSCB is required to supply anonymised information on child deaths to the Department for Education. This is so that the Department can commission research and publish nationally comparable analyses of these deaths.[37]

[37] Department for Education detailed guidance on how to supply the information on child deaths

Specific responsibilities of relevant professionals - When responding rapidly to the unexpected death of a child	
Designated Paediatrician for unexpected deaths in childhood (designated paediatrician)	Ensure that relevant professionals (i.e. coroner, police and local authority social care) are informed of the death; coordinate the team of professionals (involved before and/or after the death) which is convened when a child who dies unexpectedly (accessing professionals from specialist agencies as necessary to support the core team). Convene multi-agency discussions after the initial and final initial post mortem results are available.

Responsibilities of Child Death Overview Panels

8. The functions of the CDOP include:

- reviewing all child deaths up to the age of 18, excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law;
- collecting and collating information on each child and seeking relevant information from professionals and, where appropriate, family members;
- discussing each child's case, and providing relevant information or any specific actions related to individual families to those professionals who are involved directly with the family so that they, in turn, can convey this information in a sensitive manner to the family;
- determining whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths;
- making recommendations to the LSCB or other relevant bodies promptly so that action can be taken to prevent future such deaths where possible;
- identifying patterns or trends in local data and reporting these to the LSCB;
- where a suspicion arises that neglect or abuse may have been a factor in the child's death, referring a case back to the LSCB Chair for consideration of whether an SCR is required;
- agreeing local procedures for responding to unexpected deaths of children; and
- cooperating with regional and national initiatives – for example, with the National Clinical Outcome Review Programme – to identify lessons on the prevention of child deaths.

9. The aggregated findings from all child deaths should inform local strategic planning, including the local Joint Strategic Needs Assessment, on how to best safeguard and promote the welfare of children in the area. Each CDOP should prepare an annual report of relevant information for the LSCB. This information should in turn inform the LSCB annual report.

Definition of preventable child deaths

10. For the purpose of producing aggregate national data, this guidance defines preventable child deaths as those in which modifiable factors may have contributed to the death. These factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths.

11. In reviewing the death of each child, the CDOP should consider modifiable factors, for example in the family and environment, parenting capacity or service provision, and consider what action could be taken locally and what action could be taken at a regional or national level.

Action by professionals when a child dies unexpectedly

Definition of an unexpected death of a child

12. In this guidance an unexpected death is defined as the death of an infant or child (less than 18 years old) which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was a similarly unexpected collapse or incident leading to or precipitating the events which lead to the death.

13. The designated paediatrician responsible for unexpected deaths in childhood should be consulted where professionals are uncertain about whether the death is unexpected. If in doubt, the processes for unexpected child deaths should be followed until the available evidence enables a different decision to be made.

14. As set out the Local Safeguarding Children Boards Regulations 2006, LSCBs are responsible for putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

15. When a child dies suddenly and unexpectedly, the consultant clinician (in a hospital setting) or the professional confirming the fact of death (if the child is not taken immediately to an Accident and Emergency Department) should inform the local designated paediatrician with responsibility for unexpected child deaths at the same time as informing the coroner and police. The police will begin an investigation into the sudden or unexpected death on behalf of the coroner. A paediatrician should initiate an immediate information sharing and planning discussion between the lead agencies (i.e. health, police and local authority children's social care) to decide what should happen next and who will do it. The joint responsibilities of the professionals involved with the child include:

    - responding quickly to the child's death in accordance with the locally agreed procedures;
    - maintaining a rapid response protocol with all agencies, consistent with the Kennedy principles and current investigative practice from the Association of Chief Police Officers;[38]

[38] PJ. Fleming, P.S. Blair, C. Bacon, and P.J. Berry (2000) Sudden Unexpected Death In Infancy. The CESDI SUDI Studies 1993-1996. The Stationery Office. London. ISBN 0 11 3222 9988; Royal College of

- making immediate enquiries into and evaluating the reasons for and circumstances of the death, in agreement with the coroner;
- liaising with the coroner and the pathologist;
- undertaking the types of enquiries/investigations that relate to the current responsibilities of their respective organisations;
- collecting information about the death;[39]
- providing support to the bereaved family, referring to specialist bereavement services where necessary and keeping them up to date with information about the child's death; and
- gaining consent early from the family for the examination of their medical notes.

16. If the child dies suddenly or unexpectedly at home or in the community, the child should normally be taken to an Emergency Department rather than a mortuary. In some cases when a child dies at home or in the community, the police may decide that it is not appropriate to immediately move the child's body, for example because forensic examinations are needed.

17. As soon as possible after arrival at a hospital, the child should be examined by a consultant paediatrician and a detailed history should be taken from the parents or carers. The purpose of obtaining this information is to understand the cause of death and identify anything suspicious about it. In all cases when a child dies in hospital, or is taken to hospital after dying, the hospital should allocate a member of staff to remain with the parents and support them through the process.

18. If the child has died at home or in the community, the lead police investigator and senior health care professional should decide whether there should be a visit to the place where the child died, how soon (ideally within 24 hours) and who should attend. This should almost always take place for cases of sudden infant death.[40] After this visit the senior investigator, visiting health care professional, GP, health visitor or school nurse and local authority children's social care representative should consider whether there is any information to raise concerns that neglect or abuse contributed to the child's death.

19. Where a child dies unexpectedly, all registered providers of healthcare services must notify the Care Quality Commission of the death of a service user - **but NHS providers may discharge this duty by notifying the National Health Service Commissioning Board.** [41] Where a young person dies at work, the

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Pathologists and the Royal College of Paediatrics and Child Health (2004) Sudden unexpected death in infancy. A multi-agency protocol for care and investigation. The Report of a working group convened by the Royal College of Pathologists and the Royal College of Paediatrics and Child Health. Royal College of Pathologists and the Royal College of Paediatrics and Child Health, London. www.rcpath.org

[39] See Footnote 32.

[40] See footnote 33.

[41] Regulation 16 of the Care Quality Commission (Registration) Regulations 2009

Health and Safety Executive should be informed. Youth Offending Teams' reviews of safeguarding and public protection incidents (including the deaths of children under their supervision) should also feed into the CDOP child death processes.

20. If there is a criminal investigation, the team of professionals must consult the lead police investigator and the Crown Prosecution Service to ensure that their enquiries do not prejudice any criminal proceedings. If the child dies in custody, there will be an investigation by the Prisons and Probation Ombudsman (or by the Independent Police Complaints Commission in the case of police custody). Organisations who worked with the child will be required to cooperate with that investigation.

Involvement of the coroner and pathologist

21. If a doctor is not able to issue a medical certificate of the cause of death, the lead professional or investigator must report the child's death to the coroner in accordance with a protocol agreed with the local coronial service. The coroner must investigate violent or unnatural death, or death of no known cause, and all deaths where a person is in custody at the time of death. The coroner will then have jurisdiction over the child's body at all times. Unless the death is natural a public inquest will be held.[42]

22. The coroner will order a post mortem examination to be carried out as soon as possible by the most appropriate pathologist available (this may be a paediatric pathologist, forensic pathologist or both) who will perform the examination according to the guidelines and protocols laid down by the Royal College of Pathologists. The designated paediatrician will collate and share information about the circumstances of the child's death with the pathologist in order to inform this process.

23. If the death is unnatural or the cause of death cannot be confirmed, the coroner will hold an inquest. Professionals and organisations who are involved in the child death review process must cooperate with the coroner and provide him/her with a joint report about the circumstances of the child's death. This report should include a review of all medical, local authority social care and educational records on the child. The report should be delivered to the coroner within 28 days of the death unless crucial information is not yet available.

Action after the post mortem

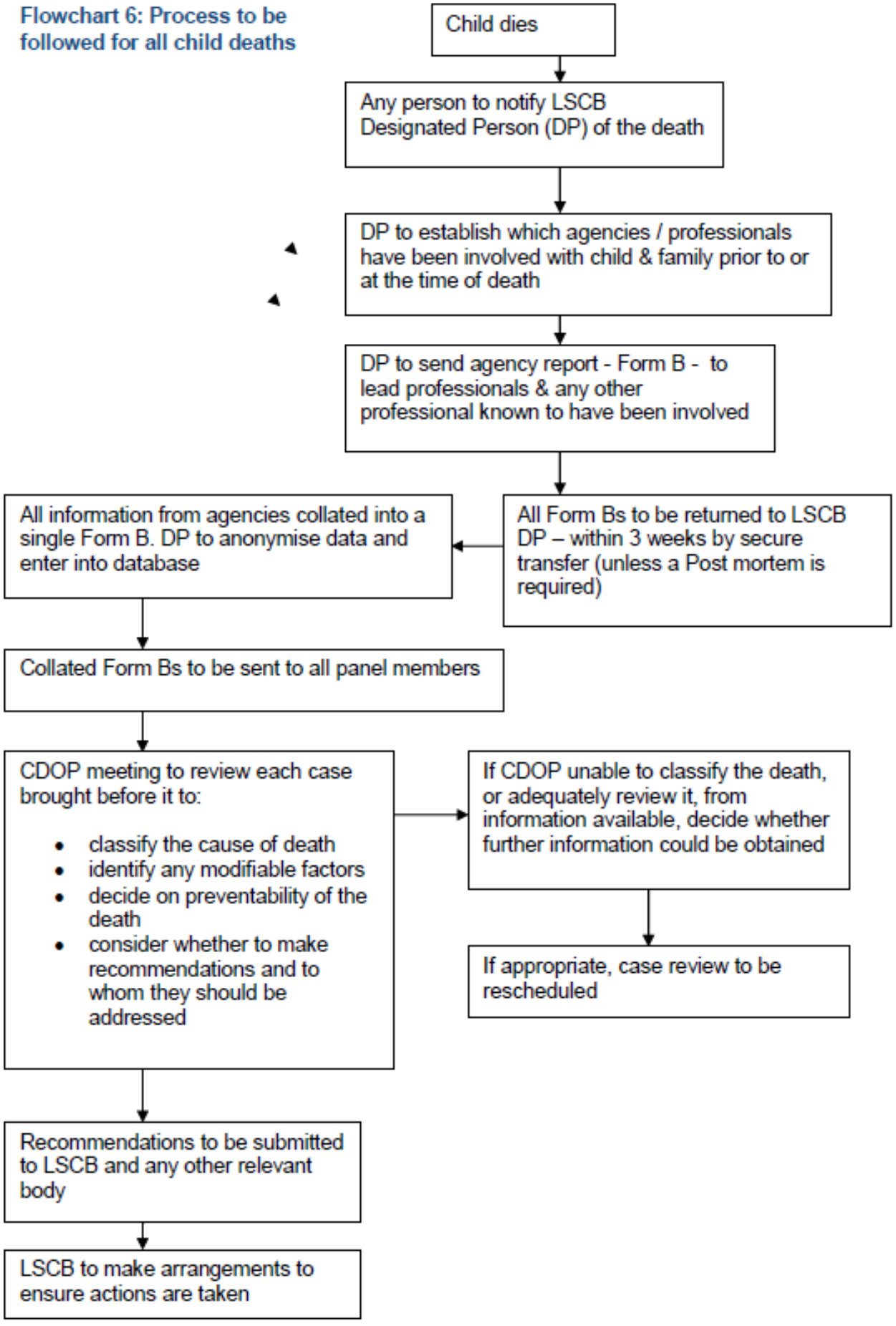
24. Although the results of the post mortem belong to the coroner, it should be possible for the paediatrician, pathologist, and the lead police investigator to

[42] Ministry of Justice guidance for coroners and Local Safeguarding Children Boards on the supply of information concerning the death of children.

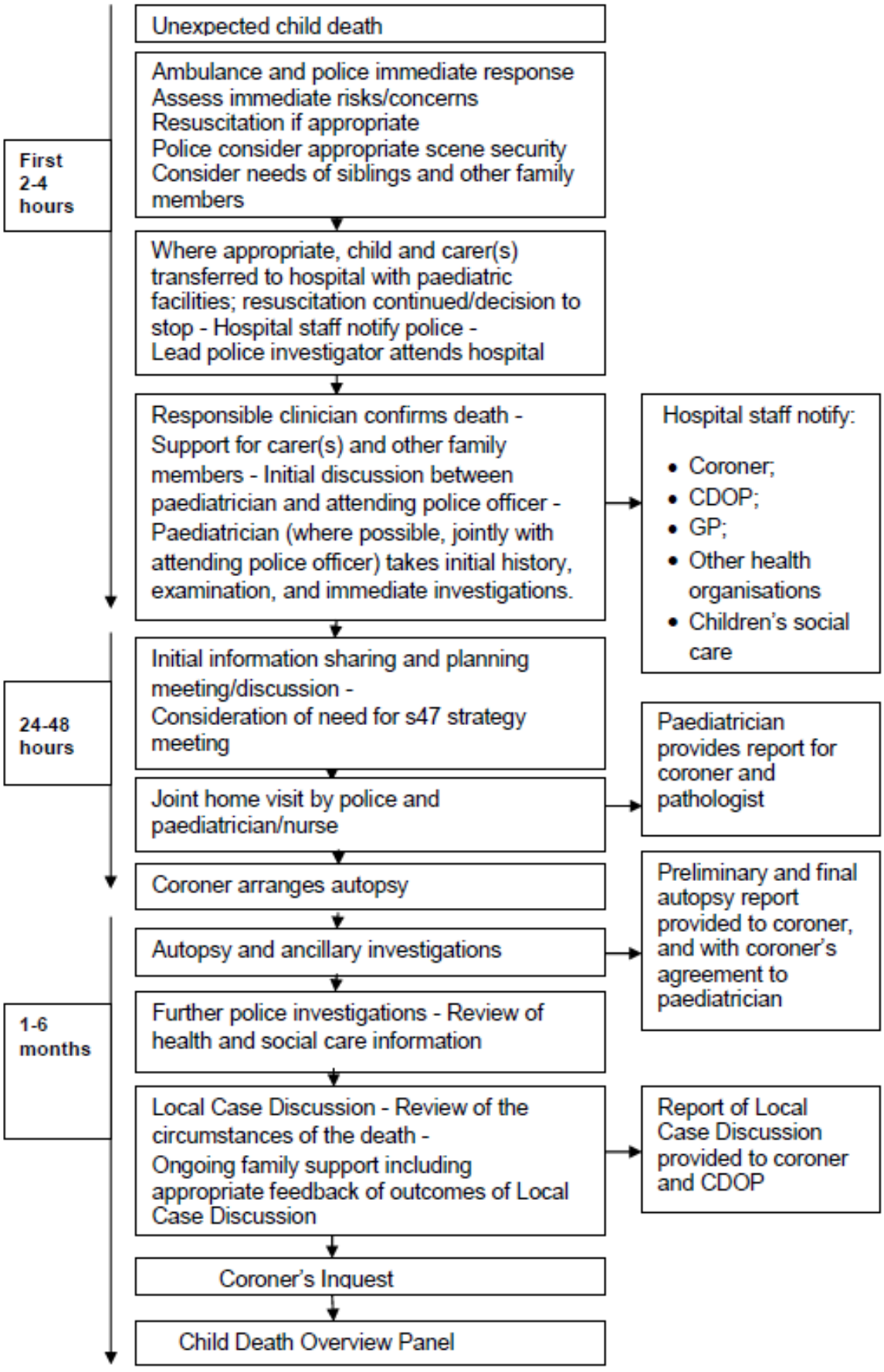
discuss the findings as soon as possible, and the coroner should be informed immediately of the initial results. If these results suggest evidence of abuse or neglect as a possible cause of death, the paediatrician should inform the police and local authority children's social care immediately. He or she should also inform the LSCB Chair so that they can consider whether the criteria are met for initiating an SCR.

25. Shortly after the initial post mortem results become available, the designated paediatrician for unexpected child deaths should convene a multi-agency case discussion, including all those who knew the family and were involved in investigating the child's death. The professionals should review any further available information, including any that may raise concerns about safeguarding issues. A further multi-agency case discussion should be convened by the designated paediatrician, or a paediatrician acting as their deputy, as soon as the final post mortem result is available. This is in order to share information about the cause of death or factors that may have contributed to the death and to plan future care of the family. The designated paediatrician should arrange for a record of the discussion to be sent to the coroner, to inform the inquest and cause of death, and to the relevant CDOP, to inform the child death review. At the case discussion, it should be agreed how detailed information about the cause of the child's death will be shared, and by whom, with the parents, and who will offer the parents on-going support

Flowchart 6: Process to be followed for all child deaths



Flowchart 7: Process for rapid response to the unexpected death of a child



http://www.workingtogetheronline.co.uk/chapters/chapter_five.html#resp

Risk Factors for Intra-Familial Unlawful and Suspicious Child Deaths: A Retrospective Study of Cases in London

Jenny Mayes, Alison Brown, Detective Chief Inspector Dave Marshall
Specialist Crime Directorate Child Abuse Investigation Command (SCD5)
Metropolitan Police Service

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Abstract

The prevention and detection of crime, the two main principles underlying all areas of safeguarding children, are brought together in this paper written by authors from multiple disciplines who have considerable experience of child homicide and suspicious deaths from their respective perspectives.

The paper details a retrospective review of 282 consecutive child deaths investigated by the Metropolitan Police Service (MPS) including suspicious (criminal activity-related deaths, including homicides) and non-suspicious child deaths to identify social, demographic and autopsy features significantly associated with suspicious or unnatural deaths.

The identification of risk factors in relation to child deaths can inform prevention initiatives to reduce the incidence of unlawful child deaths and the assessment of factors will initiate a more detailed investigation of the circumstances of a death to eliminate or confirm the possibility of any criminal offences linked to the sudden and unexpected death of a child.

The authors have endeavoured to advance what is sometimes referred to as the 'detective's gut instinct' based on their assimilation of psychological factors and anecdotal information by providing a research based list of factors, that whilst not exclusive to unlawful deaths, if present, may justify a more comprehensive examination of the circumstances surrounding a death. This is entirely in keeping with Baroness Kennedy's statement that:

Every child who dies deserves the right to have their sudden and unexplained death fully investigated in order that a cause of death can be identified, and homicide excluded.

(Kennedy, H, 2004)

This paper assists by providing a research-based approach to guide the processes in both the prevention and detection of such offences.

The findings report 54 suspicious and 228 non-suspicious deaths, aged 0-192 months at death, had social and demographic features significantly associated with suspicious versus non-suspicious deaths, such as family history of previous violence to children, mental health issues, alcohol and drug abuse, and history of domestic abuse. Almost half (43 per cent) of the suspicious deaths involved children previously known to social services, and the family had previously come to police notice for domestic abuse in almost a quarter of cases (22 per cent). The accounts provided by parents or carers were more likely to be inconsistent and at autopsy, features of head injury, fractures, bruising, or a post-mortem interval longer than stated, were more common.

The importance of social risk factors for unnatural intra-familial child deaths cannot be overestimated. Future attempts to reduce these deaths should focus on the high-risk social groups identified from this research.

library.college.police.uk/docs/J_Homicide_MII/J_Homicide_6.1.pdf

Operation Marshall Forms

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Operation Marshall - Part A

A national dataset to assist strategic analysis and inform future prevention and detection initiatives in relation to suspicious and child deaths

Contact Details for person filling this form	
Name:	
Rank / Title:	
Telephone number:	
Mobile number:	
Email address:	

General Details					
Crime ref:		Operation name:		Holmes ref:	
SIO:		Force Dealing:	**Please select…**		
Offence charged with (if any):					
Day:		Date body found:		Time:	

Venue Details (location of victim when death reported to police - if at a hospital, location immediately prior to admission or location where fatal injury occurred, if known)	
Location:	
OCU/BCU:	
Condition or premises (if relevant):	

Circumstance of Death

Brief summary of circumstances:			
Cause of Death (official C.O.D. as it appears on the death certificate if available):			
Sex of deceased:	**Please select…**	Age if between 2 - 18 years	
		Age if between 0 - 23 months	
Any additional significant injuries:			
Death related to co-sleeping arrangements:	**Please select…**		

Weapon Details	
Details of any weapons that are confirmed as the cause of any injuries at present:	
Details of any weapons that are suspected as causing any of the injuries:	

Please return the completed form or any queries to: childdeathinfo@npia.pnn.police.uk

Retention period: 7 years

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Operation Marshall - Part B

A national dataset to assist strategic analysis and inform future prevention and detection initiatives in relation to suspicious and child deaths

Contact Details for person filling this form	
Name:	
Rank / Title:	
Telephone number:	
Mobile number:	
Email address:	

General Details					
Crime ref:		Operation name:		Holmes ref:	
Force dealing:	**Please select…**				
Offence charged with (if any):					

Victim Details (under 18 years) - If there are additional victims please add them to the additional victims details tab							
Sex:	**Please select …**	Age if between 2 - 18 years	**Please select…**	Ethnicity Code:	**Please select …**	Nationality:	
		Age if between 0 - 23 months	**Please select…**				

Other victim information	**Yes**	**No**	**Unknown**	**Please elaborate**
Subject to Child Protection Plan	☐	☐	☐	
Known to Children's Social Care	☐	☐	☐	
Victim has disability	☐	☐	☐	
Pre-existing medical condition				
Death of another sibling (show cause if known)	☐	☐	☐	
Atypical hospital visits	☐	☐	☐	
Drugs present, e.g. in hair	☐	☐	☐	
Dead longer than stated	☐	☐	☐	
Atypical bruises or petechiae	☐	☐	☐	
Blood on face (not pinkish mucus regularly found)	☐	☐	☐	
Foreign body in airway	☐	☐	☐	
Fractures	☐	☐	☐	
RADI (rotatonal acceleration	☐	☐	☐	

deceleration impact injuries)				
Any other relevant information:				
Existing risk factors - VICTIM	**Yes**	**No**	**Unknown**	**Source and reference**
Repeat victim of abuse (min: 2 times in rolling 12 months)	☐	☐	☐	
Repeat MISPER (min: 2 times in rolling 12 months)	☐	☐	☐	
Sexualised behaviour by victim	☐	☐	☐	
Victim's injury caused by weapon / implement	☐	☐	☐	
Young age / Pre-mobile baby	☐	☐	☐	
Substance misuse / alcohol abuse	☐	☐	☐	
Privately fostered	☐	☐	☐	
Home educated	☐	☐	☐	
Mental Health issues	☐	☐	☐	
Trafficking	☐	☐	☐	
Other				
Existing risk factors - HOUSEHOLD	**Yes**	**No**	**Unknown**	**Source and reference**
Mental Health issues (suspect/family)	☐	☐	☐	
Chaotic / co-sleeping arrangements	☐	☐	☐	
Emotional stressors within the household (financial, illness, high conflict separations)	☐	☐	☐	
Divided family structure	☐	☐	☐	
Person with new or revived access to the child	☐	☐	☐	
Deprivation or poverty in home/local area	☐	☐	☐	
Substance misuse (amongst family / household)	☐	☐	☐	
Sibling subject to child protection plan (current or previous)	☐	☐	☐	
Other	☐	☐	☐	

Suspect Details - If there are additional suspects please add them to the additional suspects details tab							
Sex:	**Please**	Ethnicit	**Please select…**	Nationality		Place of	

	select …	y Code:		:		Birth:	
Immigration Status:		PNC/CRO:		Relationship to Victim:			
Other children in case (if any and relationship):							

Other suspect information	**Yes**	**No**	**Unknown**	**Please elaborate**
Substance / drug misuse	☐	☐	☐	
Alcohol use	☐	☐	☐	
Domestic violence	☐	☐	☐	
Mental health issues	☐	☐	☐	
Suicide attempt	☐	☐	☐	
History of violence to children	☐	☐	☐	
Criminal record	☐	☐	☐	
Inconsistent account	☐	☐	☐	
Evidence of grooming / control	☐	☐	☐	
New or revised access to victim	☐	☐	☐	
Suspected of / history of previous abuse towards children				
Suspected of / history of domestic violence	☐	☐	☐	
Tendency towards violence	☐	☐	☐	
Other	☐	☐	☐	
Suspect admissions / explanations:				
Any other relevant information:				

All medical or other experts presently used - If there are additional experts please add them to the additional experts details tab

Title:	**Please select …**	Name:	
Establishment / Organisation:			
Area of expertise:			
Any other relevant information:			

Please return the completed form or any queries to: childdeathinfo@npia.pnn.police.uk

Retention period: 7 years

Victim Details (under 18 years)							
Sex:	Please select…	Age if between 2 - 18 years	Please select…	Ethnicity Code:	Please select…	Nationality:	
		Age if between 0 - 23 months	Please select…				

Other victim information	Yes	No	Unknown	Please elaborate
Subject to Child Protection Plan	☐	☐	☐	
Known to Children's Social Care	☐	☐	☐	
Victim has disability	☐	☐	☐	
Pre-existing medical condition	☐	☐	☐	
Death of another sibling (show cause if known)	☐	☐	☐	
Atypical hospital visits	☐	☐	☐	
Drugs present, e.g. in hair	☐	☐	☐	
Dead longer than stated	☐	☐	☐	
Atypical bruises or petechiae	☐	☐	☐	
Blood on face (not pinkish mucus regularly found)	☐	☐	☐	
Foreign body in airway	☐	☐	☐	
Fractures	☐	☐	☐	
RADI (rotatonal acceleration deceleraton impact injuries)	☐	☐	☐	
Any other relevant information:				

Victim Details (under 18 years)							
Sex:	Please select…	Age if between 2 - 18 years	Please select…	Ethnicity Code:	Please select…	Nationality:	
		Age if between 0 - 23 months	Please select…				

Other victim information	Yes	No	Unknown	Please elaborate
Subject to Child Protection Plan	☐	☐	☐	
Known to Children's Social Care	☐	☐	☐	
Victim has disability	☐	☐	☐	
Pre-existing medical condition	☐	☐	☐	
Death of another sibling (show cause if known)	☐	☐	☐	
Atypical hospital visits	☐	☐	☐	
Drugs present, e.g. in hair	☐	☐	☐	
Dead longer than stated	☐	☐	☐	
	☐	☐	☐	

Atypical bruises or petechiae				
Blood on face (not pinkish mucus regularly found)	☐	☐	☐	
Foreign body in airway	☐	☐	☐	
Fractures	☐	☐	☐	
RADI (rotatonal acceleration deceleraton impact injuries)	☐	☐	☐	
Any other relevant information:				

Victim Details (under 18 years)							
Sex:	Please select…	Age if between 2 - 18 years	Please select…	Ethnicity Code:	Please select…	Nationality:	
		Age if between 0 - 23 months	Please select…				

Other victim information	**Yes**	**No**	**Unknown**	**Please elaborate**
Subject to Child Protection Plan	☐	☐	☐	
Known to Children's Social Care	☐	☐	☐	
Victim has disability	☐	☐	☐	
Pre-existing medical condition	☐	☐	☐	
Death of another sibling (show cause if known)	☐	☐	☐	
Atypical hospital visits	☐	☐	☐	
Drugs present, e.g. in hair	☐	☐	☐	
Dead longer than stated	☐	☐	☐	
Atypical bruises or petechiae	☐	☐	☐	
Blood on face (not pinkish mucus regularly found)	☐	☐	☐	
Foreign body in airway	☐	☐	☐	
Fractures	☐	☐	☐	
RADI (rotatonal acceleration deceleraton impact injuries)	☐	☐	☐	
Any other relevant information:				

Suspect Details							
Sex:	Please select…	Ethnicity Code:	Please select…	Nationality:		Place of Birth:	
Immigration Status:		PNC/CRO:		Relationship to Victim:			
Other children in case (if any and relationship):							

Other suspect information	Yes	No	Unknown	Please elaborate
Substance / drug misuse	☐	☐	☐	
Alcohol use	☐	☐	☐	
Domestic violence	☐	☐	☐	
Mental health issues	☐	☐	☐	
Suicide attempt	☐	☐	☐	
History of violence to children	☐	☐	☐	
Criminal record	☐	☐	☐	
Inconsistent account	☐	☐	☐	
Evidence of grooming / control	☐	☐	☐	
New or revised access to victim	☐	☐	☐	
Suspected of / history of previous abuse towards children	☐	☐	☐	
Suspected of / history of domestic violence	☐	☐	☐	
Tendency towards violence	☐	☐	☐	
Other	☐	☐	☐	
Suspect admissions / explanations:				
Any other relevant information:				

Suspect Details							
Sex:	Please select…	Ethnicity Code:	Please select…	Nationality:		Place of Birth:	
Immigration Status:			PNC/CRO:		Relationship to Victim:		
Other children in case (if any and relationship):							

Other suspect information	Yes	No	Unknown	Please elaborate
Substance / drug misuse	☐	☐	☐	
Alcohol use	☐	☐	☐	
Domestic violence	☐	☐	☐	
Mental health issues	☐	☐	☐	
Suicide attempt	☐	☐	☐	
History of violence to children	☐	☐	☐	
Criminal record	☐	☐	☐	
Inconsistent account	☐	☐	☐	
Evidence of grooming / control	☐	☐	☐	
New or revised access to	☐	☐	☐	

victim				
Suspected of / history of previous abuse towards children				
Suspected of / history of domestic violence	☐	☐	☐	
Tendency towards violence	☐ ☐	☐ ☐	☐ ☐	
Other				
Suspect admissions / explanations:				
Any other relevant information:				

Suspect Details							
Sex:	Please select…	Ethnicity Code:	Please select…	Nationality:		Place of Birth:	
Immigration Status:			PNC/CRO:			Relationship to Victim:	
Other children in case (if any and relationship):							

Other suspect information	**Yes**	**No**	**Unknown**	**Please elaborate**
Substance / drug misuse	☐	☐	☐	
Alcohol use	☐	☐	☐	
Domestic violence	☐	☐	☐	
Mental health issues	☐	☐	☐	
Suicide attempt	☐	☐	☐	
History of violence to children	☐	☐	☐	
Criminal record	☐	☐	☐	
Inconsistent account	☐	☐	☐	
Evidence of grooming / control	☐	☐	☐	
New or revised access to victim	☐	☐	☐	
Suspected of / history of previous abuse towards children	☐	☐	☐	
Suspected of / history of domestic violence	☐	☐	☐	
Tendency towards violence	☐ ☐	☐ ☐	☐ ☐	
Other				
Suspect admissions / explanations:				

Any other relevant information:	

Suspect Details							
Sex:	Please select…	Ethnicity Code:	Please select…	Nationality:		Place of Birth:	
Immigration Status:		PNC/CRO:		Relationship to Victim:			
Other children in case (if any and relationship):							

Other suspect information	**Yes**	**No**	**Unknown**	**Please elaborate**
Substance / drug misuse	☐	☐	☐	
Alcohol use	☐	☐	☐	
Domestic violence	☐	☐	☐	
Mental health issues	☐	☐	☐	
Suicide attempt	☐	☐	☐	
History of violence to children	☐	☐	☐	
Criminal record	☐	☐	☐	
Inconsistent account	☐	☐	☐	
Evidence of grooming / control	☐	☐	☐	
New or revised access to victim	☐	☐	☐	
Suspected of / history of previous abuse towards children	☐	☐	☐	
Suspected of / history of domestic violence	☐	☐	☐	
Tendency towards violence	☐	☐	☐	
Other	☐	☐	☐	
Suspect admissions / explanations:				
Any other relevant information:				

All medical or other experts presently used			
Title:	Please select…	Name:	
Establishment / Organisation:			
Area of expertise:			
Any other relevant information:			

All medical or other experts presently used			
Title:	Please select…	Name:	
Establishment / Organisation:			
Area of expertise:			
Any other relevant information:			

All medical or other experts presently used			
Title:	Please select…	Name:	
Establishment / Organisation:			
Area of expertise:			
Any other relevant information:			

All medical or other experts presently used			
Title:	Please select…	Name:	
Establishment / Organisation:			
Area of expertise:			
Any other relevant information:			

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Operation Marshall - Part C

A national dataset to assist strategic analysis and inform future prevention and detection initiatives in relation to suspicious and child deaths

Contact Details for person filling this form	
Name:	
Rank / Title:	
Telephone number:	
Mobile number:	

Email address:					
General Details					
Crime ref:		Operation name:		Holmes ref:	
Force Dealing:	**Please select…**				
Offence charged with (if any):					
Court / Coroner's Verdict					
Court Result:					
Coroner's Verdict:					
Any other relevent information:					
Key Issues for Investigation					
Lessons Learned					
All medical or other experts used - not previously listed on part B form - If there are additional experts please add them to the additional experts details tab					
Title:	**Please select…**	Name:			
Establishment / Organisation:					
Area of expertise:					
Any other relevant information:					

Please return the completed form or any queries to: childdeathinfo@npia.pnn.police.uk

Retention period: 7 years

All medical or other experts used - not previously listed on part B form			
Title:	**Please select…**	Name:	
Establishment / Organisation:			
Area of expertise:			
Any other relevant information:			

All medical or other experts used - not previously listed on part B form			
Title:	**Please select…**	Name:	
Establishment / Organisation:			
Area of expertise:			
Any other relevant information:			

All medical or other experts used - not previously listed on part B form			
Title:	**Please select…**	Name:	
Establishment / Organisation:			
Area of expertise:			
Any other relevant information:			

All medical or other experts used - not previously listed on part B form			
Title:	**Please select…**	Name:	
Establishment / Organisation:			
Area of expertise:			
Any other relevant information:			

New version found on the National Injuries Database POLKA Community

- Documents
- National Injuries Database
- Child death dataset and Op Marshall

Child Homicides: A suspect in the family. Issues for the Family Liaison Strategy

DCI Dave Marshall
SCD5, Metropolitan Police Service

Abstract

In London the Child abuse Investigation Command (SCD5) of the metropolitan Police Service has two dedicated major investigation teams whose remit includes the investigation of intrafamilial child homicides and suspicious child deaths. Over the last three years we have dealt with over 85 such cases, 35 of which were subsequently classified as child homicides. The following article outlines the issues we have encountered that impacted specifically on the family liaison strategy and that are often unique to this type of investigation. Consideration of these issues has informed the generic strategy that can be adapted for similar investigations. A copy of the generic family liaison strategy is included in the appendix.

The author and contributors to this article have been involved in this area of crime for over three years. In this article we will endeavour to identify and explain the often unique investigative environment, issues and options in terms of the family liaison strategy in this type of case. It is hoped that this article will assist others in formulating a family liaison strategy when involved in investigating the intra-familial deaths of children. In addition, some areas may be relevant to other types of homicide investigation where there is a suspect in the family.

Web link

library.college.police.uk/docs/J_Homicide_MII/J_Homicide_4.1.pdf

Effective investigation of Intra-Familial Child Homicide and Suspicious Death Investigations

Detective Chief Superintendent Russell Wate,
Cambridgeshire Constabulary
Detective Chief Inspector Dave Marshall,
Metropolitan Police Service

Abstract

The purpose of this article is not to repeat how forces deal with sudden unexpected death in childhood (SUDC). These are adequately covered within the *ACPO (2006) Murder Investigation Manual* and imbedded within forces through their response to *HM Government (2006) Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children* (hereafter referred to as *Working Together*). There are of course many principles from these sets of guidance that must be carried out in order to investigate suspicious child deaths but the purpose, is to deal purely with those investigations of child homicides that are intra-familial in nature. The article aims to provide guidance for senior investigating officers (SIOs) and encourage them to think wider and more thoughtfully about how they deal with these offences.

Web link

library.college.police.uk/docs/J_Homicide_MII/J_Homicide_5.2.pdf

WORKBOOK FOR THE CREATION OF ACPO GUIDANCE/PRACTICE ADVICE

This workbook, with all sections completed, must be included in the final document as an Appendix and submitted, through the Head of the Business Area, to the Programme Support Office for quality assurance prior to submission to Cabinet for approval as ACPO Doctrine.

ACPO EQUALITY IMPACT ASSESSMENT TEMPLATE (DIVERSITY AUDIT) AS AGREED WITH THE CRE

1. Identify all aims of the guidance/advice

1.1	**Identify the aims and projected outcomes of the guidance/advice:**
1.2	**Which individuals and organisations are likely to have an interest in or likely to be affected by the proposal?**

2. Consider the evidence

2.1	**What relevant quantitative data has been considered?**
Age	
Disability	
Gender	
Race	
Religion / Belief	
Sexual Orientation	
2.2	**What relevant qualitative information has been considered?**
Age	
Disability	
Gender	
Race	
Religion / Belief	
Sexual Orientation	
2.3	**What gaps in data/information were identified?**
Age	
Disability	
Gender	
Race	
Religion / Belief	
Sexual Orientation	
2.4	**What consideration has been given to commissioning research?**
Age	
Disability	
Gender	
Race	
Religion / Belief	
Sexual Orientation	

3. Assess likely impact

3.1 From the analysis of data and information has any potential for differential/adverse impact been identified?	
Age	
Disability	
Gender	
Race	
Religion / Belief	
Sexual Orientation	
3.2 If yes explain any intentional impact:	
Age	
Disability	
Gender	
Race	
Religion / Belief	
Sexual Orientation	
3.3 If yes explain what impact was discovered which you feel is justifiable in order to achieve the overall proposal aims. Please provide examples:	
Age	
Disability	
Gender	
Race	
Religion / Belief	
Sexual Orientation	
3.4 Are there any other factors that might help to explain differential/adverse impact?	
Age	
Disability	
Gender	
Race	
Religion / Belief	
Sexual Orientation	

4. Consider alternatives

4.1 Summarise what changes have been made to the proposal to remove or reduce the potential for differential/adverse impact:
4.2 Summarise changes to the proposal to remove or reduce the potential for differential/adverse impact that were considered but not implemented and explain why this was the case:
4.3 If potential for differential/adverse impact remains explain why implementation is justifiable in order to meet the wider proposal aims:

5. Consult formally

5.1 Has the proposal been subject to consultation? If no, please state why not. If yes, state which individuals and organisations were consulted and what form the consultation took:

Age	
Disability	
Gender	
Race	
Religion / Belief	
Sexual Orientation	
5.2 What was the outcome of the consultation?	
Age	
Disability	
Gender	
Race	
Religion / Belief	
Sexual Orientation	
5.3 Has the proposal been reviewed and/or amended in light of the outcomes of consultation?	
5.4 Have the results of the consultation been fed back to the consultees?	

6. Decide whether to adopt the proposal

6.1 Provide a statement outlining the findings of the impact assessment process. If the proposal has been identified as having a possibility to adversely impact upon diverse communities, the statement should include justification for the implementation:

7. Make Monitoring Arrangements

7.1 What consideration has been given to piloting the proposal?
7.2 What monitoring will be implemented at a national level by the proposal owning agency and/or other national agency?
7.3 Is this proposal intended to be implemented by local agencies that have a statutory duty to impact assess policies? If so, what monitoring requirements are you placing on that agency?

8. Publish Assessment Results

8.1 What form will the publication of the impact assessment take?