'Investigating child deaths- achieving a balanced approach between sensitivity and the investigative mind set'

A project submitted to Middlesex University for the degree of Doctor of Professional Studies by Public Works.

Russell John Wate QPM MSc

Institute of Work based Learning at Middlesex University

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'The views expressed in this research project are those of the author and do not necessarily reflect the views of the supervisory team, Middlesex University, or the examiners of this work'

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Finally I would like to thank John Fox and Dave Marshall who are two individuals who have worked and supported me in developing the police response to child deaths. These are two people who with me were described by Cook and Tattersall (2011), in his book the 'Senior Investigating Officer handbook'.

> *"For assistance in writing Chapter 14 [Investigating sudden and unexpected child deaths] we are also greatly indebted to three very wise men, namely Russell Wate, John Fox and Dave Marshall "(*Cook and Tattersall, 2011, p.Xii)

I hope that this context statement and public works associated with it clearly demonstrate my role in bringing about a transformation in the police response to the investigation of child deaths.

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1. Introduction

'Today is not a victory, we are not victorious, there are no winners here we have all lost out'

Sally Clark 2003

The investigation of child death is a complex and emotionally demanding specialism for investigators. I intend, within this context statement, to try and answer both for myself, and others, how, and why this became my specialism and to follow the journey I made in becoming the national police lead, changing policy and practice. In my view, the above comments of Sally Clark given from the steps of the Royal Courts of Justice, when her convictions for the murders of her two children were deemed to be unsafe, aptly sum up that there is no victory for anyone. Brandon et al (2009) carried out an analysis of serious case reviews into the death, or serious harm to children. My thoughts and personal knowledge, about how emotionally demanding dealing with these deaths of children are, is supported by their findings below.

> *"Interviews with a small number of practitioners showed the profound and long lasting impact of being involved with a case where a child died or suffered a serious injury through abuse or neglect. "(Brandon et al, 2009, p.5)*

The first time that Professor Brandon (2008) and her team carried out the biennial analysis of serious case reviews into child deaths, they made the following comments. These further support my thoughts on both the emotional nature and complexity of dealing with child deaths.

> *"The findings about the children and their circumstances make powerful and painful reading. Prevention of child death or injury through abuse or neglect is uppermost in the minds of practitioners and managers working with children and families. However, the complexity of family circumstances means that even if the 'whole picture' of family circumstances had been known, it would not always have been possible to predict an outcome for most of the children. "(Brandon et al, 2008, p.7)*

My understanding of the subject means that, I feel any investigation must be a search for the truth, rather than to convict someone. This ethical dilemma has been a huge issue that I have strived to overcome in policing, as it is to many, a conflict in their known professional

practice. In some respects, I just happened to have the right temperament. I also had the appropriate and necessary experiences, and the depth of knowledge, that supported me to be positioned in this leadership role, of the complex area of investigating child deaths.

My submission to be awarded a Doctorate in Professional Studies by public works is fully encompassed in this context statement. These public works, I believe, evidence my role as someone who has been the lead, influencing and changing national practice in relation to the investigation of child deaths. I could cite many publications and pieces of work, but I feel the key ones are as listed below. I have chosen these because they trace both my professional impact and growing understanding of the complexity and multi-disciplinary nature of these investigations.

The public works are:

i) my authorship of the national policing guidance for investigating child deaths with three versions; 2006,2011 & 2014.

ii) the national police training course on investigating child deaths

iii) three publications a) investigating child deaths b) public inquiries following a child death c) deposition sites of children's bodies.

This context statement is in six sections. Within this introduction I outline a history of dealing with child deaths, where my works fit in, and how this is a contribution to national knowledge and practice, not only for policing, but also for multi-disciplinary partners.

Within the second section I briefly explain my career, and how I came to be the national policing lead for dealing with child deaths. Also in this section, I make clear my knowledge and beliefs, which are both as a practitioner, but also as a strategic leader outlining my contribution and impact in relation to investigating these deaths. Within this section from an ontological perspective, I demonstrate certain aspects that have influenced my stance on this topic. This stance is encapsulated in the heading for this context statement, 'Investigating child deaths- achieving a balanced approach between sensitivity and the investigative mind set'.

What do I mean by this statement? The investigative mind set is described by ACPO within its practice guidance on investigative doctrine (2012) as:

> *"The application of an investigative mindset will bring some order to the way in which investigators examine material and make decisions. There is no process map that will assist investigators to develop the mindset: it is a state of mind or attitude which investigators adopt and which can be developed over time through continued use. It involves applying a set of principles to the investigation process. This will enable investigators to develop a disciplined approach which ensures that the decisions they make are appropriate to the case, are reasonable and can be explained to others. "(ACPO, 2012, p.84)*

As you can see from the above quote, an investigative mindset is a state of mind or attitude. It is essential that investigators use this. I often use the example of Madeline McCann, and ask students, 'Who thinks that Kate or Gerry McCann had anything to do with Madeline's disappearance'? The answer is, as am I sure you would answer, 'we just don't know'. Figures from the Office of National Statistics (2013:23) state that in 2011/12, there were 47 homicide victims (England & Wales) aged less than 16 years. In line with previous years, the majority of these victims were killed by a parent or step-parent. This is why a police investigator must, for both the child, but also their parents, ensure they use the investigative mind set, to establish if they have, or haven't harmed the child.

The challenge for me has been to try and get investigators to channel this state of mind and attitude, but to also be sensitive. The vast majority of child deaths are not homicides, Wolfe et al (2014) state:

> *"Annually, around 6,000 children between 0 and 19 years die in the UK. Around two-thirds of those deaths happen in the first year of life." (Wolfe et al, 2014, p.18)*

NSPCC figures (2013:12) show that there were 56 child homicides (includes Scotland & Northern Ireland) across the UK in 2011/12 (This is for children less than 16yrs and not under 18yrs, the age for investigating child deaths). So a very small percentage of the deaths are in fact homicide. Although, when you look at the findings of Brandon, Bailey and Belderson, (2010) when they analysed over 600 cases, stretching back 6yrs, they found that where the child is under 1yrs old, and harm has been the cause of death, 95% of it is caused by a family member. Notwithstanding this however, when you look at volume of deaths, the parents are very likely to be innocent grieving parents, and must be dealt with accordingly. However, as Sidebotham et al (2011) describes, when they examined the Home Office, Office of National Statistics and the DfE data on child deaths, that this figure

does not pick all possible homicide deaths. I will expand on this later in a further section of the context statement, in relation to investigators being aware of the covert nature of some deaths.

> *"All three data sources are likely to miss some violent deaths or deaths due to maltreatment. Thus there will be some covert homicides which are not detected by any agency and thus get recorded as deaths from other causes, and not investigated as homicides or maltreatment-related. Other deaths may initially be investigated as potentially suspicious, but subsequently concluded not to be. Most notable are the sudden unexpected deaths in infancy (SUDI). In at least 50% of these deaths, no cause of death is found after a thorough investigation, and the deaths are correctly recorded as sudden infant death syndrome (SIDS), or an equivalent term. It is well recognised that a small, but nevertheless significant proportion of these will be covert homicides. Most researchers and practitioners estimate that up to 5-10% of SIDS may be covert homicide, thus of the 250 cases of SIDS annually, up to 25 could in fact be homicides. "(Sidebotham et al, 2011, p.16)*

I strongly believe that my stance of, 'Investigating child deaths- achieving a balanced approach between sensitivity and the investigative mind set' is the best approach for all professionals, not only within the police service when dealing with child deaths.

In section three, I describe and critique each of the three sets of public works, that I believe, shows how I delivered the responsibility that the national police service gave me. It demonstrates how my leadership of this policy and practice area changed how the police and partners carried out these investigations. Within the section I articulate the processes I went through, how I problem solved, and engaged with the wider police and multi-agency audience to influence the works being accepted as national practice. In order to develop these sets of guidance, unbeknown to me at the time, (until this doctorate process) I was in fact an action researcher. Revans (1983) summarises below how I came to be the one to carry out this research.

> *"In a learning community we create conditions in which real people are obliged to tackle real problems in real time. Thus we must first find somebody with real responsibility for getting a job done who is not too sure that he/she can do it, and so is ready to have a go at something new. "(Revans, 1983, p.39-50)*

I believe one of my strengths as an action researcher, which is in contrast to Revans (1983) comments below, is that I do have, as described throughout this context statement, a strong belief in what I have been trying to achieve.

> *"Participation in an action learning programme demands that risks shall be taken, and this can be done only when one's own values and beliefs are known. Those who are unaware of what they prize, and who do not understand to what they may be committed when the chips are down, do not know who they are, and have little right to prove the inconsistencies in others." (Revans, 1983, p.46-52)*

Section four demonstrates what I have learnt from my reflection, study and submission of the public works. In order to achieve this development and changes in how I do things, I have made great use of my academic adviser, Dr Sutton, who has not only helped me to think differently, but also worked on helping me develop a different writing style. As a police officer we do tend to think and write in a specific way. I am no different, and I have developed over the years, a good and consistent method and style of working for the police environment. The challenge for me though, has been to do things differently. Argyris C (2002) states in the below text, that we get so tuned into doing things a certain way, we forget that there may be a different way of doing things.

> *"Human beings learn their theories-in-use early in life, and therefore, the actions that they produce are highly skilled. Little conscious attention is required to produce skilled actions. Indeed, conscious attention could inhibit producing them effectively. The lack of awareness owing to skill and the lack of awareness caused by our unilaterally controlling theories-in-use produce a deeper lack of awareness; namely, we become unaware of the programs in our heads that keep us unaware. "(Argyris, 2002, p.213)*

This Doctorate programme has given me the opportunity to now be more aware of my actions and to focus my work for any appropriate audience. My consultant, Malcolm Ross, has also been helpful in challenging my established way of working. He has been instrumental in giving me advice on the training course, how he manages his consultancy, and deals with serious case reviews of child deaths.

In the final sections, as well as recording any references I have included the public works; these are abbreviated copies due to their size. Full copies can be sourced if required. The

full copies were submitted to the University for them to make the assessment that the public works are of the correct level, and standard, to be classed as doctorate level.

I feel that it is appropriate in this introduction, to outline the major influences that I draw from the history of child deaths. I also feel it is important that I cover here some advice for other officers carrying out a similar role, both now and in the future. Finally, I outline other significant achievements (separate to the public works submitted) in the specialist field of investigating child death. These other achievements I believe bring about a different aspect of my contribution to the investigation of child deaths. A good example of this is my involvement in the 'Pink case', where I showed my skill and knowledge as an Investigator. Another example is when I received the Queens Police Medal QPM, which was for my work as an Investigator within the 'Holly Wells and Jessica Chapman' case.

The investigation of child deaths has a long history that is covered well in a book authored by David Marshall QPM (2012). I was a contributor and a critical friend for the book titled 'Effective Investigation of Child Homicide and Suspicious Deaths.' Within the book, he states, when talking about history of child deaths;

> *"Within more recent history there have been several key events that have come to be seen as defining moments in the investigation of child deaths and which have impacted on the investigative process." (Marshall D, 2012, p.8)*

From these areas of history there are those that are more appropriate, and key, to how they have influenced my thinking and actions, either as an investigator, or, as a national policy and strategic lead. These include the deaths of Maria Colwell and Jasmine Beckford. Both deaths emphasise to me that we/I must put children at the centre of our enquiries. (These two children were almost invisible to agencies that should have been caring for them.) The serious case review process started at this time, and it is a driver to my current and future work, to ensure we learn lessons from the deaths of children. One of the difficulties I have encountered over the years, when dealing with child deaths (where the death is physical abuse), is that it takes an exceptionally tragic case to engage the public. Crieighton (2007) writing in the Child protection handbook, describes below, where the media and public interest is.

> *"Child maltreatment is a culturally defined phenomenon. In the UK the death of Maria Colwell at the hands of her stepfather led to the establishment of multidisciplinary child protection procedures. Initially these focussed on the physical*

abuse (non- accidental injury) of children. In contrast, the media, and through them the general public, have focused on child sexual abuse. "(Crieghton in Wilson K, 2007, p.47)

If we look at today, and the current major media and public interest, it is focused on Child Sexual Exploitation (CSE). A lot of my current work is engaged with CSE, but I am also keen that we can ensure that there is a priority also, to tackling physical abuse (sometimes leading to death) in children.

When Riki Neave died (1994) I had only just started as a detective sergeant in child protection. I must admit that when I went with social services to execute a court order to remove his younger siblings from his mother, I really didn't know what I was doing. It was my first exposure in a role of responsibility to do enforcement, rather than empathetic action, with a parent whose child had just died. It resonated within me that it is such an enormous action to take, (removing someone's children) that I must always be as certain as I can before I take similar actions in the future.

The death of Victoria Climbé is, without a doubt, the child death that shaped not only how the police service deal with child protection but also all of the multi-agency partners. In, 'Messages from Research', Davies and Ward (2012) highlight the importance of partners working together. This is something I believe very strongly.

"Evidence from high-profile reports into child deaths, including those of Victoria Climbé and Peter Connolly, provide compelling evidence about the need for services to work together to protect children from harm. Findings from the biennial analyses of serious case reviews, further highlight and reinforce this. 'Lord Laming's Inquiry into the tragic death of Victoria Climbé found serious problems in inter-agency and inter-disciplinary practice at a local level, which needed urgent attention." (Ward and Davis, 2012, p.117)

The Children Act of 2004 came as a result of the Climbé report and has been the facilitator to allow me to do much of the work that I now do. The section from the Act, which includes the creation of Local Children Safeguarding Boards, has given me an opportunity since I left the police service, to be involved in child protection locally. This is as an independent chair of a safeguarding board where I help lead a multi-agency partnership to protect children. This also allows me to carry out serious case reviews to learn from the deaths of children.

Around this time (2004), there were a number of other high profile cases in the court of appeal similar to the case of Sally Clark, from which I took my quote for this introduction. These cases really affected me and made me overly cautious in my own investigations, and in the advice which I gave to others concerning their investigations. I don't believe it was the fear of one of my cases leading to an acquittal at the Royal Courts of Justice which caused me to do this, but more to make sure I was prosecuting the right people, regardless of the outcome. 'Should all SIOs (Senior Investigating Officers) treat the death of a child under two as suspicious?' this was the title of the dissertation that I completed for the award of Master's Degree (2003), which included a chapter on the Sally Clark case. The conclusion I came to was yes, they should.

There are other cases, including of course, my own case of Holly Wells and Jessica Chapman, and the death of Peter Connolly, that have impacted not just on my working practices, but those of all colleagues within the cross disciplinary partnership. In my view, we must take notice and learn from these cases in order to do better when the death of a child occurs.

I have described above how cases have influenced me. In the table below, I show where the police service, and my position in particular, is placed against a number of the external influences during the last 15 years.

Figure 1 – History of National Police activity in relation to child deaths.

Date	ACPO Lead	Activity of Significance	Multi-agency
Pre 2000	No lead	Some local force procedures.	1989- Children Act -Some Local Authority procedures in particular the Avon process.
2000-2005	D/Supt John Fox	2002- Infant Death guidance	2003-Victoria Climbie report 2003-Attorney General review into shaken baby cases. 2004-Children Act 2004-Baroness Kennedy SUDI guidance
2005-2010	DCS Russell Wate	2006- Child Death Guidance 2009-National Training Course	2006- Working Together – Child death guidance chapter 7 2009-progress report Lord Laming
2010-2012	DCS James Vaughan	2011- Child death guidance (author Russell Wate)	New legislation update to Section 5- causing or allowing death or serious injury (key policing leads Dave Marshall & Russell Wate)
2012-2014	DCS Kier Pritchard	2014- Child Death Guidance (author Russell Wate)	2013-Working Together guidance
2014-	D/Supt Geoff Wessell	Proposed Update of the Training Course. Proposed National Journal (editor Russell Wate)	

I believe the above table shows just a small amount of the activity that I have carried out, and still carry out to show my position nationally. For five years I was in the fortunate position, and was given the autonomy to have this high level of responsibility for the production of the public works as shown in the table. This was not only for myself, but

enabled me to provide the necessary leadership for others in their work in this area. This was not just for plugging gaps, but in writing and influencing national policy for the police and partners and also being able to change and bring about new legislation. This, I believe, shows that I was able to overcome the paradigms of my own discipline (police), and not allow it to inhibit my ability to translate this across other disciplines. For example, in order to change legislation I worked with parliament and other professionals and multi-disciplinary teams, eg NSPCC who were needed to support us making the new legislation become a reality.

I look back at my time when I was the head of crime, with pride, at the work that I and my sub group achieved, to change not only policy but the culture of policing toward these deaths. I don't believe that I let my force down in any way by my national policing responsibilities. Part of my role as a Chief Superintendent was to run as a director, my directorate, and sit as a member of the executive board. I don't think in the six years that I was a member I missed a meeting due to my national and International responsibilities. The carrying out of national work was all in addition to my core force role. It wasn't a secondment or attachment.

One of the aims which I had in the undertaking of the doctorate was a research question to look at any impact that the guidance and training course had had nationally, within policing. A further aim was to give advice to anyone else that may find themselves in a similar position of leading nationally an area of policing.

In order to try and determine these two aims. I used the following methodology for my research.

- I enquired of all 43 police forces if they had in place child death procedures
- I surveyed all 151 LA websites to see if their child death procedures included any reference to the ACPO procedures.
- I enquired with the College of Policing and Dave Marshall (the two main trainers of the child death course) as to how many students had been trained since the course commenced.
- I sent a questionnaire to past students who had completed the training course.
- I sent a questionnaire to the child death sub-group members.

- I sent a questionnaire to my in force Detective Superintendents.

In relation to the three sets of questionnaires, I have included the actual questions that I asked for each one, as an appendix at the end of this context statement.

I have also included the results from this research at various stages within the context statement, but in particular have used these insights within the impact sections of the public works.

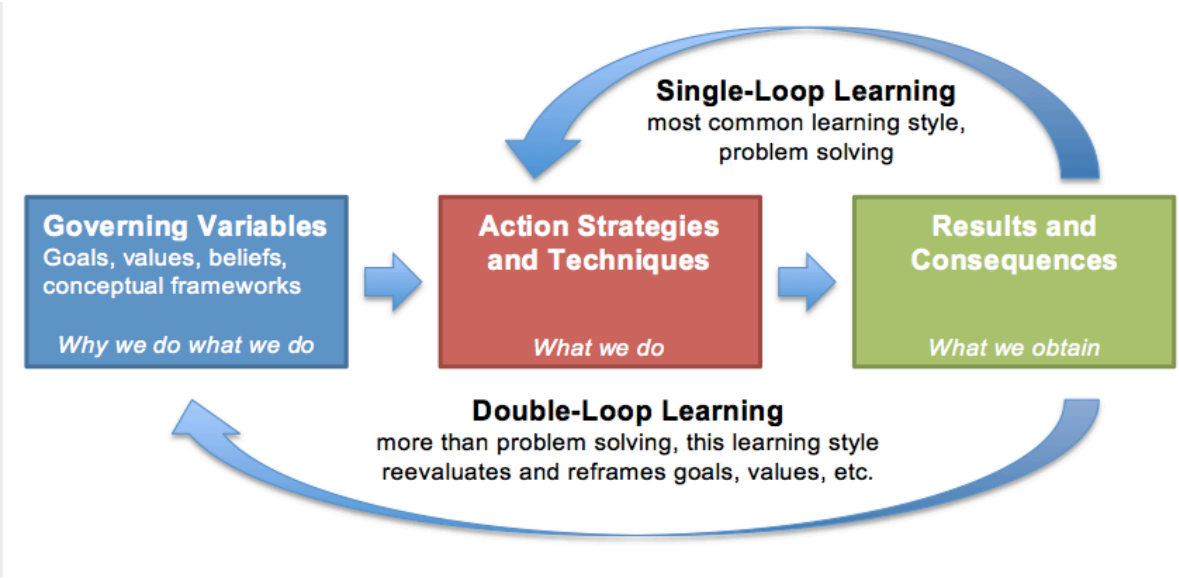
I know there are limitations to this research due firstly to the lack of assessment of use of the guidance in both police forces and Local Authority areas. The research sought only to establish if they had included reference to the guidance within their local procedures. Secondly, the questionnaires were sent directly from me to both the sub-group and Detective Superintendents. I did try to use a third party for the training questionnaires, but this would not have been ideal as the respondents would have known they were being returned to me.

In spite of this, I do believe that the results were not only useful to me for the purposes of this doctorate, but were also useful to the child death sub-group, enabling us to have some idea of the impact of our work over the last ten years. So, a real validity to both me within my public works of investigating child deaths, but also within the police nationally and on how it engages significantly with partners.

The challenge for me at the start of this doctoral programme was developing within myself the ability to analyse what, and why I did things. To then change my writing style to make myself the narrator of my own story. Then to have the dichotomy of looking at myself and my works, and then from the other view to see what the position and impact of the works has been, in my case not just for policing, but investigating child deaths nationally.

The research I have described above helped me to do this from these two different angles. Another useful methodology that helped was developing further, an understanding of the double loop learning. As I have stated elsewhere in this context statement, I didn't really understand it the first time I came across it whilst a member of Professor Munro's team. The below diagram is a good example of 'double loop learning' developed from the writings of Argyris.

Figure 2



(AFS/ICL resources 2012, pg1)

The aim of the research and questionnaires was to take myself right back to the start as I systematically worked through why I/we, did the works that we did. What I/we did and what was the impact. This fits this double-loop learning diagram above.

I think that Argyris (1977) describes below how useful 'double loop' thinking is when trying to carry out works that seek to influence how people behave:

> *'Changing private assumptions involves helping people to become aware of these internal maps; helping them to see how their present assumptions are counterproductive for the very kind of learning they need to be effective (for example, how to combine articulate advocacy of their views with questioning by others of these views); providing them with new assumptions that reduce greatly the counterproductive consequences; showing them how to move from old to new assumptions; and teaching them the skills necessary to implement the new behaviour in work settings.'* (Argyris, 1977, pg.7-8)

I now think that when I completed the third set of guidance, I should have gone back to the start of the process, rather than a focused update. I will definitely do this for the next iteration that I am hoping to complete by 2016. This will help me to better engage in the process of challenging the assumptions that I and the other professionals that work in this

field have. A gap I now see in my research is that we have never really engaged with any detailed and systematic feedback from parents or carers. This will need to be done sensitively, and the ethics around how we do it, thought through carefully. However, by doing so it will open up the possibility of new ways of working, how we should behave and do things. These new core assumptions, may lead to new, and potentially more rooted ethical decision making, and action for not only the police, but also our multi-agency partners in the future.

As mentioned above, one of the areas I looked at as part of my studies for the award of this doctorate, was the testing of my perceptions with my six, in force Detective Superintendents, by sending them a questionnaire. They all answered and I was really reassured by their answers. I have highlighted a few below in relation to the following question:

> *'As you may remember, I was involved in four groups for ACPO nationally CP(child protection), FLO (family liaison officer), HWG(homicide working group) and the national lead for investigating child deaths. Did you feel that my being so heavily involved nationally impacted on my role as head of CID for Cambs?'*
>
> Answer:
>
> *'No – far from it. Whilst Head of Crime you were the heartbeat of the Department'*.
>
> *'Cannot ever recall an instance when I sought you out and you were unavailable to me. As well as regular formal and informal 1:1s you regularly held Senior Management Team meetings, so we received individual and collective support'.*
>
> *'No, you had the ability to allow sufficient space for me to manage my business without being too remote. You always expressed interest in what I was doing and on many occasions advocated on my behalf.'*

I only embarked on being so heavily involved nationally once I had in place a team whom I had the trust in, and who had the sufficient skill and ability to manage their own departments. This took a year or so to put in place, from the time I was promoted to Detective Chief Superintendent. I asked them in the questionnaire:

> ' *What advice would you give to anyone that you work with, either now, or in the future, who has a national role, as well as a key in force role, on how to manage the balance after working with me for all those years doing this?'*

Some of their responses are as follows:

> *'The first priority should be the force role. But with effective time management it should be perfectly feasible to adopt a national role without compromising commitment to the force role. Seek a position where both roles complement one another – in order that you can contextualise the specialism in the 'real politick' of operational service delivery. ''Set parameters with regard to the amount of time you will devote to each aspect. Ensure you have a competent "lieutenant" in your primary role to ensure you are fed relevant information that may impact upon the business area. ''I am doing something very similar now and my advice is/would be to continue to do it and make sure you manage your diary well and have a very good PA!'*

They highlight some key learning points, for any other DCS who is currently, or may in the future carry out a number of important national roles. It is easy to be seduced into these roles when you can make such a difference on a national scale, but the day job still needs to be paramount. I have had to make effective use of resources, knowing that the work, both internally and externally, is complex, and can have huge impact on not just my work, but the work of others. Time management and knowledge of what you need to do, and what others can do for you, are key skills. Delegation of the right tasks to the right people, (pick your team) seems to me, to be a key to achieving any success in this role. Hayes J (2010) quotes:

> *"Nadler and Toshman (1989) suggests that one of the most scarce resources to senior staff is time and observed that when senior managers are so overloaded that they are unable to invest sufficient time to attend planning meetings, make presentations, attend special events, get involved in training and so on change initiatives are more likely to fail. "(Hayes 2010, p.266)*

The above resonates with me, because not just my time, but my Detective Superintendents and the sub-group members were all senior officers, so time was/is a scarce resource for them, as much as for me. Within the feedback I am now getting, I am sure that I prioritised their, and my time well. However, this must be at the forefront of any future leader's thoughts with similar responsibilities. Covey (2013) sums it up well. Delegation is not just to others, but also the delegation of your own time to a particular task as well.

"We accomplish all that we do through delegation-either to time or to other people. If we delegate to time we think efficiency. If we delegate to other people we think effectiveness. Many people refuse to delegate to other people because they feel it takes too much time and effort and they could do the job better themselves, but effectively delegating to others is perhaps the single most powerful high-leverage activity there is."(Covey, 2013, p.180)

As well as internally getting the right team in place, this also needs to be done externally. I did this by establishing a team of experienced individuals to support me in my national responsibilities. The sub-group members were in essence, my police action researchers. Reason (2013) outlines well how important it was for me to develop this community of inquiry.

"Building democratic, participative, pluralist communities of inquiry are central to the work of action research; action research is only possible with, for, and by persons and communities for political, moral, and epistemological reasons. This point is argued throughout the action research literature." (Reason, 2006, p.193)

One of the sub-group members in answer to my recent questionnaire to them summed it up well.

'I believe the sub-group approach was the correct way to inform national practice around child death investigations. Firstly it enabled work to be shared and secondly it enabled a number of people with different experience and specialisms to contribute to the process – the success of the group could be said to have been due to the sum of its individual parts'.

One of the main strengths that I have, as the lead in this area, is my personal knowledge and experience of being an investigator of child deaths. One of my cases was that of Pink, where a five month old boy was killed by his father. At the Court of Appeal in 2006, Lord Justice Latham made the following comment, 'This case was an exemplar of the best way to present conclusive medical evidence.' Baroness Kennedy also commented, ''This is a model case for both the police and judiciary to aim for'. She circulated nationally the judgement.

It is important to note here, the climate within the medical profession in the UK was one of fear. This made my investigation extremely hard to achieve, the search for the truth that I have always felt is required in child deaths. The below quotes from Rose and Barnes (2008)

who was analysing SCRs from 2001-03 and Williams (2010) when discussing two particular paediatricians Professors Meadows and Southall, evidence my point.

> *"Another set of issues was also preoccupying both media and policymakers during this time in relation to sudden and unexpected deaths of infants. Confidence in expert evidence given in criminal proceedings that some deaths of infants had been the result of deliberate acts of harm had been eroded by a series of judicial decisions resulting in successful appeals against convictions." (Rose and Barnes, 2008, p.27)*

> *"It is every parent's worst nightmare to be wrongly accused of abusing their child. Parents therefore need to feel safe when seeing a paediatrician that they are not suddenly going to find themselves fighting to prove that they have not harmed their child'.(Williams, 2010:2) 'This has led to continuing recruitment difficulties in community paediatrics, and paediatric trainees are reluctant to consider a job with specified child protection responsibilities. These difficulties have very grave implications for the protection of children subject to abuse and this is why the matter is so serious." (Williams, 2010, p.3)*

My approach was to be as open and transparent with all of the medical evidence, sharing it between both prosecution and defence. I also convinced the original trial Judge to hold an experts meeting, this was with both prosecution and defence to resolve disagreements, which it did.

The case is still highlighted as best practice. At the ACPO Child Death annual symposium dinner in March 2014 the key note speaker was Professor Tony Risdon, a paediatric pathologist. He highlighted in his speech that the Pink case is what we need to strive for and replicate nationally, not just in policing, but through the multi-agency partnership. Although happy to receive the praise that this case gave to me and my colleague Dc Martin Abbitt , if I am honest, there are things I would now change with the handling of the case. If any lessons come from this, it is that no case is perfect and you can improve on aspects all of the time.

On the 15th June 2008 in the Queen's Birthday honours list I was awarded the Queen's Police Medal (QPM). There are 19 QPMs awarded each honours list; from this there are only seven for non-chief officers. A rare award in policing that I was very fortunate and honoured to receive. One of the key areas of the citation for this award (another area of

course was my part in the Holly Wells and Jessica Chapman case) was in relation to my national leadership on behalf of the police service relating to the investigation of child deaths.

I wouldn't want, for one moment, to describe myself, or for others to class me as an expert in the investigation of child deaths. Drs Fleming and Sidebotham (2007) who are two paediatricians that I have worked with extensively and I would describe as experts state:

> *"We do not put ourselves forward as experts. There can be no experts when it comes to responding to a child's death, any more than there can be a perfect response." (Sidebotham, Fleming, 2007, p. Xi)*

What they, and I, have always tried to achieve, is providing the professionals involved in these cases with some guidelines to improve the response, and to support them in their work. Stice (1987) in the quote below corroborates my thinking of working with other professionals, but also having the ability to see the perspective from other professional's points of view makes your thinking clearer. So with the help of professionals from other disciplines, your thinking can be cross-disciplinary.

> *"It is generally accepted that problems cannot be solved without our knowledge base. Medical problems can only be solved with a knowledge base in medicine, legal problems with a knowledge base in law; engineering problems, with the knowledge bases specific discipline of engineering; and so on. While the knowledge base of problem-solving* is *domain specific, the thinking skills can be generalised across boundaries between disciplines."* (Stice, 1987, p.23)

When I moved from being a serving police officer to a consultant, I was invited to sit as an advisor, and was a part of Professor Eileen Munro's review of child protection in England on behalf of the Government. I found this experience hugely beneficial to me, not only as personal development, but it also gave me a greater voice in government on behalf of policing. An added bonus was that I was able to work as part of the team that brought out the 2010 version of the statutory guidance 'Working Together to safeguard children'. This helped me to be part of ensuring we honed the child death chapter as best we could. An example of my impact and influence here was a subtle but important change to include the words 'specialist nurse' as a change from the 2006 version to the 2010 version (WT, 2010:228). I had picked up through both my work nationally, but also through the sub-group members, that areas were struggling to only have paediatricians on a rapid response

rotas. These areas had employed specialist trained nurses. My pragmatic review of this was, it was a help rather than a hindrance.

The final section of this context statement covers a reflection on what I have achieved so far, it also looks to what I am doing now and want to do in the future. I could now relax and let others take on the development of investigating child death within the police service. I could just deliver the child death training and carry out serious case reviews for local areas. However, I feel that I have not completely finished with wanting to be at the heart of making a difference to how the police and their partners deal with child deaths. I still want to build on what I have already achieved, and continue to re-define this knowledge, and develop new approaches. The successive ACPO leads since I retired from policing, equally feel that they want to harness my drive and passion. The current lead has sanctioned me to be a part of the development of the training course and the College of Policing have asked me to work, on their behalf, on changes to update the course. This doctoral process has inspired me to want to do new things and I have been inspired by this and am now the editor of the 'National Journal for Investigating Child Deaths'. I will expand on what this entails in my final section of this context statement.

Finally, I believe one of my national sub-group Superintendents has captured (below) extremely well my ability to work in collaboration of this critical community with my sub-group members. This sums up what I have strived for throughout my previous and continuing involvement, in the investigation of child deaths.

> *'Without you Russell I think that child death would have been a single task action group. I am really pleased that you gripped it and channelled the membership into what it became. I am sure that the outcome of your work and discussions of the group have achieved three things 1. Fewer deaths. 2. Less traumatised families (including wrong prosecutions) 3.More convictions'.*

2. A Reflective Auto-Biography of Russell Wate – Investigator of child deaths. (Ontological and epistemological foundations)

"Our children are our greatest treasure. They are our future. Those who abuse them tear at the fabric of our society and weaken our nation."

Nelson Mandela (1997)

I have often wondered how I ended up being the Association of Chief Police Officer (ACPO) lead for investigating child deaths. It might be best if I asked myself what started my journey to be this person that produced the ACPO guidance for investigating child deaths (public works), and at what point did I actually start this journey?

Firstly, I need to step out of looking at myself as a police officer, and look at myself from a wider perspective. I believe the protection of children should be the moral duty of every member of society. It is worth us looking at a selection of quotes made by Nelson Mandela during his lifetime relating to society and children. Whatever your thoughts are in relation to Nelson Mandela, and mine were varied when he was first released, he was a world statesman, and this re-enforces my thoughts on the moral duty of people to protect children.

> *"History will judge us by the difference we make in the everyday lives of children.(2002) -- Our children are our greatest treasure. They are our future. Those who abuse them tear at the fabric of our society and weaken our nation. (1997)-- The true character of a society is revealed in how it treats its children."(1997).*

I could argue that the protection of children is the duty of the whole of society as outlined above by Nelson Mandela. In my view, it definitely is a duty for multi-agency professionals, such as police officers. The Children's Act 2004 agrees with me, and states in section 11 that there is a duty on professionals to safeguard and promote the welfare of children. Most police officers are unaware of this statutory duty. A number of my peers actively do not want to work in this specialist field; hence most police forces make it a voluntary posting.

I believe that I have always had an underlying desire to protect children, whether I recognised this at the time, or not. It has been the driving force in relation to much of the

work I carried out in the police service, and a key which enabled me to produce these public works. This is the work that I do today as an independent safeguarding consultant.

It is important, when I try to answer the question of why I took this path, to reflect on my first years in the police force. What was it that drove me into being a detective, as an overarching specialist discipline for the majority of my service? Was it having an interest in solving crime that led me to make this choice? If I turn this around and consider Adair J (2013) who said:

> *"It is usually easier to identify the fields that you are not suitable for, because you lack the necessary level of interest or mental aptitude, or temperamental characteristics to do really well in them."* (Adair, 2013, p.77)

It may be that I was not interested, or did not have the temperament for uniform policing, rather than actively wanting to be a detective. However, I believe that my greatest skill is my want, and ability, to problem solve. The work of a detective is primarily about problem solving; how a crime occurred and who did it. I feel this aptitude informed my choice and the force recognised this and confirmed my posting to this role.

I spent a number of years as a generic detective. During this time, I became in my view, an experienced investigator. I dealt with all aspects of crime, ranging from car thefts to being part of murder enquiries. I was certainly successful, having a reasonably high detection and conviction rate, hence my view that I was an experienced investigator. After a number of years I was promoted to sergeant. I spent time as both a uniform sergeant and also as a detective sergeant.

It was during this time that my core values started to change, both within my personal life, and within my career. Without a doubt, the biggest catalyst to these changes came about when I went with a friend, and a number of others, on an aid convoy to Bosnia (1994). I only signed up to go on the convoy due to the encouragement of this friend, Paul Sutton. We had both been on a Sergeant's course together and after eight months the course re-convened as a development module. On the first day of this module, we each had to discuss something that had happened to us during our time apart. I spoke of a trip my family and I had taken to Florida and how I had visited the local police and learnt some new techniques. Paul Sutton spoke of an aid trip he had made to Bosnia, and how he was learning to be an HGV 1 driver, so that he could take even more aid with him the next time he went. Although what I had done was interesting and exciting, I strongly felt that I

wanted to experience what Paul had. I agreed to go on the next convoy, and prepared for it through organising various collections; this included collecting shoes and coats from every school in the town where I lived. My desire to help children always seems to be present in my thoughts.

Paul was the leader of the convoy; we set off with five vehicles. Whilst we were there Paul tragically died in Sarajevo of a burst ulcer. At this time, Paul and the other driver in his vehicle had gone to deliver some aid separately. The rest of us were at our base in Zagreb, Croatia. Hearing this news was one of the most shocking experiences of my life. I wanted to go straight home to my family and leave the trauma behind. Fortunately, I was able to speak to my wife quickly, so she could tell others that I was safe. This was certainly needed as the media at home reported on the news that a local police sergeant, a father of three, (this of course fitted me, as well as, Paul) had been killed in Bosnia. Within the police, at home at this time, there had been a breakout from Whitemoor prison of a number of IRA terrorists. A large team was investigating, a number of whom were my friends and colleagues, they were eating lunch when this was broadcast on the news. They believed it was me that had died and were visibly very upset.

I went out for a walk to try and clear my head, reflect on what I had just heard, and to try and think through what were the options for me/ us, and what to do now. When I came back, the other members of the team were waiting for me. We needed someone to take charge, to make decisions on whether we should finish delivering the aid or go straight home. Somehow this person, who was to be our leader turned out to be me. Did I volunteer, or was I nominated by the team? It is not clear to me why, but I did step forward and agree to lead, and finish the job that my friend Paul Sutton had started. It could have been an unconscious desire to take responsibility for outcomes. Something needed to be done and I was willing to step up and make sure that it happened. John Adair (2013) describes how the role of leader could be considered:

> *"Your role as leader: Leader-qualities of personality and character. Situation-partly constant, partly varying; the group-followers: Their needs and values. "(Adair, 2013, p.34)*

Munro (2011a) emphasises the importance of leadership by highlighting comments made by Lord Laming (2009) outlined below. This initial experience within a humanitarian environment, certainly helped to put in place within me core values of helping children.

These have remained with me ever since, and in particular, when I moved into both local and national leadership roles.

> *"Effective leadership sets the direction of an organisation, its culture and value system and ultimately drives the quality and effectiveness of the services provided. It is essential that there is sustained commitment to child protection and promoting the welfare of children at every level of government and in every one of the local services." (Lord Laming (2009) quoted in Munro, 2011a, p.80)*

The team were very clear they wanted me to take charge. I was also keen that we finished delivering the aid to the remaining camps, a view fully supported by the team. I knew from past experience that I had the personality, but was not sure I had the characteristics of leadership at this stage. In the situation we were in, it was clear to me that I was going to have to be as flexible as possible, as this was a totally new experience to me, taking a convoy across Europe. I knew the team had really strong values, hence we all agreed to continue to deliver the aid as planned, before heading home. One of the highlights of the trip was a visit to an orphanage, seeing how pleased the children were with the coats, shoes, but mostly the sweets we had taken with us. Getting the team back successfully seemed to cement in me that I wanted to, and had the ability, to take responsibility. This was probably the first time I had demonstrated being, or wanting to be, what can be described as a professional. Tarrant P (2013) describes this succinctly.

> *"It is important to acknowledge that being professional is about much more than 'what you do'. It is also about' how you do it' and the values that go along with it. It is about how you behave; it is about whom you are and how you see yourself." (*Tarrant 2013, p.3)

My faith plays an important part in my life, whilst on the trip home, I felt that I was being called to be baptised. This happened not long after getting home. A short while later, I saw advertised, a post for a Detective Sergeant in charge of a child protection team. This would be a totally new role for me, and although I knew it would be a big challenge, it was really going to be different because it would require me to do lots of thinking from other people's perspectives. I would need to think for victims, more than ever before, and also other agencies, rather than me thinking about the police perspective alone. Although the thinking for victims wasn't entirely new to me, it is vitally important in child protection work.

In terms of other agencies, they each have a different responsibility to safeguard, and promote the welfare of children, but must do this as a multi-agency partnership. Although, to a certain extent, I had to ensure that the paradigm of my own professional training and a police position wasn't lost. This interdisciplinary way of working really helped to develop my thinking. It shaped how I worked through the rest of my service, and how I came to author the public works, as well as my work now as a consultant. There is so much written in the academic literature in relation to both how hard, but essential, this joint agency working is. As Davis and Ward (2012) in their book on 'Messages from Research' commented:

> *"There is compelling evidence of the need for effective inter-disciplinary and inter-agency working at all stages of child protection work. Evidence comes from multiple ways of looking at service delivery including analyses of what happens when things go wrong, and research on everyday routine practice. It is also clear that joint working both at an inter-agency and front-line level is difficult and involves overcoming cultural differences as well as organisational and cross-sector boundaries. The challenge is to achieve continual improvement in the interests of children and families." (Davis and Ward, 2012, p.136)*

My immersion into the world of investigating child deaths came about quickly. Although it was emotionally traumatic, at the same time I felt the experience mentally stimulating. Within a very short time period of only a couple of months I found myself dealing with three infant deaths; very few things in my career up until this point had prepared me for the impact that this would have on the way I carried out my professional responsibilities. I also realised, for the first time that others, namely health professionals, were looking at how I carried out these professional responsibilities.

When you deal with such emotive and traumatic deaths as these, everyone involved wants a definitive reason as to why the child died. The parents want to know, to enable them to assuage potential guilt and find a way to move through the grieving process. As professionals, we want to establish cause, so that we can improve our response and hence save another child who may be at risk. From the police investigator point of view, we want to arrest and convict someone if they are responsible for the child's death. Society at large and the media in particular, if believed to be an abusive death, wants / needs someone to blame; often not the abusive parent(s), but a professional for slipping up, missing opportunities and letting it happen.

At this time I was what I, and others, would regard as a very experienced investigator. However, this experience was in the clear cut cases of burglary, vehicle crime, and adult assault, not cases where there is such ambiguity on whether a crime may, or may not have occurred. I had what could be described as a good gut feeling when it came to these investigations. Munro (2011a) when quoting Gigerenzer (2002) states that this is acceptable.

> *"Gut feelings are in fact neither impeccable nor stupid; they take advantage of the evolved capacities of the brain, and are based on rules of thumb, that enable us to act fast and with astounding accuracy. "(Munro, 2011, p.38)*

My problem with dealing with these cases then, is that I had no rule of thumb, or basis, to even dare use my gut feeling. In at least one of these cases I am sure abuse played a part. Of course, if this was the case with me, it would be for others in the future.

As it turned out for all three of these child death investigations, the medical tests were inconclusive, and no cause of death could be determined. I had to learn early on, and resolve that ethical dilemma, that not just sometimes, but often, you just can't find a cause when dealing with child deaths. But what you need to do is everything in yours, and others in the multi-agency partnerships capability, to determine what happened. A number of my colleagues, at the time that I was dealing with these first few deaths, would have not have had this multi-agency approach as their motivation. They did, and do say, the police's primary focus is to solve a crime.

It resonated with me that we needed to learn more about how we, in the police, deal with these deaths. I really felt that there was absolutely nothing to help and guide me at this time as an investigator. The stock police stance, and what had happened many times before, was to arrest the parents, and if unable to subsequently find a cause of death, let them go. I am a parent of three children, who, at that time, although not babies were still very young. I could, and did imagine myself in the parent's position.

My Christian faith was also an influencing factor in my thinking. Please don't get me wrong, I would have, and have had, absolutely no qualms about arresting abusive parents and have done this many times since. I remember at the time, although not really sure after which death this occurred; doing something with my children that I thought the mum would never again be able to do. I also remember when I left my daughter at University crying for a short period on the way home, not for her/us, as she was so ready to go out

into the world, but for Kevin Wells who would never have this experience. I had dealt with Holly, his daughter, and a friend of hers, Jessica Chapman's deaths, so had got to know him well[1].

There is no doubt in my mind, that through professional experience, although obviously not fully, I could begin to understand the loss of a child. I felt that by putting in place procedures to follow, we could reduce the stress on officers who found themselves dealing with these deaths. Part of this stress is the need to find an answer, or to arrest, which is exactly the stress I felt when I dealt with these first cases. We could also help the parents through the grieving process, by being clear about our role and what part we performed with other multi-agency professionals. My rank and role at that time, was such that I was not in a position within the police force that would allow me to make this sort of change, or to make a difference. This was probably right that the National police service didn't allow me the autonomy, or the level of responsibility, to be able to change national practice. What this learning did give me, was the knowledge, and personal experience, for when I did become the person with the national autonomy, and high level of responsibility, to make the changes that my public works cover. It also helped when supporting changes, to get the police service to work cross discipline, that I actually understood what needed to be done to make a difference in these investigations.

Over the next few years, and through various ranks, I continued to deal with child deaths on a local basis. Some of these deaths were eventually seen as non-suspicious and others were homicide investigations. I didn't, but neither was I, in a position to influence anyone, or any area, in relation to their procedures and how they dealt with these deaths. What this time did do however, is build up my personal experience, knowledge and skill base.

As I have previously mentioned, my dissertation for a Master's Degree, focussed on investigating child deaths. This was the first time that I had completed any real research, and development of my academic thought, into investigating the deaths. All of my earlier involvement had been as a practitioner, personally investigating the deaths. There is no doubt that the broadening of my thinking was, and is, extremely helpful to build up my now increasing theoretical understanding and depth of knowledge, in this complex area of what needed to be done to improve the police and their partners response to child deaths. The core of my research and development came from the work of Professor Peter Fleming, then later on Dr Peter Sidebotham, and the work they had both done in Avon. I had not

[1] Holly Wells and Jessica Chapman were murdered by Ian Huntley in August 2002.

met either of them at this stage; it was their thinking that strongly influenced me then. As can be seen throughout this context statement, these two individuals have really influenced national thinking, and not just mine.

As stated earlier, I dealt with the deaths of Holly Wells and Jessica Chapman. The article that I had published in relation to the recovery of the girls bodies is one of my public works that I will cover in the next section. There is so much I could say, both personally and professionally, about my involvement in the investigation into the girl's deaths, that I could fill the whole of this context statement. What dealing with the girl's deaths did give me, was a worldwide recognition of a case that I played a significant part in. This recognition was/is, not only from policing but also multi-agency partners, and in fact the public in general. Most people, including professionals, only know what they saw and read in the media, and as a result have no in-depth knowledge of what actually took place. I have found the case has been, rightly or wrongly, a bridge, and a door opener for me in all sorts of situations.

One key action that I carried out in this case, I will however, mention here. It relates to mementos. This, I believe, shows that I have ingrained in me, from my earliest days of dealing with child deaths, the want to ensure that we treat parents with sensitivity. This demonstrates a real heuristic application of all my knowledge for these families. In the current ACPO 2014 guidance I included the below section.

> *"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." (ACPO, 2013, p.20)*

I also included the below section, from the SIO journal article that Dave Marshall and I authored (public works 3.3 (iii)) on 'Effective investigation of intra-familial child homicide and suspicious death.

> *"A common complaint from parents and professionals has been that the police were sometimes intransient when it came to a request from bereaved parents to be allowed to hold their baby or receive mementos such as a lock of hair or fingerprints. Training will help SIOs to be confident that in most cases no harm will come from allowing these basic human requests from the family". (Wate, 2009, p.35)*

Without going into any personal detail's, out of respect for the Wells and Chapman families, I suddenly thought at 1am, whilst in the post mortem, that we needed to do this. I very much took responsibility and made the leadership decisions to ensure that we (my medical colleagues) did this. I know that the families were really appreciative, as they personally fed this back to me. Without my awareness of the sensitivity needed in dealing with families in tragic circumstances, these families would not have had these particular mementos. By including this in the national guidance and in a journal article, as well as in any training courses that I deliver, I have tried to influence others to ensure they consider fulfilling these simple human needs.

In terms of cases of mine that could be described as significant in challenging and changing practice, not just in policing, but across the criminal justice profession and medical profession, is the Pink case, which I mentioned in my introduction. The key action that I would highlight is how I made use of the medical experts in this case. We held a prosecution expert meeting; I shared with the defence at a very early stage all of the medical evidence. At a preliminary hearing, I managed to convince the Judge, who didn't want to proceed with the case, to make use of guidance from Baroness Kennedy (not at that time yet published) to hold an experts meeting. This was the first time such an experts meeting was ever held in criminal cases in England and Wales. The convincing of the Judge, and others, through my arguing an alternative approach here, was due to the fact that I was able to analyse the conflicting information and opinions. I was fortunate in that I was up to date with current thinking and publications, such as the then to be published Kennedy report, so was able to redefine and get others to use this new approach. I know that the positive endorsement from Lord Justice Latham, Baroness Kennedy and Professor Risdon helps, but I believe that all SIOs can, and should use medical experts in this way. It is still, unfortunately, not common practice, but I shall continue to ensure that SIOs put pressure on Judges and lawyers to hold these meetings.

In 2004, the group chaired by Baroness Helena Kennedy, published, on behalf of the Royal Colleges of Paediatric and Child Health and Pathology, this report on how the multi-agency partnership deals with infant deaths. I represented the police service when this group re-convened a year later, sitting as a member for a further year to judge impact. This was something that at the time I felt really proud of, and still see it as having been a great experience. I was fully accepted as a member of the 'Working Group', I believe, not just because I was representing the police service, but as much due to my personal knowledge

and experience of dealing with child deaths. As Baroness Kennedy stated within the guidance the below quote:

> *"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. 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 siblings and any future children who may be born into the family concerned."(Kennedy, 2004, p.6)*

I personally believe, that the above comments within one paragraph, sum up the key goal for all investigators of child death. It was the Kennedy guidelines, coupled with the statutory guidance from 'Working Together 2006', which I used as the cornerstone to my first version of the ACPO guidelines to officers on investigating infant deaths.

In policing there is not widespread recognition that the officers working within the service are professionals, and should be treated as such by members of the public and other disciplines. I believe that as I went through the ranks, and in particular, as I became a specialist in an area that was multi-disciplinary in nature, others recognised me as a professional in my field. Lord Stevens chaired a commission that reviewed the police service and he made the below comment in the final report.

> *"The Police Service as a body of practitioners who bring meaning and dignity to their work through dedication, self-improvement, and ethical commitment, aligning their own interests with the interests of those they serve. Professionalism offers an antidote to corruption and underperformance, and a way of emphasising that the police have, or should have, special skills and knowledge." (Stevens, 2013, p.110)*

This may not be the case across all aspects of the police service. However, for all of the officers who work in the field of investigating child deaths, because of my efforts when representing them on national cross discipline bodies, they are now respected as equal partners and professionals in the field of investigating child death.

After the Holly and Jessica trial, I was the force SIO for the 'Bichard Inquiry'. This was a Public Inquiry that looked at the girl's case, and information sharing, relating to their

murderer, Ian Huntley. I will cover this in more detail in the next section - 3.3 i. I had never been involved in a Public Inquiry before, so this was a huge learning experience for me. My personal beliefs, and experience, did come through on how we presented our evidence to the inquiry. I know that I had dealt with the girl's deaths, and without a doubt this emotionally influenced my decision making. From the very start of my involvement, I was quite clear with my Chief Constable, and all of our lawyers, that we should not be defensive, but as open as possible. Two young girls had died, and we, (Cambridgeshire Constabulary) and the country, needed to learn lessons from their deaths.

On analysis of whether my stance was the correct one or not, Lord Bichard gave me feedback that he appreciated the openness of our approach. The senior civil servant informed me that the Inquiry secretariat had been very impressed with our/my approach. When David Blunkett addressed the House of Commons on the day the report was published, he was complementary of the Constabulary. Finally, my Chief Constable informed me that my judgement had been, throughout the Inquiry, excellent. I believe the learning for everyone is, that when dealing with child deaths, in whatever environment, (in this case a Public Inquiry) that the search for the truth should be paramount. I was able to translate my depth of knowledge, in dealing with child deaths, across to this Public Inquiry.

One thing I know for sure, is that being the SIO at this Public Inquiry, tested, and developed my communication and negotiation skills to a higher level than ever before. The Inquiry itself, whether the lawyers, senior civil servants, other high ranking and profile witnesses, and the world's press, were not safe audiences. On an almost daily basis I had to modify my/our approach to any changing circumstances.

The Bichard Inquiry report (2004) made the following comment:

> *"I place on record my appreciation to all those who submitted information and evidence to the Inquiry. Humberside Police and Cambridgeshire Constabulary in particular submitted detailed written evidence that clearly required considerable effort on their part and in a tight timescale." (Bichard, 2004, p.20)*

As a result of becoming the ACPO lead for investigating child deaths, as well as the national guidance and training course, which I will go into more detail in the next section, I represented the police service on various national groups including implementing Government guidance (Working Together 2006, child death procedures). I am sure I didn't

recognise the significance at the time, and it only really resonates with me now, as I re-read the report by Sidebotham et al (2008) on Preventing Future Child deaths.

> *"Working together 2006 which set out the new processes that dealt with childhood deaths and followed on from Baroness Kennedy's report (2004) and Lord Lamings report into the death of Victoria Climbé (2003) 'This set the scene for England to become the first country in the world to have national standards and procedures for the investigation and management of unexpected child deaths and for reviewing all child deaths." (Sidebotham et al, 2008, p.10)*

It was within my leadership role, to ensure that the police service in England played their part and implemented these worldwide first procedures. I know I succeeded, and I am sure my first public works, the ACPO guidance in 2006 helped with this. I effectively still did it alone, whilst reflecting now; I feel that I should have pursued the sub-group approach earlier.

I also represented policing on the re-convened Baroness Kennedy Working group. I was aware as I have mentioned in my introduction that I shouldn't do this alone and should set up the sub-group approach.

It may be that as a leader, it is easier to just cater for yourself, and not to complicate your decision making by seeking the views of others within your profession. I tried this for about a year, but I did/do not believe, it is the most effective form of leadership, in particular when you want to influence several thousand officers across the country on a daily basis. A good way to articulate this is by Adair (2013).

> *"Thinking is both solitary and social. We need to think for ourselves- and make time to do so. But we also need to talk with and listen to others, for stimulus and encouragement, fresh perspectives and new ideas. Conversation at its best is a form of mutual thinking. "(Adair, 2013, p.42)*

I was keen to expand my sphere of influence, through others, into every area by setting the sub-group approach, which covered all of the regions of the UK. As Covey (2013) describes, I found this the best way to be proactive and influence others.

> *"Proactive people focus their efforts in the circle of influence. They work on the things they can do something about. The nature of their energy is positive,*

enlarging and magnifying, causing their circle of influence to increase." (Covey, 2013, p.22)

I hoped, that by setting up the sub-group approach, it would allow me to get a foothold into a number of the 'critical communities' that I needed to, so that we could firmly establish this new way of working. It would also help us to reflect and collaborate as much as possible. Tarrant (2013) describes how essential these communities are to make better interactions.

> *"The term 'communities of practice' were coined by Jean Lave and Etienne Wenger (2006). It refers to the process of social learning that occurs when people have a common interest: Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly". (Tarrant, 2013, p.108)*

> *"As Wenger (2006) puts it: 'Communities develop their practice through a variety of methods, including: Problem solving, requests for information, seeking the experiences of others, reusing assets, coordination and synergy, discussing developments, visiting other members, mapping knowledge and identifying gaps. "(Tarrant, 2013, p.115)*

Put simply by Hayes (2010)

> *"Kotter (1999) argues that this leadership has to be multiplied and shared if the changes are to be successful." (Hayes, 2010, p.164)*

Through the others in the sub-group, I was multiplying my leadership throughout the UK. I was very fortunate that I was able to enlist an incredibly capable group of individuals to be members of the sub-group. Kotter (2014) sums up below that this opportunity I was giving them to be involved in this national work was one that they embraced.

> *"an opportunity that seems to them both sensible and emotionally compelling. This makes all the difference in the world in drawing people to be volunteers, doing their regular jobs plus more… True urgency around an emotionally appealing opportunity taps into people's genuine desire to do something meaningful. "(Kotter, 2014, p.24)*

Another gap that existed nationally, in my view, was the use of peer reviews for officers and their partners, concerning those investigations that had hit stumbling blocks. I therefore organised for the sub-group to convene the evening before our quarterly

meetings, with an open invitation around the country, for officers and other related professionals to attend, and for us to de-brief their investigations with them.

As my academic adviser Sutton (2012) stated:

> *"Consider the value in peer review where staff/employees routinely ask respected peers for their opinion of important elements of their work. Take every possible opportunity to connect people; collectively they will create new knowledge." (Sutton 2012, p.3)*

We always had officers eager to attend these peer reviews. The success of this initiative was probably best demonstrated by there being at least two charges, one for murder and another for administering a noxious substance. These came as a result of the peer reviews. In response to the questionnaires that were completed for me by the sub-group one of them stated:

> *'The collective knowledge and experience around the table amounted to a consultancy that (very nearly) money could not buy. This was a national police resource that should continue to be developed and nurtured'.*

For a number of years I led and chaired annual conferences for other ACPO groups. One of these was the ACPO Child Protection conference in which I included sessions on child deaths. The Family Liaison conference also included cases that involved the investigation of child deaths.

I recognised that there was a gap with my child death ACPO group not holding a conference. I thought that this was an ideal vehicle to facilitate greater learning, not just within policing, but across all of our partners that worked with the police on investigating child deaths. I appointed an organising committee with myself as chair. My goal was for us to always include inputs, not just from SIOs, but also medical expertsI was .and lawyers , to a certain extent, not surprised by the willingness of everyone we approached to be involved.

The conference was held over two days, and included in the audience a number of partners. The feedback we received was exceptional, not only from the police officers present, but also all partners. There was a strong request for this to be an annual event. After a small hiatus the conference is now held each year. Although I still attend, I am no

longer part of the organising committee. I am delighted that others have continued with my original initiative and see the value in this as another strand of development for the national investigating child death community.

I am still heavily involved in changing national practice in relation to investigating child deaths. I will expand in the next section detailing my public works.

Since leaving the police service I have had an opportunity to be involved in child protection from a much broader perspective. I was given the opportunity to become the national police representative on a new Government initiative to coordinate child protection, called, the National Safeguarding Delivery Unit. This unit came about as a result of a recommendation from Lord Laming's Inquiry following the death of Peter Connolly. He describes the proposed unit below.

> *"Therefore a National Safeguarding Delivery Unit should be established that can work flexibly to take urgent action to challenge and support local services to improve provision for children and young people. The remit of the NSDU should include: Raising the profile of safeguarding and child protection across children's services, Health and police; Supporting the development of effective national priorities on safeguarding for frontline services and the development of local performance to drive these priorities; Leading a change in culture across frontline services that enables them to work more effectively to protect children." (Laming 2009, p.70-71)*

This was a wonderful initiative, and I felt very privileged to be a part of it. It gave me an opportunity to influence, on behalf of policing, all partners that were members of the NSDU. Likewise, how we in policing, were able to further improve our child protection practice.

When the coalition Government came into power, they disbanded the NSDU. Whether I agreed with the decision to disband or not, I found the ruthlessness of how a Government changes over to be deeply unsettling. I am sure civil servants become hardened to it, but they must have had a similar feeling to me the first time it happened to them. However, the new Government asked that I represented policing for them, as a key member of Professor Eileen Munro's review of child protection. I have been involved in areas out of my comfort zone. A good example of this is where I led on the review of care proceedings. I

had little past experience of family courts, as almost all my area of expertise was in the criminal court. This really challenged me to think wider on which process was the best for the child and how best to run parallel processes. Although, I was undoubtedly a police officer that thought broader than prosecution being the only means of protecting children, my thinking was pushed broader still by my research into care proceedings. This was demonstrated by the looked after children we consulted with, and their feedback to me/us. My findings were published in both the interim and final reports.

Most reviews are conducted after a high profile death has taken place, and as Rose and Barnes (2008) highlight below, this has concerned professionals.

> *"Understandable concern has been expressed by professionals, local government and external commentators about the influence of individual high profile serious case reviews and public inquiries. It has been feared that they may lead to knee jerk responses, particularly when they result in media and political pressure, and that their impact may be both disproportionate and inappropriate. The checks and balances within the policy process mediate this danger to an extent. One policy official described the merit of building in a 'gestation period' so that a considered policy response could be delivered." (Rose and Barnes, 2008, p.58)*

The 'Munro review' was meant to be different, as it didn't neatly follow the tragic death of a child. Professor Munro has been a professional social worker, and is now widely acknowledged as a worldwide expert in child protection. In her final report Munro (2011b) highlights the below comments.

> *"Whilst child protection almost always attracts the general public's attention following a high profile serious incident, the intensity of that reaction places enormous pressure on Government and professionals to act and act quickly in order to improve practice. This has meant that the majority of reform to the child protection system over the past forty years has taken place in the midst of a clamour for change. This review is unusual in that it is being conducted in a less emotionally charged atmosphere." (Munro E, 2011b, p.17)*

I will freely admit that I, and I am sure, other members of the team, did not feel that the atmosphere was any less emotionally charged, than if we were carrying out the review following the tragic death of a child. In the space of 11 months, against a backdrop of huge political and nationally practitioner expectation, the review produced three reports. The

final one, made a whole raft of recommendations, which have hopefully contributed nationally to the safeguarding of children.

Another key achievement, not just for myself, but all criminal justice partners, came about through the amendment to Domestic Crime and Victims Act 2012. Many years earlier I had been the police representative on the criminal law review of non-accidental injury to children and vulnerable adults. This group had recommended that as well as where a death had occurred, serious injury was also included in any prospective future legislation. At that time it wasn't in this legislation as the Law Commission would have wished. This really niggled away at me as many alleged offenders were possibly getting away with the crimes where death couldn't be ascertained, but serious injury had resulted. As the ACPO lead I visited the Department for Children Schools and Families, to try and see if I could encourage them to support plugging this gap. At that time, they felt that it was too early in the life of the then, current legislation to consider making any amendments. I found this very frustrating but knew another opportunity would arise.

This opportunity came two to three years later, when Dave Marshall (who equally wanted to change the legislation) persuaded an MP, Sir Paul Beresford, to take out a private members bill to make the amendments. I was by this time working on the 'Munro review' for government. I met with the civil servants from DCSF and the Home Office. Dave and Sir Paul met with the Justice Minister (Jack Straw) and the DPP. We also managed to get the NSPCC, as a voluntary sector pressure group, to support us. The NSPCC were the key pressure group that helped to bring in the original legislation. In their publication (2003) 'Which of you did it' they highlighted the issue of physical assault to children.

> *"Each week three infants suffer serious injury or death when in the care of adults who should be protecting them. The statistics show that less than a third of the cases reported to the police result in an adult actually being prosecuted to conviction." (NSPCC, 2003, p.11)*

I felt, as did Dave, Sir Paul and Lord Laming, that we had an opportunity here to improve this statistic by the bringing in of the proposed new legislation. This way of working, in consensus, with the other three, I found to be really effective. It was for me personally rewarding, to see a great parliamentarian (Sir Paul) at work.

Through the skill of Sir Paul as a parliamentarian and our use of Lord Laming in the House of Lords, the amendments are now legislation. I feel very strongly, that this amendment to this legislation is something that will now ensure justice for a large number of children in England and Wales over the years to come.

In the last section, I will explain how, through my other work as the Chair of a Local Safeguarding Children Board, (responsible for the rapid response of professionals to child death) and through carrying out serious case reviews into child deaths, how I try to ensure that we investigate child deaths with sensitivity, whilst at the same timehaving an .set-investigative mind

3. Public works

3.1 ACPO Guidance on investigating child deaths i) Publication 2006 ii) Publication 2011 iii) Publication 2014

> *"The utility of the policy and legislation has been pressed on me by contributors throughout this report. In such circumstances it is hard to resist the urge to respond by saying to each of the key services, if that is so 'NOW JUST DO IT!' With greater ambition and determination I am sure it can be done. Now is the time to prove that the well-being of every child and young person really does matter."* Lord Laming (2009, p.6-7)

Lord Laming, when he carried out his review after the death of Peter Connolly, made the above statement within his report. There are lots of policies in place in agencies to keep children safe. The three words that impressed me the most are 'Just Do It'. I have used this phrase many times when presenting to multi-agency audiences on investigating child deaths.

There are many reasons behind why guidance is produced, in particular in my case, where it was national guidance. One reason could be, to reduce the existence of a post code lottery in relation to investigating child deaths, so that wherever you reside in England or Wales, in terms of a response to child deaths, it is a consistent response. As mentioned previously, Baroness Kennedy (2004) chaired a working group to formulate a national multi-disciplinary process. She states in her report the need for this protocol.

> *"There is still great variance around the country as to how a sudden infant death is handled by doctors and the police. There are 43 police forces in England and Wales, each with their own procedures, and there are 28 Strategic Health Authorities. There are also many social service departments. The geographical remits of these different agencies do not coincide with each other and they have different operational methods. The coroners who sit within these areas can also have quite distinct ways of working. This diversity creates a very complicated patchwork in which good practice can often be found, but stories of insensitivity and failure are still sadly and angrily being told: parents being treated with inappropriate suspicion, numbers of policemen in uniform arriving shortly after an emergency call, babies being taken straight to mortuaries and parents being given too little information or information that is communicated with little sensitivity. The need for*

a compulsory national protocol for the investigation of a sudden unexpected death in infancy is now vital." (Kennedy, 2004, p.2)

As mentioned in the previous chapter, when I became the national police lead for the investigation of child deaths, it was made clear to me that any changes to policies and procedures were my responsibility. All other agencies would look to me for the police response on a national level. An example of an urgent need for changes and clarity in police thinking was that, the police service thought that these investigations only applied to infant deaths. Even with infant deaths there was confusion whether this only dealt with children who were younger than 12 months old, or, as applied in some police forces, less than two years old. I was able to clear up the confusion with it being an officially recognised definition of less than 12 months old. This put the police out of step with the medical professionals and no consistency around the country. Brandon et al (2013) describes what SUDI means.

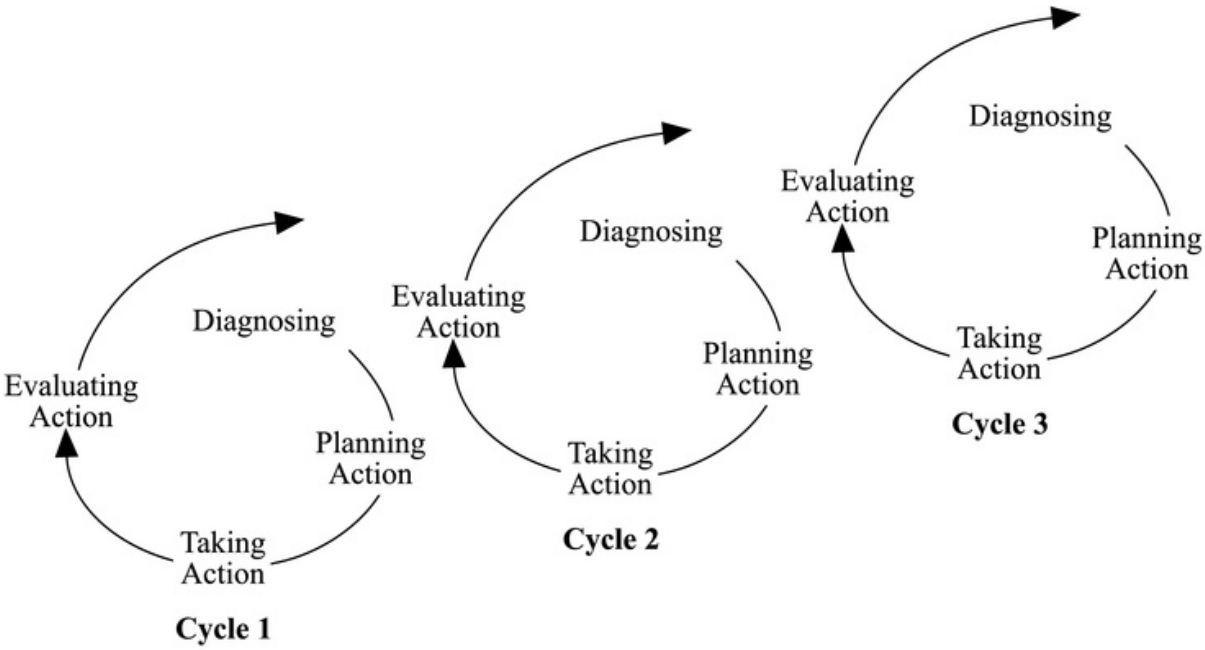
"The term SUDI, sudden unexpected death in infancy, can be defined as the death of an infant (aged younger than one year) which was not anticipated as a significant possibility by any professionals or carers involved with the child 24 hours prior to the death (Fleming et al 2000).Sudden infant death syndrome (SIDS) is a subcategory of SUDI, where the cause of death remains unexplained following a thorough case investigation (Willenger et al 1991)". (Brandon et al 2013, p.59)

Within the Government and other agencies, it was clear that child death procedures applied to all children under the age of 18yrs old. I needed to make some major adjustments to the police service thinking in relation to how they dealt with all child deaths under the age of 18yrs old. I used my role, experience and connections to ensure that the problem solving of these issues obtained the necessary influence to develop the practice based changes.

I will now reflect on what I did, why I did it, and what sources I relied on to formulate the first and subsequent sets of national policing guidance. Looking back it is clear that I was engaged in action research and the process that I carried out, fits one described by Coghlan and Brannick (2001) in their book 'Doing Action Research in your own organization': their process is described in Figure 3. However, the framework to a certain extent doesn't adequately describe the complexities of carrying out action research in large organisations such as national policing, or multi-disciplinary organisations. In essence though, this

framework is helpful for anyone doing action research and it is a useful process to guide my reflective assessment of what I did, or didn't do.

Figure 3



Source: Coghlan and Brannick (2001) p. 19

I shall now use the above diagram to describe the process that I carried out as I believe that it demonstrates the validity of the methods I used. In an ideal world I might have been more systematic in defining research questions, a methodology, data sources and analytical methods. However, I was dealing with real life problems that needed to be resolved in real time.

I feel that Jean McNiff, in her editorial to the book on 'Value and Virtue of Practice-Based Research', fully supports my approach and the results it produced, by the publication of the national guidance. McNiff (2013) states:

> *'All research programmes are guided by specific methodological steps: identify an issue, explain why it is an issue, gather data, consider actions taken, generate evidence, test the validity of the emerging knowledge claims, explain the significance of the research, modify practice and thinking in light of the evaluation. From an action research perspective, the 'end' of the enquiry turns into the beginning of a new one; the process is ongoing, a continual process of asking*

questions and seeing possibilities in everything, which is the very nature of a life of enquiry.' (McNiff, 2013, pg. 2)

She points to the cyclical nature of action research and its role in questioning 'eternal truths' and accepted practice. I can now see that my writing, improving and updating of the guidance was informed by my own learning and from the developing professional approach that the guidance produced within the police service.

Looking at the Cycle in greater detail the 'diagnosing' step is quite clear as it refers to the fact that there was to be in place a statutory procedure in England for investigating all child deaths. I, as the national police lead, had the responsibility to make sure that the police conformed to this statutory guidance. I established that there were a number of gaps within policing that needed to be filled by the new national policing guidance. There was in existence a chapter written by Dr Fox (retired 2005) four years earlier (2002). Even though it was pre- statutory guidance, it was a good starting point for me. This initial guidance had a variable uptake nationally by police forces as established by the FSID research. A research project (Reeder and Nicol, 2003) was undertaken on behalf of the Home Office and was more positive in terms of looking at the take up of the guidance it stated that:

'The overall picture shows high levels of awareness of the guidelines at a senior level and good uptake into policy, but lower levels of application in practice. A variety of factors were identified as contributing to the failure to change practice'. (Reeder and Nicol 2003 pg 6)

The challenge for me now in my planning of what action to take was to ensure that the gap was filled and that in doing so it brought about a change in practice.

In the planning action part of the framework my focus was the identification of the source documents that I would rely on. Two key one's were the statutory guidance, 'Working Together to Safeguard children '(2006), and 'Sudden Unexpected Death in Infancy' (2004) Baroness Kennedy. I had completed a Master's degree where my dissertation was titled 'Should all child deaths under two be investigated as suspicious?' As a result of my studies for that degree I had an extensive, literature knowledge base to inform my thoughts. I also had to take into account the ACPO guidance on core investigative doctrine and a draft ACPO Murder Investigation Manual. Besides all of these things I had my extensive personal investigative experience of dealing with child deaths.

The taking action part of the framework was my writing a first draft guidance. This did take a few weeks, due to my many other day to day and national commitments.

The evaluation part for the guidance was the key part for me. I circulated the draft guidance via the ACPO Investigating child abuse working group to ensure that practitioners, as well as strategic leaders in England, had a chance to give me feedback. I felt in addition to this I needed to consult multi-agency partners so enlisted two paediatricians (Fleming and Sidebotham), one paediatric pathologist (Wright), one forensic scientist (Lamb) one Forensic pathologist (Cary), and the chief executive FSID (Epstein). An additional purpose of this circulation was to deal with some of the ethical issues of dealing with grieving parents; I had become all too aware of the importance of an ethical perspective through personal experience and also from my literature research. I had to deal with a series of ethical dilemmas that affected both the police paradigm and the sensitivity to the parents. Good examples of this are parents holding the baby (police evidence), taking memento's (police evidence-when best to take these). Asking for blood samples from the grieving parents (drugs and alcohol). I knew I had to compromise the police approach to ensure that we were being both ethical and sensitive in our dealings with parents.

I instinctively knew that to bring about change I needed to engage in as wide a consultation as possible. I now see that in doing so I was making use of double loop learning as described by Argyris (1977) within his paper in the Harvard Business review on 'double loop learning in organizations'.

> *'The emphasis would be on double loop learning, which means that underlying assumptions, norms, and objectives would be open to confrontation. Also any incongruities between what an organization openly espoused as its objectives and policies and what its policies and practices actually were could also be challenged.'* (Argyris, 1977, pg. 13)

I feel that I was open and that I examined all of my assumptions and core principles as I grappled with the construction of the guidance and that I embraced a critical approach by opening the process to be confronted and challenged by others. These others were not only from within policing but a wide range of other multi-agency partners.

On receipt of the feedback I conducted further evaluation of the comments and then came full circle to 'diagnosing' what else needed to be done, in order to complete the guidance. This cycle then took place once more, but the planning action didn't require me to find, or use, any additional source documents.

The guidance, along with the Murder Investigation Manual was published in 2006. After this I needed to ensure that all police forces in England adopted the guidance and Chapter 7 from Working Together by 1st of April 2008.

When I was commissioned to carry out the authoring of the 2011 version, I firstly addressed the diagnosing part of the action research cycle. It was clear that although a number of changes were now required, due to the publication of 'Working Together 2010, the 2006 guidance was still a sound document. I had personally and professionally developed in this time, having worked as part of the Government team on the 'Working Together 2010' guidance. I had also spent 12 months working as a part of Professor Eileen Munro's team that reviewed child protection in England; I had personally authored several sections of all three of her reports. I had also written an article jointly with Dave Marshall on investigating child deaths (cited as one of my public works). There were a number of other recently published articles, and a book on unexpected child deaths by the two paediatricians with whom engaged for the development of the guidance: Drs Sidebotham and Fleming. These, including my own personal experiences and professional development were my data sources and the foundations to build this second iteration of the guidance.

I found that my personal development whilst on the 'Munro review' really helped me as a reflective practitioner to not become too specialised as Donald Schön (1983) describes in his book the 'The Reflective Practitioner: How Professionals Think in Action':

> *'There is a suggestion that a professional might become so familiar with a given field of expertise that s/he ceases to be surprised and hence "his knowing-in-practice tends to become increasingly tacit, spontaneous and automatic". A negative effect of this is that the person's practice, rather than becoming specialised, can become parochial and narrow of vision.'* (Schön, 1983, pg.61)

The comments above are important to me and how I work. In terms of policing, I am keen that the investigation of child death is not seen as a 'silo' practice. I am keen that it is not parochial and narrow of vision. It is still an investigation, albeit with a specialism to it. Officers that carry out these investigations into child deaths also carry out many other forms of investigations. I do not want them to forget their paradigm of professional practice and training. I just want them to be aware of the nuances involved, like acting with sensitivity is important.

In terms of taking action, I produced a draft guidance, which was then circulated to the sub-group members and by them to relevant officers within their regions for comment and feedback. I used the same multi-agency partners as before, but included now the policy lead from Government for child deaths.

The evaluation this time took place with two others, Dave Marshall and John Fox. I felt this was appropriate so as to use both their knowledge, but also their support, in relation to any changes I needed to do to make this guidance fit for purpose. I found there was a real value of this collaboration and co-creation in the actual process of compiling the guidance. It helped with my self-appraisal of what needed to be done. It also made sure that reflective inquiry was intertwined with this. Dave and John were the two others who were with me delivering the training course to the 'critical communities' of operational officers. It gave me a greater understanding of the current challenges faced at the operational level. These two colleagues brought for me new perspectives from their engagement with others.

I then went through the action cycle again in order to get the document through the various ACPO bureaucracy hurdles, receiving feedback from other interested parties from different ACPO groups. It was then formally accepted as ACPO policy. This took approximately nine months to achieve.

The third, and current guidance I authored by a much shortened process to complete the document. On the diagnosing part of the cycle, I analysed what needed to be done to comply with the new 'Working Together guidance' 2013. I also found on this review that the parallel proceedings section didn't adequately cover care proceedings. My planning action therefore, was to find someone with the necessary skills to be able to help me to author this section. On taking action, I completed a draft of the guidance and circulated it within the police service, but not as widely as the previous occasion, as the changes to practice were negligible. I did however; source a family court lawyer, who helped me

greatly to edit (co-author) the parallel proceedings section. The evaluation then meant that I had little changes to complete to the draft guidance. The cycle then began again with sub-group members making very few comments, and the guidance proceeded successfully through making the guidance national policing approved practice guidance.

I will now look at further aspects for the production of each publication.

i) Publication 2006

As mentioned earlier the police had in place at this time its first investigating child death guidance, which was written by John Fox in 2002. This guidance only dealt with infants (under the age of 12 months). In 2006 as the national police lead (a role, at the time, I carried out by myself without the support of a sub-group) I quickly realised that large gaps had now been created by the publication of the Baroness Kennedy report. I was sitting as a member of her reconvened group on behalf of the police service, which meant I was at the leading edge of practice. It was clear to me that the police service needed to understand and implement her recommendations. Another gap had developed, where, after the tragic death of Victoria Climbé, Lord Laming produced a report from which two key developments occurred. One was the introduction of the Children Act 2004, making it a statutory duty for all professionals to safeguard and promote the welfare of children. The second was in 2006, where the Government re-issued the Working Together to Safeguard Children statutory guidance. Within this was the multi-agency guidance included in chapter 7 on responding to child deaths.

The Government through this new Working Together was positioning and emphasising the multi –agency approach required by all agencies when dealing with child deaths. There is no doubt, in my view, that their key driver was the death of Victoria Climbé and the core issue here was that agencies just hadn't worked together. The police were not immune to this Government statutory guidance, and my role was to ensure that the police service nationally changed their method of working to fit in with the thought paradigms that were operating cross Government at the time, as drivers for change. I had to ensure that the police service rightly played their equal part in the multi-agency approach to investigating child deaths. The period that Rose and Barnes (2008) looked at was 2001-2003; however, their analysis took place following a huge period of change in how we nationally dealt with child deaths. They make the following comments.

> *"Other studies reinforced policy thinking about the need for reform, such as Fleming and colleagues' earlier work on sudden unexpected infant deaths (Fleming et al 2000) The cumulative impact of these findings suggested not just a radical overhaul of the safeguarding system was required but a new and more open approach to quality and performance that would lead to the review of all deaths in childhood." (Rose and Barnes, 2008, p.27)*

> *"The conclusions reinforced the difficulties experienced in working within and across professional agency boundaries. Without rehearsing again the well covered territory of interagency or cross-boundary working, there is a wealth of literature that emphasises how difficult it is to achieve effective interagency working in practice and yet how fundamental it is to work with children and families."(Rose and Barnes, 2008, p.43)*

This really emphasised the difficult task that I had to get one of those interagency partners -the police- to take their equal part in the investigation of child death, and the guidance was one of the ways to achieve this.

There had also been at the time of my authorship of the first publication, and in fact all of the publications, a real concern in relation to non-accidental head injury (shaken baby syndrome). This concern was so great, as Williams (2010, p.402) describes, that Margaret Hodge MP (Children's Minister) ordered a review of 30,000 cases in the family court. At the same time the Attorney General, Lord Goldsmith, had ordered a review of cases in the criminal court. At the completion of his review early in 2006, he made the following comment in the House of Lords.

> *"The House will recall the high-profile cases of Sally Clark, Trupti Patel and Angela Cannings, all of which related to allegations of unlawful killing of children. It was following these cases that I undertook to review cases where a parent or carer had been convicted of killing a baby or infant under the age of two in the past 10 years. While I believe that, after careful review, the vast majority of shaken baby syndrome convictions do not give rise to concern." (Goldsmith, 2006, p.1080)*

As well as the information from the Working Together guidance, I knew I needed to include a section on non-accidental head injury, as an additional partner that the police need to work with is the criminal court.

I knew how the police service worked and that they needed policies and procedures in order to get them to change practice and guidance on how to carry out their roles. Kotter (2014) however describes how this may impact on the speed required for me to change policing practice.

> *"You find that policies, rules, and procedures, even sensible ones, become barriers to strategic speed. These inevitably grow over time, implemented as solutions to real problems of cost, quality, or compliance. But in a faster moving world they become at a minimum, bumps in the road. "(Kotter, 2014, p.8)*

Originally, I was working by myself as the national police lead and the police expert on investigating child deaths. I set about writing the police guidance to fill the professional void, now opened up by both Kennedy, and in particular the 'Working Together' chapter, as I saw this rightly or wrongly as my responsibility. Fortunately, I had considerable depth of knowledge and experience of the complexity of dealing with these deaths, so I compiled the guidance myself over a period of several weeks. I circulated the guidance to all police forces in the country via the ACPO child abuse working group. As stated earlier I also used a number of multi-agency professionals whom I was now working with, through the Baroness Kennedy re-convened group. As well as medical professionals, for example, Paediatricians and Pathologists, I also circulated the draft guidance to a charity, the 'Foundation for the Study of Infant Deaths'. As I have already highlighted earlier in this context statement, by my research and the formulation of this guidance, that I was carrying out action research. As mentioned by McNiff and Whitehead (2010) below, I of course couldn't do this by myself; I needed the help of others.

> *"Action research demands that you work with others. You are doing your research into your practice, but your practice is about how you are with others, and is carried out in company with others. (pg.70) Your validation group is made up of colleagues, participants, principals and managers, and other sympathetic people who you feel would be able to comment fairly but critically on your research (pg.69). Action research is of course different because it is not only about working with human participants, but also about trying to influence their thinking so you need to be extra aware of ethical issues(pg.82)." (McNiff and Whitehead, 2010, p.70, 69, 82)*

My reasoning for this method of wide consultation was to get an inclusion of cross agency thinking, also to be clear I was fully sighted on any ethical issues that may arise. I received a

number of responses from all over the country, and, as result of this, I went through each response and decided whether to change what I had written, or not. Elder and Paul (2013) describe how my method of changing my original opinion could be acknowledged as good critical thinking.

> *"A hallmark of a critical thinker is the disposition to change his or her mind when given a good reason to change. Good thinker wants to change their thinking when they discover better thinking. In other words, they can and want to be moved by reason. "(Elder and Paul, 2013, p.73)*

> *"To become more reasonable, open your mind to the possibility, at any given moment, that you might be wrong and another person might be right. Be willing to change your mind when the situation or evidence requires it. Recognise that you don't lose anything by admitting that you were wrong; rather you gain in intellectual development. "(Elder and Paul, 2013, p.74)*

When I critique how I prepared and completed the national guidance in 2006, I feel that the document I produced was sound, as I had used good foundations in the two multi-agency guidance's (Kennedy and Working Together.) This coupled with my investigative knowledge (I felt from this point of view that the draft was of a good standard.) However, it could be argued that the people I used as the external cross agency consultants to policing, could be described as like-minded people to me. Two of these are Drs Sidebotham and Fleming, who comment in their handbook on 'Unexpected Death in Childhood' (2007) about cross agency working.

> *"Whilst different professionals may approach the death of a child with differing priorities and perspectives, it is very clear to us that these perspectives, far from being conflicting are in fact complimentary. No one professional has a monopoly of knowledge or skills and we do rely on each other in our responses." (Sidebotham and Fleming 2007, p. XI)*

My answer to this would be that as the national police lead, the people I came into contact with, like Sidebotham and Fleming, were only like-minded, because they were regarded by their organisation or discipline also as a national lead, or, had a high level of expertise in this field.

I was quite open to listen to views, as I was keen to ensure the guidance was accepted nationally. During 2006 I chaired a national conference for the investigation of child abuse.

Whilst there I had a conversation, the result of which I was unaware of until some years later. When I attended (2013) a retirement event for a Detective Superintendent from London, he mentioned in his retirement speech that he had initially met me at that conference. He had been told to speak to me about three changes to the draft guidance that the police in London wanted. I spent some time with him and said that I could accommodate two of the changes, but not fully the third. I gave him reasons, as to why this could not be accepted. He had been very London centric, but now saw that there was experience and knowledge outside of the capital. He thought that my leadership of this area of business was, in his view, highly effective and appropriate. Adair (2001) highlights the importance to leaders of getting these chance meetings and conversations right.

> *"For a good leader is sensitive to the touch of others in the course of a busy day, the little unrecorded meetings, or chance encounters in a corridor, each one of these brief encounters in its small way is moment of truth . Each one, too, calls upon the leader's resources of time and energy. Yet touching is a two way process; leaders can also be inspired or uplifted by a word or spontaneous act."* (Adair, 2001, p.143)

I am glad that I made the time for the Superintendent, as it was important that London bought into the guidance as they make up over 20% of the police officers in England and Wales.

The guidance was published by being included in the Murder Investigation Manual and was widely circulated, marketed and incorporated into policing. I did, (at the time) and have many times since, presented publically, not only to police officers, who to a certain extent are a safe audience, but to others in different disciplines, which challenged some processes but were convinced by my views. The strength of having consulted widely came to the fore here.

ii) Publication 2011

We will now look at the second subset to my authorship of national guidance. The writing of this took place in 2010/11. The fact that I was commissioned to be the author of the guidance, showed, I believe, my enduring impact as being the lead for investigating child deaths. I had at the time just left the police service as an officer. I was still heavily involved in setting government guidance, being a consultant to the government department that deals with safeguarding children. I helped them to bring out the revised version of 'Working Together to Safeguard Children' in 2010. A lot of my input was on updates to the

investigating child death chapter (7). As I have already mentioned, I was a key member of the team that brought out a multi-agency review of child protection in England 'The Munro review'. The Munro review was very concerned with the length of statutory guidance, and in her first report, (2010) which I was working on at the time I was writing this public works, stated.

> *"Professionals working with children and young people in social care, health, education, and police services have access to detailed guidance and procedures to inform the way they work together to safeguard children and young people. Parton(2010) reports that the first formulation of Government guidance in 1974 was seven pages long, whilst the latest statutory guidance, published in 2010, has 390 pages and makes references to ten other pieces of supplementary guidance that provide a further 424 pages. "(Munro, 2010, p.10)*

Further comment was made by Munro after research in the next report (2011).

> *"Research by Eisenhardt & Sull, (2001) has shown that thick manuals of results can be paralysing because they prevent managers from moving quickly enough to seize opportunities." (Munro, 2011a, p.90)*

Or the comments made in the final Munro (2011b) report, when quoting Klein G (2009).

> *"Procedures can lull people into a passive mind set of just following the steps, and not really thinking about what they are doing. When we become passive, we don't try to improve our skills. Why bother, if all we are doing is following the procedures? So the checklists and procedural guides can reduce our motivation to become highly skilled at a job." (Munro, 2011b, p.40)*

As I was part of the review and party to the discussions taking place, I was able to understand the debate as well as anyone else. However, I just knew due to my experience of being the national policing lead that the guidance for child death had to be as detailed as possible. This was because of in the main, the multi-agency nature of these investigations. Paradoxically, the 2011 guidance was in fact substantially longer then my 2006 version.

At this time I was still a member of the ACPO investigating Child Death sub-group, and after I handed over to the new chair, I asked him if the time had now come for me to stand down. He felt that it would be a huge mistake for the group not to continue to make use of my experience, knowledge and influence with the multi-agency partners.

As part of my research for this doctorate and looking at the impact on others of my public works, I surveyed the sub-group members that were with me for the majority of the time. One of which has now taken over in 2014 as the chair of the group, and is the new ACPO lead, and two others are also still on the group. Five of the group of eight who answered the questionnaire (there were two other members that I couldn't find) when highlighting the question 'key things we achieved' stated that one of them was the national guidance I was the author of.

As Lord Laming states in the quote at the start of this chapter, that policies and procedures are in place. As someone who was, and still is, the author of the police part of the safeguarding guidance, I felt it incumbent on me, to make sure it was up to date and relevant.

As mentioned above, I was commissioned by the Homicide Working Group to be the author to update the guidance that I had authored, published and brought into practice in 2006. Since this time, one of the national child death activities I carried out was representing the police service on a Government Working Group to ensure that all police forces implemented Chapter 7, Working Together. My 2006 guidance was a huge step towards enabling the police service to do this. However, for me being involved in this cross discipline working really changed my personal paradigm from policing to think much wider. The Government published the findings from this group in a document 'Preventing Future Deaths'. This was beneficial to me as I used it as one of the reference points for updating the guidance. There were also a few updates that took place in the updated 'Working Together' 2010. A very good reference book publication (Unexpected Death in Childhood- A handbook for practitioners') had also been published, and was authored by two of the paediatricians whom I use as my consultants in the medical field, Dr Peter Sidebotham and Dr Peter Fleming.

Within the ACPO group, we had now moved onto the structure that I had established as a sub-group of the Homicide Working Group, with representatives from all areas of the country. I could now count on the sub-group representatives as my national network, into not just senior managers, but the frontline workforce, to assist in a wider consultation. This actually wasn't as successful for this guidance as I would have hoped, as I describe later. However, as Reason (2006) describes the original purpose of the sub-group, grew and changed as we developed our contribution, influence and impact nationally.

> *"Because action research starts with everyday experience and is concerned with the development of living, situational knowledge, in many ways, the process of inquiry is as important as specific outcomes. Good action research emerges over time in an evolutionary and developmental process, as individuals learn skills of inquiry, as communities of inquiry develop, as understanding of the issues deepens, and as practice grows and shifts changes over time." (Reason, 2006, p.197)*

Over the next few weeks I formulated an update to the guidance (almost) as a re-write, but still keeping at its core, my initial guidance. I felt that I had really matured in my writing of national guidance, and was confident I had in place the wider consultation networks to deliver a successful product. The next stage was to circulate this guidance to John Fox and Dave Marshall and receive back their initial feedback. I updated the draft then circulated it via the national sub-group for them to ensure relevant people within their areas were allowed to see, and to comment back directly to me. I was in the first instance able to independently evaluate and critically reflect on what improvements to the guidance were needed. I used the same group of multi-disciplinary professionals that I had the first time to give their comments. I also included (this time) the policy lead from Government. On receiving the feedback, I organised a day for John and Dave to join me to work out what changes I should make. This was a long but successful session and the use of these trusted colleagues helped me to do a co-creation model.

The guidance was then put to the sub-group; I presented it and it was accepted. It then went to the Homicide Working Group from whom I received a little bit of further feedback which I was able to resolve. Finally, it went through the ACPO bureaucratic mechanism to become the guidance used by police officers in England and Wales for the use of all officers investigating child deaths.

However, at one of the next meetings of the sub-group, two members, who hadn't been at the original sign off meeting didn't feel it had been agreed and suggested more discussion. I unfortunately wasn't present. If we look at the quote by Elder and Paul (2013) below, maybe I should have had more dialogue with the two individuals concerned.

> *"Good thinkers value thinking within from opposing viewpoints. They value gaining new insights and expanding their views they appreciate new ways of seeing the world they don't presume their perspective to be the most reasonable one. They are willing to engage in dialogue to understand other perspectives. They don't fear*

ideas and beliefs they don't understand or have never considered." (Elder and Paul, 2013, p.55)

I felt I had done enough of this already, valuing other peoples thinking, and we had just progressed to it being accepted as National Practice. Maybe, because I was no longer the leader of the group, I felt I had completed as much dialogue as was needed. I convinced the chair of the group that the discussion and consultation had been held, and we now needed to accept what we had, even if it didn't fully please all of the people. I fully accepted the ethical issues of not everyone being fully engaged, but the compromises had been made. This he accepted, and no further changes were required. The mechanism to get guidance accepted through ACPO is, in my view, extremely bureaucratic, and very long winded.

iii) Publication 2014

In April 2013 a new version of 'Working Together' became operational. The guidance from 2011 was therefore already out of date. I had helped to consult on this new 2013 version of 'Working Together'. I did this through working independently and through the sub-group trying to ensure that the guidance was still quite prescriptive, in relation to the chapter on investigating child deaths. We were fully aware that the Government direction from Ministers, was to strip out much of the national direction, and let areas decide what was best for them. This, in mine, and others views was not helpful when trying to achieve consistency across the country. Sidebotham (2012) describes what is required in terms of guidance, in particular in an age of austerity.

"Senior Executives and managers with responsibility for developing local policies and procedures need clear national guidance to draw on to ensure consistency, high standards and accountability. At the same time frontline practitioners need accessible practice guidelines, so they know where they stand and how to act appropriately to safeguard and promote the welfare of children." (Sidebotham 2012, p.313)

Whether by me, or others, having the necessary influence, the detail in chapter five, which is the one that now deals with child deaths, is more in depth than any other section, or chapter, anywhere else in the document.

One of the things I hadn't given much thought to before I got to the point of this refresh, was in relation to thresholds for intervention. Since working for Government, and being a

LSCB Independent Chair, I had developed a much broader view of safeguarding in general. History has taught us that when thresholds go up, children slip through the net for a timely intervention. Likewise, when they go down, far too many children get taken into State care, as was the case, for example, in Cleveland in the 80s, and after the death of Peter Connolly. Taylor and Russell (1939) developed a model that shows this really well. Munro (2010) included this in her first review report.

> *"The Taylor-Russell diagram helps to illustrate how trying to reduce false positives (over-estimating risk) inevitably increases the rate of false negatives (underestimating risk) other things being equal. The two axes measure the degree of actual abuse and the assessment of risk. A low threshold for intervention produces a high rate of false positives while, conversely, a high threshold leads to a high number of false negatives, missed cases of serious abuse." (Munro, 2010, p.22)*

I remember our discussions on the Munro review quite clearly in relation to this, and it was quite clear there is no magic formula on when to intervene. However, I was mindful, that both national and my police guidance needed an almost identical response to all unexpected child deaths. I was though, throughout many years, fully conversant and knowledgeable of the research that states that cases had been missed, and underestimations of death rates due to abuse occur, as the next two quotes show. The first quote is by Friedman (2010), and the second by Levene and Bacon (2003).

> *"Underestimations of death rates, however, pervade the literature. There are hidden pregnancies and hidden corpses, medical examiner misjudgements of homicide as being accidental or natural (eg, sudden infant death syndrome) or undetermined, and unwillingness to place responsibility on a grieving parent." (Friedman, 2010, p.10)*

> *"It is impossible to be certain of the frequency of covert homicide among sudden infant deaths. By definition covert homicide is hard to identify, either from the history, because the perpetrator acts in secret and conceals what has happened, or from the post-mortem examination, because there may be no diagnostic signs. In addition, the existence of a category of unexpected and unexplained deaths that result from natural causes, namely sudden infant death syndrome, offers an acceptable alternative explanation." (Levene and Bacon 2003, p.443).*

So with this in mind, and in evaluation of the negative impact that thresholds can have, I felt it important, that we still needed to include some prescription to officers' actions, in the first instance. My analysis and synthesis of this was to ensure as best as possible, all opportunities to identify those covert homicides are taken. At the same time, once those initial actions are taken, that some judgement takes place. We include in the training course (covered in the next section of public works) research by Mayes et al (2010) into suspicious factors that may help to raise appropriate suspicions. The investigative mind set was at the forefront of my thoughts at the time of writing the guidance.

With the sponsorship of another new ACPO lead, I set about revising and refreshing the national policing guidance, to ensure it matched this new chapter. This actually didn't take too much of a refresh. However, there were one or two clear gaps that I had identified that needed filling since my previous version. One of these was the parallel procedures section, with particular need to update the Family Proceedings element. I drafted the section. I had been, within the previous few months, present at a conference where a lawyer had presented on similar aspects of parallel proceedings. I had his contact details and sent him the draft as someone I regarded as an expert in this field. I felt that the police service could benefit from any advice he could give me to edit this section of the guidance. He suggested a few amendments and additions which I incorporated. I didn't on this occasion consult with any multi-agency partners, as there were very few fundamental changes that needed consultation, challenge or scrutiny. I added a couple of flow charts and key details from the new chapter 5. I also, through the National Crime Agency, added in forms to record information on the investigation of child deaths. These would help us learn lessons and develop our skills, and those of our multi-agency partners better in the future to improve how we deal with child deaths. I had been, amongst others, an adviser to the CPS guidance in relation to abusive head trauma. This followed on from the original controversies in 2003 (Sally Clark etc.) and included three stated cases in the court of appeal that had confirmed the prosecution approach. The author of the guidance Squibb-Williams on behalf of CPS (2011) thanked mine, and the group's involvement.

> *"A range of senior pathologists, paediatric medical experts, investigators, representatives from academia and professional bodies was involved in updating the guidance. This group has provided valuable insight into the complex spectrum of medical issues and scientific terms involved in these cases, and I would like to*

thank them for their involvement in the production of this updated guidance." (Squib-Williams K, 2011, p.1)

The sub-group members, when consulted, made no suggestions or changes. The guidance was then fast tracked to be published on what is now known in policing as Approved Professional Practice (APP). Although distributed, and used, to a certain extent by all areas; it was only published as APP in March 2014 (I submitted the guidance in June 2013 to the sub-group and made minor changes at the request of a higher level ACPO (Crime Business Area) in September 2013.) This guidance is the current one that policing uses and partners refer to. A review is due to take place in 2016. Although there are a few minor updates I would probably like to do now!

Impact

I feel it is important to consider was the guidance of which I was the author, on behalf of national policing, actually being used? What has been the impact of it becoming an integral part of procedures that are in place around the country?

In 2003 the FSID did a survey of every police force in the country and found that only 12 of the 43 had in place procedures to deal with child death. The 2002 ACPO guidance on infant death investigations clearly had made only little impact (in terms of influencing policy) across the country. I was keen when I took over the ACPO lead to plug this gap, spurred on by being a member of both the re-convened Kennedy group and the Governments 'Preventing Future Death Group'. As part of my research for this doctorate, (2014) I reviewed every police force and found that all 43 had in place investigating child death procedures. Although some of them were past the review date, they all had in place either the 2006 ACPO guidance or 2011 guidance.

As stated above, in April 2013, the Government issued a revised version of Working Together to Safeguard Children. It states in Chapter 5 (Child Death reviews)

"The joint responsibilities of the professionals involved with the child include: Responding quickly to the child 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." (DfE, 2013, p.79)

This is in once sense really pleasing; it is evident that the national policing guidance that I have produced is a key and integral part of statutory multi-agency guidance. I feel that this is a great endorsement of the impact of both the guidance, but also the role that police officers are performing every day, up and down the country, in relation to dealing with child deaths. However, the other part to this is the pressure on the police service to make sure the guidance is up to date and relevant. This responsibility still sits with me, even though I am no longer the ACPO lead, I was still the one to lead and author the two updates in 2011, and 2014. In fact the main reason I was spurred on to update the guidance for publication in 2014, so soon after the 2011 version is the above statement in 'Working Together', which states, 'current investigative practice'. I needed to ensure it was current on behalf of national policing.

The next area to critique in relation to that statement from 'Working Together' is 'locally agreed procedures'. For this doctorate, and to measure the impact of my work, I researched every local area in the country to see if it has a reference to the ACPO child death guidance within it. I know that the police service are aware, because of the guidance being issued to each force, it is also now on the College of Policing website, as, Approved Professional practice, but did local areas also include it?

There are 151 Local Authority areas. I used the methodology of searching their Local Safeguarding Children Board (LSCB) website to find their multi-agency child death procedures. Then, with a search criterion of either, ACPO or Police procedures/ guidelines, I researched each areas procedure, to see if it included the national policing guidance. A lot of the areas make use of a company called Tri.X. I know that after the 2013 version of 'Working Together', they updated all the procedures for the LSCB's that they have a contract with, to ensure areas were consistent with the current investigative practice from ACPO. The LSCB I chair also uses Tri.x and this was what they did for us. All of the areas did include police procedures.

A concerning point, which I think highlights my observations on the length of time that it took to put in place the 2011 update version, is, that a number of the local multi-agency procedures that only detail my 2006 version . However, the procedures also include Working Together and this would cover the updated procedures. We would, through the training course, have extensively covered the latest procedures for police officers, although we obviously missed some forces policy authors. It leads me to conclude that the marketing of the 2011 guidance either didn't take place or wasn't very successful with our

partners. I was no longer the ACPO lead, and, I think I took for granted, that the new ACPO lead would have marketed it and implemented it. I also have to appreciate that as the author I had closer personal ownership. The timing for getting the guidance published was also compounded by ACPO drowning in a plethora of different guidance and policies, as they were going through a rationalise process relating to them. Consequently the child death guidance may not have been at the top of their priority list. In my learning from this doctoral process, I found the below comments from Costley and Armsby (2009), that in future I should, and will, take into account on how best to market and implement guidance, or bring about changes, not just in policing but in all appropriate future work.

> *"Their research approach is linked to their professional work and their positionality within it. They need to access particular insider information, and inform and bring about significant changes to practice, and this can only usually be done if the candidate holds enough seniority to make organisational changes."(Costley and Armsby, 2009, p.349)*

There has been research already carried out in relation to the effectiveness of the guidance. This was carried out by Dr John Fox in 2008. As the then ACPO lead, I wrote the foreword to this publication, with the research being carried out on behalf of ACPO, NPIA and the University of Portsmouth. I do appreciate that since this publication, the training course (covered in the next section) has been run extensively around the country, and even more significant development, and adoption of procedures has taken place. However Fox (2008) states:

> *"The police response to SUDI has come a long way since the period up till the late 1990s. During that time there was no special training, no multi-agency protocol, and often little guidance given to officers about the need for sensitivity when attending the scene of an incident which by its nature, would usually be far more traumatic for a family than the sudden death of an older person."* (Fox, 2008, p.13)

The most pleasing finding from this evaluation is Fox's conclusion from his research.

> *"My research showed police officers overwhelmingly feel the police response to SUDI has improved a great deal since the inclusion of the specific document (The 2006 guidance) on the MIM (Murder Investigation Manual) cd-rom." (Fox, 2008, p.21)*

These comments are further supported by the research carried out by Vaughan and Kautt (2009).

> *"The survey of police forces examined the current uptake of ACPO guidance; it was shown that the focus at senior levels within the police service has improved significantly and that specialists are better supported in carrying out investigations." (Vaughan and Kautt, 2009, p.98)*

In the next sub-section relating to the training course I do provide comment in relation to feedback in terms of impact from other stakeholders and the frontline officers dealing with these cases. This applies equally to the guidance as much as the training course.

This critique I believe is a positive endorsement of the impact, in particular within the police service of my national investigating child death guidance.

3.2 ACPO national training course on investigating child deaths

'I hear and I forget. I see and I remember. I do and I understand.'

Chinese proverb

I need to start this section by being clear that, prior to being involved in the development of this training course, I had no previous experience, whatsoever, of what it entailed to construct any form of training course. In terms of my personal development, this course provided me with an insight into a new area. Although it was great self-development for me, this was not the reason; I embarked on this course of action.

In 2012 The Lullaby Trust (formally known as the Foundation for the study of infant death) published 40 stories from parents, or Grandparents, telling of when their child died. Within this publication a parent made the following comment.

> *"Two CID officers arrived. They were the coldest most arrogant people I have ever met in my life. One of the officers said to me. 'I know you're a bit under the weather today but we will need to interview you'. At this point my mum jumped in and said: 'Under the weather? She has just lost her son; how can she be a bit under the weather?"*
>
> *"I shall never forget those policemen. They made me feel as though they believed I had murdered my son. A year after Jon-Lee's death I made a complaint and I*

received a written apology on special headed paper saying the two policemen involved had been spoken to and my son's death was the only cot death they had attended. To me they should have had some sort of training". (FSID, 2012, p.32-33)

The publication covers 40 years of true life cases written from the parent's perspective. The above example is from the mid-90s, just about the time that I began as an investigator of child deaths. At the time I was working in a specialist child abuse unit, so I would like to think that it was not how I dealt with these situations. However, I am also sure that the above incident wasn't a one off. That sort of approach would probably have happened, at times, all over the country.

The NPIA published a briefing paper by Fox (2008) on his evaluation of developments in the investigation of sudden unexpected death in infancy. Within this paper, I make the following comment, reflecting on how we did things in the 1990s:

"Very very badly. Police officers turned up with blue lights blazing. In my own experience you'd turn up with your DI who was in the main used to dealing with adult homicides- no child protection experience. You'd have SOCO's (scenes of crime officers) there –they'd photograph everything. You'd seize all the bedding. Often parents were arrested. The police role then was very much about enforcement." (Fox, 2008, p.14)

It is against this background that I felt driven to change the way that the police responded to, and dealt with child deaths. I had the responsibility to do something about making sure the feedback, as seen above, was a rare, rather than regular occurrence.

Along with a colleague, who was one of my Detective Superintendents, but more importantly the investigating child death sub-group representative for the Eastern Region, we attended a course run by the Warwick University medical school. This had been developed by two paediatricians whom I have mentioned already throughout this context statement, Drs Sidebotham and Fleming. The Warwick Programme is outlined below:

"The Warwick Training Programme in Unexpected Child Deaths is a flexible training programme which aims to equip practitioners and managers from all relevant agencies to respond to and learn from unexpected child deaths. The programme is primarily aimed at practitioners from across the UK where child death review processes are in place. It will be of benefit to those in other countries who want to learn from the English approaches. Key audiences include:

•Front line practitioners from health (medical and nursing, hospital and community), police and social services involved in responding to unexpected child deaths

•Other professional and lay persons involved in responding to unexpected child deaths

•All members of local Child Death Overview Panels, including panel chairs, managers and administrators

•Practitioners and managers involved in Serious Case Reviews

•Managers of services providing input to Child Death Overview Panels and the rapid response to unexpected child deaths"

The course was, and still is very good. However, I felt that for police officers, it shouldn't be the only training that they received. We felt that there was a real gap in this training for senior police detectives (SIOs). John Fox, who was a member of the faculty for the Warwick course, equally agreed when I consulted with him. I now found that the time was right for me to do something about changing the way policing nationally did things, in addition to the guidance that I had authored a couple of years earlier. I really felt strongly that I needed to build on just having the guidance for officers, I felt I needed to create something to grip them to make the step change required. Kotter (2014) below describes how this change action should take.

> *"Action that is head and heart driven… Most people won't want to help if you appeal only to logic. You must also appeal to how people feel. As have all of the great leaders throughout history, you must speak to the genuine and fundamental human desire to contribute to some bigger cause. "(Kotter, 2014, p.9)*

A training course would help to convince officers the need to change their way of working to a multi-agency one.

As Senge (1999) stated in his book 'Dance for Change', up until this point I had failed to think about learning. This is clearly due to on one hand, because I had issued national practice guidance and as a disciplined service we should get on with it. On the other hand, my lack of knowledge and background in learning just didn't allow me to think about it.

> *"Most advocates of change initiatives be they CEOs or internal staff, focus on the changes they are trying to produce and fail to recognise the importance of learning capabilities. This is like trying to make a plant grow. Consequently, their initiatives*

are doomed from the start to achieve less than their potential-until building learning capabilities becomes part of the change strategy". (Senge et al, 1999, p.9)

I then set in motion the mechanics of trying to develop the course. Firstly, I obtained support from the HWG, as the training of SIOs was their responsibility (mine as well, as I was a member of the HWG). I then wrote to the then, head of the National Policing Improvement Agency (NPIA), and asked for permission to use his staff to develop the course. This involved two key individuals that needed little convincing from me, Andy Kay (manager) and Jeff Boxer (a very knowledgeable trainer and child protection officer). My intention in obtaining the authority from the HWG and NPIA was to ensure the public works of the training course had the influence to guarantee it became the sole national course. My plan, along with the others that I have mentioned, was to create from scratch, a two day continuous professional development (CPD) course for SIOs.

This plan was de-railed fairly early on by the interventions of others on what they thought was needed! I decided to hold a focus group from within the sub-group members who had expressed an interest in being involved in the development of the course. Attending the focus group meeting was Jeff Boxer (NPIA), along with two experienced training course developers; I made professional use of these two individuals to help with my own learning. We had a board blast of ideas on what should be included in the course. Early on, it became clear, that what I envisaged the gap to be, was in some of the focus group member's minds a much bigger gap, which could be filled by this course. The trouble was that not everyone agreed. They wanted me to stick to the original plan as per my mandate from HWG. However, I was in a fortunate position that I not only represented HWG, I was also the representative for the ACPO specialist child abuse group. I had clear autonomy and responsibility to lead and develop what I believed the police service needed. In the end the final decision was going to be mine. As Adair stated (2013):

"When the decision making process is over, you still have to take the decision. "(Adair, 2013, p.42)

In critique of the process I went through here, I shouldn't have gone into it with a pre-conceived idea of what was required. I also shouldn't have gone ahead to negotiate a mandate for something that ended up much wider than my original brief to others. As Adair (2013) states:

> *"You need to open your mind into wide focus to consider all possibilities that is where generating ideas comes in. But then your valuing facility must come into play in order to identify feasible options. 'Feasible' means capable of being done or carried out or realised. If it is feasible it has some real likelihood of being workable, it can attain the end you have in mind." (Adair, 2013, p.22)*

I definitely did this, albeit unconsciously. It actually turned out for the best, and I will cover feedback in the impact part of this section. I personally received feedback from one of the members of the focus group that my leadership skills in my ability to listen, and pragmatically change my opinion, were, in their view, excellent. I should state that this person was the most vociferous for us to change to a wider course. It could be argued that I showed good leadership skills by going with their opinion! However, others equally expressed this opinion. The below quote from Elder and Paul (2013) shows that I can be a good critical thinker if I am open towards others thoughts and ideas, as was the case with the training course.

> *"A hallmark of a critical thinker is the disposition to change his or her mind when given a good reason to change. Good thinker wants to change their thinking when they discover better thinking. In other words, they can and want to be moved by reason." (Elder and Paul, 2013, p.73)*

The course we ended up with consists of two modules. Module one, is where the death maybe suspicious or not and module two is a homicide investigation from the start. This we felt made the best training package for all police officers and not just SIOs.

'I hear and I forget. I see and I remember. I do and I understand' this best describes how a training course should be constructed. Due to my lack of knowledge of training course construction, I thought it should be different. At that time as a national authority on investigating child deaths I felt that what I needed to do was just tell officers how to do it. However, as the quote states 'I do and understand', we put in place, for each of the modules a case study for the students to work through. These were real case studies that we adapted to fit the training environment and get the best out of them.

The use of case studies, and all of the material we included in the course, was what I believe would bring about the culture change that I was hoping for. However, whilst undertaking this professional doctorate I came across Schein's comments in Senge (1999) 'Dance for Change'.

"People who try to change organisations often run up against attitudes that seem unchangeable 'WE can't seem to make any headway' they decide, unless we can create a new culture around here. Already they have made an irreversible mistake. You cannot create a new culture… You can propose new ways of doing things, and articulate new governing ideas. Over time, these actions will set the stage for new behaviour. If people who adopt that new behaviour feel that it helps them do better they may try it". (Senge et al, 1999, p.334)

If we look at my title to this context statement 'achieving a balanced approach between sensitivity and the investigative mind set'. This is not an easy a concept as I thought, for most investigators to believe in. It needed some explanation and learning to get them to believe that this new way of thinking, and behaviour will help them to do things better. I had a good theoretical and practical base to my knowledge, which not all others had. The training course would help to develop this.

When discussing the training course with my consultant Malcolm Ross (he runs the course for the Wales region) we talked through alterations that he has made to the case study and different speakers that they use. I found this really enlightening, as my experience was only of the original course, with a few additions that Dave Marshall has made to it. Malcolm and I challenged each other as to why we included a covert policing tactic. He has taken it out of the Wales course. I understand his point of view, as some forces that we deliver the course to are unable to obtain covert authority to do what we ask in the case study. Other forces can though, so I was keen for it to remain.

We ran a pilot course, and although there was an open advert around the country for students to attend the course, I did hand select a few attendees. My thoughts behind this were to make sure that we had in place knowledgeable students. After a few adjustments, I signed off the training course (One of my public works) as the national policing lead and allowed it to be used by all police forces in the country to train their staff in the investigation of child deaths.

I have had, over the last two to three years, a few ethical issues in relation to the intellectual property rights of the training course as a product. This has extended to fees and payment for the information (course materials) etc. As the person who was the lead in the development of the course, from its inception, to the fruition of a national training course, I have been able to show both mine, and others, total integrity of the training

course as a product. The resolution is that, the training course has the joint intellectual property rights of the ACPO sub-group and College of Policing (formally NPIA). Police forces can only use it with their permission, which they will give, at the same time offering to deliver the course themselves. The ACPO sub-group also ensure that the subject matter expert is just that, and currently there are only four or five of us whom we would recommend to carry out this role. I realise that I had to compromise with this in order to make the product available. Although I wanted every force and officer to have free access to this public information, I now believe this is for the best as it definitely allows control of the quality assurance of the actual delivery of the course.

Impact

As a rough estimate, this course has now trained in excess of 1500 officers countrywide. The immediate feedback from the course has always been extremely good from all students. I personally have been involved in the training of about half of that number I have also delivered certain aspects of the training course and guidance to several hundred officers on a specialist child abuse investigators course. The feedback taken at the end of these courses has also always been excellent.

The results of the questionnaire that I sent to my sub-group members show that almost all of the respondents felt that the course was one of the highlights of achievement for us.

I have made quite extensive use of the three questionnaires, as already highlighted throughout this context statement. It could be argued that I have geared up the questions to elicit positive answers that I am relying on to show my impact in investigating child deaths. However, I am fully aware that the people who have answered the questions are individuals who very much have their own opinions. Hayes J (2010) in the quote below highlights why I used the questionnaire method and how effective it has been.

> *"Questionnaires are sometimes referred to as self-administered interviews. They are designed to obtain information by asking organisational member (and others) a predetermined set of questions about their perceptions, judgements and feelings. Using questionnaires to collect diagnostic information can be more cost-effective than using interviews, because they can be administered simultaneously to large numbers of people without the need to employ expensive interviews. Also, they can be designed around fixed response type questions that ease the burden of an analysis. "(Hayes, 2010, p.126)*

As I have already mentioned, the feedback at the conclusion of the course can only be described as excellent. For the purposes of this doctorate study, and a further way to assess enduring impact from the course, I circulated a limited questionnaire to past students. This ranged from those that attended between 12 months, to 4years ago. I received over 20 replies which I took as a good response.

One of the questions asked was, what key points do they remember? Almost all of the responders stated that the two key points were sensitivity, and multi-agency approach. I found this extremely pleasing. These two points are exactly the culture change within policing, that I have strived for almost ten years to achieve.

Finally, I asked their overall perception of the course. There were no negative comments and in fact the opposite was evident. A couple of the responses are shown below.

> *'It is the best course I have been to in 16 years, informative, experience of trainer, passion and excellent experienced guest speakers – all of which was delivered at the right level!'*
>
> *'Excellent course – No one should attend / be expected to attend a child death without the accreditation this course provides.'*
>
> *'It was one of the best courses I have done and probably one I learned most from in relation to my role.'*

I attempted to get people to respond indirectly to me and used a third party. This was to try to eliminate people avoiding making any negative comments concerning the course because they were replying directly to me. The courses have not always been delivered to safe audiences, and in regard to this I feel that the responses from the questionnaires and general feedback to me are very complimentary of my communication skills and show how I have helped to develop others individual skills.

Last year (2013/14) a colleague and I delivered 10 courses for Greater Manchester Police. We received unsolicited, the following feedback from another professional body (paediatricians), outlining the impact of the course we had delivered.

> *'just a bit of feedback from the SUDC steering group - Glowing praise indeed for the SUDC course.*
> *The feedback from the paediatricians has been excellent and they say they have*

noticed a marked difference in the response/investigations for the better. Always nice to be able to pass on good news!'

This was good to receive, as most, if not all, of our previous feedback had come from police officers who had attended the course. Silverman (2005) below confirms that it is good to look at a wider perspective than just policing.

> *"Your single minded pursuit of your (ideally) narrow research topic should not lead you to show disrespect for earlier research or to disconnect your work from the wider debate in which it figures." (Silverman, 2005, p.297)*

I found some further information from families, about the essential, sensitive approach, and how it is appreciated when it works well. Morris, Brandon and Tudor (2012) in their research found this response from a family:

> *"Skilled practice was required and when encountered was particularly appreciated: 'I think they did see us as a family you know, a family that were going through stress and obviously the distress of losing my daughter and brothers and sisters and everything, a loved one. I felt they treated us with sensitivity and I think they were very approachable and you know I just got really positive, you know I just felt really positive and I mean that's why I thanked them because to me they did, they were very sensitive, they didn't come in sort of saying oh we are the professionals, you know they came in as human people and I think you know that's what needs to be seen really". (Morris, Brandon and Tudor, 2012, p.9)*

Although the guidance and the training course have been extensively circulated, I know that this doesn't mean that every force is implementing the learning from both of them completely. Dr Joanna Garstang, from Warwick Medical School, has been leading a study into the impact of the joint agency approach (JAA). They spoke to 23 families, so in my view, valuable feedback which I, and the police service, need to listen to. Some early findings (2013) have been published in the child abuse review. I found concerns in the below extract from this publication.

> *"Cases where non-accidental injury or homicides were the likely causes of death from the outset are not included in this audit as these were police led investigations with serious case reviews. These cases did not follow the JAA and therefore Form Ds were not completed so no audit data are available". (Garstrang, Debelle and Aukett, 2013, p2)*

The training course and the guidance is very much focused on whether the death is a homicide or deemed suspicious. The best approach when dealing with these deaths is the joint agency one. I am pleased to say, that in July 2014, I ran a course almost exclusively for the West Midlands Police (area covered by Dr Garstang research.) The force is now fully cognisant of the guidance and how important it is to have the joint approach.

Dr Garstang, also sent me (July 2014) some further findings from the research (as yet not published as part of a Phd submission by herself). These findings state there is still work to be done. Although the specialist police response is good, there were concerns about the initial police actions from non-specialists. The police are addressing these issues. The below conclusion from an initial research paper by Dr Garstrang fits in totally with my thoughts in relation to the guidance and the training course that I have developed and deliver.

> *"Overall most parents feel supported by professionals during the JAA; however there is scope for improvement. Professionals can be compassionate whilst carrying out a thorough investigation. Non-specialist police should not routinely attend infant deaths. Paediatricians should ensure that parents are kept updated with the progress of the investigations. Some parents require more emotional support and professionals should assist them in accessing this." (Garstrang, 2014, p.2)*

Although I am not entirely sure that this comment below, from a parent, is an impact of the training course, it came after we had commenced the course and after the guidance had been published. It is taken from the Lullaby Ttrust 2012 publication, and is in stark contrast to the previous quote I used earlier in this section. I hope that it shows that the police service has moved on from those earlier days.

> *"I take my hat off to all the police officers involved in our case. The two officers from CID were fantastic. It was obviously very hard for them as well but they were so understanding, and we never felt under suspicion". (FSID, 2012, p.67)*

To sum up this critique, undoubtedly the course has made a difference, and was an innovative approach to translate the knowledge and theory of dealing with child deaths in a multi-disciplinary way. The course has produced a workable model of practice for all officers to use.

The course is now at a stage where I feel that it needs refreshing. In the final section I will cover how I, and others, am looking to complete this.

3.3 Articles from Journal of Homicide and Major Incident Investigation i) Responding to Public Inquiries: Lessons learnt from the Bichard Inquiry ii) Deposition sites iii) Effective investigation of Intra-familial child homicide and suspicious death.

'The detective oversaw the investigation of the ditch where the bodies of Holly Wells and Jessica Chapman were found - one of the most complex forensic investigations in British criminal history' (Daily Telegraph.14th Oct 2008)

I have included as part of my public works, three articles. These have been published within the Journal of Homicide and Major Incident Investigation. I could have included a number of other publications, but I felt that this journal reflected how I was trying to influence a different audience from those in the other public works which I have already covered within this context statement.

The journal is aimed at investigators, not just in the field of child protection, but all major crime investigators in the UK. It is also read by some university students, especially those who are studying criminology or psychology. I am aware of this from the amount of enquiries and research questions that I have received, not only from undergraduates, but also Masters and PhD students. They had read, in particular, the article on the deposition site for Holly and Jessica.

A good example of this is that the University of South Wales has the entire collection of the Journals on their criminology research site. This is also the case with some of the other university, criminology department, and research sites throughout the country.

All of my completed articles were peer reviewed by critical communities working in major crime in the UK. I felt that being able to engage in a communication in this way with others, who had not seen my work, was an important way to influence a different thinking. All three articles, in particular, give the message that a child should be at the centre of investigations. I also articulated that major crime investigators needed to consider a different way of working, in cases where a child is involved, from that in which their professional experience and training was directing them. This different way of working meant that we need to carry out our investigations with a multi-agency approach.

(i) Responding to Public Inquiries: Lessons learnt from the Bichard Inquiry

As I mentioned in the last section, being involved in a Public Inquiry was a new experience not only for me, but for my Constabulary. I was, to a certain extent, other than having to be cognisant of the opinions of my chief officer leads, and the lawyers we had employed, been left with total autonomy of leadership for our response. I felt that in order to understand, and try and make sense of this complex and political world, I needed to seek out others who had previously been involved in public inquiries, as a knowledgeable resource.

There had been two main public inquiries that had affected the police service in the years immediately prior to this one. These were the inquiries into the deaths of Stephen Lawrence and Victoria Climbé. I visited a number of key individuals who were involved in giving their responses, including a panel member from Victoria Climbé Public Inquiry. I had no trouble seeking out others who knew more about this situation than I did. Elder and Paul (2013) describe below this seeking out help from others. I just wanted me/us, to learn from, increase our knowledge base so that we would be able to give the best and most considered response that we were able to:

> *"People with a high degree of intellectual humility (they are rare) understand that there is far more that they will never know, then they will ever know. They continually seek to learn more to develop their intellectual abilities and to expand their knowledge base always with a healthy awareness of the limits of their knowledge." (Elder and Paul, 2013, p.48)*

I know I received extremely positive feedback at the end of the Inquiry on my/our approach.

The way we as a team approached the analysis, and then our submission of evidence, was in fact dealing with it as a problem that needed to be solved by action learning. Gray (1999) highlighted the below at a conference in Finland that year.

> *"Action learning was originally identified as a style of learning most suitable for the development of managers in organisations because it i) addresses directly the problems and issues of organisations ii) goes beyond simulation or case study work iii) allows the participants to engage on real work issues, to determine and describe real problems and positive factors, and iv) demands that intellectual and practical knowledge and skills be combined to 'solve' problems". (Gray, 1999, p.1)*

However, if I critically reflect on whom I consulted, they were all from within the police service. It would have been more beneficial to have a wider perspective, for example communication with the civil service. The 'Bichard Inquiry' was led by Lord Bichard, a civil servant. The other two inquiries were led by a Judge, and a retired senior social worker. Not long after the Inquiry I realised that I had not spoken to my consultant, Malcolm Ross, who at that time was seen as a national expert in relation to public inquiries due to his involvement in the Hillsborough public Inquiry. However, I had been to a special interest seminar which he had spoken at, and was able to refer to paperwork from this.

After the Inquiry I was asked by a number of people if I could produce some guidance regarding public Inquiries. One of those people who requested this was Her Majesties Chief Inspector of Constabulary, Sir Ronnie Flanagan, for him to be able to use when he was presenting to senior officers.

Besides using my own experience, I included what I had learnt from the others whom I had spoken to. I reviewed, and analysed, previous Public Inquiries and appeals, including a Royal Commission that looked at fairness to all parties in Public Inquiries. My view was that my article would be at its most useful to others, if it included the technicalities of a Public Inquiry.

Through the article, I was able to translate the complexity of being involved in a Public Inquiry by disseminating a model and theory to others. This then would have some guidance for others if they were involved in Public Inquiries in the future. This was not just from a police perspective, but a whole trans disciplinary approach, because I had ensured that I articulated what each stage entailed.

Impact

I am not sure what the impact of this publication has been on individual officers. I have already acknowledged the impact to the senior people involved, but this wasn't from the publication itself, but from, in essence, my actions during the Inquiry. I feel I acted as a professional in relation to how we/I, conducted ourselves. Tarrant (2013) below sums up how I perceived my actions to be.

> *"It is important to acknowledge that being professional is about much more than 'what you do'. It is also about' how you do it' and the values that go along with it. It is about how you behave; it is about who you are and how you see yourself." (Tarrant, 2013, p.3)*

I know that the senior command course for aspiring chief officers (ACPO) used my article as part of their course. The impact of this is that for a number of years, 50-60 students on the course have had the impact of my knowledge.

My consultant, Malcolm Ross, ran a national major linked and series crime course, for in the main, senior detectives, but also ACPO staff. He informed me that he was using the guidance I had written on the course. The knowledge which I had accumulated would have also been communicated to them.

When the Shipman public inquiry[2] into the actions of Dr Shipman, was due to commence, I gave advice on how I had managed the Bichard Inquiry for Cambridgeshire, and in addition, was able to provide them with more detailed information than the article contained.

(ii) Deposition Sites

I have for a number of years presented on both my role and the overall investigation into the deaths of Holly Wells and Jessica Chapman. I have carried this out both nationally, and internationally. There has always been a demand, from not just policing, but other disciplines, for them to understand the learning that came from this case.

I was approached by a number of people to see if I had written any guidance resulting from this case that they could use. This included where there was a long term missing child or person, where murder was suspected, and asking for my recovery strategy in these situations.

In light of these requests and recognising the continuing media interest in all aspects of the girl's deaths I decided to write an article for the Homicide Journal. As I have detailed in the quote I started this section on the published articles with *'The detective oversaw the investigation of the ditch where the bodies of Holly Wells and Jessica Chapman were found - one of the most complex forensic investigations in British criminal history'.* This was taken from the Daily Telegraph on the day on which I received the Queens Police Medal, it shows the huge media interest in this aspect of the investigation into the girls deaths.

I needed to be certain that what I had done at the deposition site would be beneficial learning for others. I know the criminal court agreed with my actions and the evidence we recovered helped to convict Ian Huntley. However, I wanted to clarify what others had

[2] The *Shipman Inquiry* was the report produced by the British government into the activities of general practitioner and serial killer Harold Shipman.

done. I asked along with a colleague, Mark Birch, if we could review the land based deposition sites for the prostitute murders in Ipswich. This would be of two fold benefit. Allowing the peers involved in the Ipswich investigation to review what I had done, and for me to analyse how my handling of the deposition sites for Holly and Jessica compared with the actions they had taken in relation to the deposition sites in Ipswich. By this reflection I would be able to improve the information that I was about to impart nationally. Facione (2013) better describes below my thinking in using this method.

> *"Beyond being able to interpret, analyse, evaluate and infer, strong critical thinkers can do two more things. They can explain what they think and how they arrived at that judgment. And, they can apply their powers of critical thinking to themselves and improve on their previous opinions." (Facione, 2013, p.6)*

When I completed the first draft, I included the fact that Kevin and Nicola Wells were escorted to the deposition site, where I described to them how Ian Huntley was linked to the area. At this point Nicola started crying, I also started to get upset. Kevin put his arms around both of us and suggested we move on. My colleague, Mark Birch, felt that I shouldn't include this in the article as it would expose me to a national audience. After some thought, I decided to leave it out. This wasn't because I was worried about my exposure, but because Kevin Wells didn't include this in his book 'Goodbye Dearest Holly'. I do, however, always include this interaction in my presentations on the deaths. I haven't reflected on my omitting this before I undertook this doctorate study. I now feel that it would have had value being included, as it showed a human face and what an emotional impact dealing with child deaths has on everyone involved.

Impact

Kevin Wells informed me that the Mail on Sunday was going to print an extract from his book, the following week. He was aware that it might be seen to reflect badly on me, especially regarding a decision I had made, which was to leave his daughter's body in a ditch overnight. This could be seen as demeaning to them as parents. He assured me that this was out of context. He relayed to me the whole paragraph which I detail below from his book (2005) 'Goodbye Dearest Holly'

> *"A decision has been made that the girls' bodies will remain in situ overnight. This should allow enough time for all the experts to visit and complete their tests. The priority now is to secure as much evidence as possible to convict the person or*

persons responsible for the murders. That makes sense. But what hurts at this moment is the fact that Holly although dead, is going to be left in a ditch. It seems so demeaning". (Wells K, 2005, p.102)

I made sure that I included the whole of the paragraph above in the journal article. I know that the impact that this has had on other SIOs was not for them to be hurried, yet at the same time, acknowledging the hurt to families. The fact that Kevin Wells acknowledges what mine, and other SIOs priorities are, which is to secure evidence, is a help to support other SIOs in their actions. As the below quote from Kevin Wells (2005) shows, actions we take can have an impact on families which is unknown to us.

"Once we have been signed through both the police cordons Det Supt Russell Wate meets our group. Like all the scenes-of-crime officers, he is dressed immaculately in suit and polished shoes, as a mark of respect. Given the quagmire around us it is a gesture that we appreciate deeply." (Wells K, 2005, p.120)

It was a conscious decision of mine that the Crime Scene Manager and Crime Scene Investigator and I wore suits, rather than our forensic white all in one suits. I included this within the journal article as well as the impact of this action on the family. The above quote that I included in my journal article was included by Tony Cook and Andy Tattersall in their SIO handbook, not within the section on child deaths, but in the Family Liaison Officers (FLO) section, as good practice. The unintended impact of including this in the journal article was that it went to a much wider audience than SIOs, it now also included the FLO community as well.

Criminology students have also regularly approached me after reading the article for more information in relation to links between Huntley and the deposition site.

iii) Effective investigation of Intra-familial child homicide and suspicious death.

In 2009 I made a decision with Dave Marshall to write an article for the Journal. The ACPO guidance had been in place for three years. Both Dave and I had been presenting on the wider aspects of investigating child deaths, and the guidance, although very useful in a formal policy sense, needed more explanation. A journal article would facilitate this. I had made an evaluation and had found that there were gaps in knowledge nationally that the article could plug. One of the areas was the legislation around causing, or allowing the death of a child or vulnerable adult. We often were asked to include this as a presentation when giving lectures around the country. I wanted to be able to influence, by disseminating

this knowledge to others, so they could use this new approach as a workable model, to develop their investigations further.

I had added more in the NPIA/ACPO (2009) Guidance on investigating child abuse and safeguarding children. I included in this section a check list of actions that needed to be taken when dealing with the case of the unexpected death of a child. I also still included my focus on investigative mind set and sensitivity.

> *"Police actions should balance consideration for the bereaved family with the need to thoroughly investigate a potential crime". (ACPO, 2009, p.44)*

Although I had in place my ACPO sub-group, I felt it was important that I authored this journal article and included Dave, who was a member of the sub-group, to assist. The reason I wanted to be the author of this guidance was that I felt a responsibility of leadership. By being one of the two key spokespersons I felt it gave the article more of an official authentication. It was not at any time meant to replace the ACPO guidance. I didn't use the sub-group to consult on content, as I felt it worthwhile, to consult with the different community of SIOs throughout the country. This would ensure that we achieved an article that was useful to them. I made good use of Dave as a resource, to co-author the article with me, and I negotiated with him which part of the article was to be completed and by whom.

Impact

This journal article is highlighted as key further reading in the 2011 ACPO Investigating Child Death Guidance and then again in the National Policing (ACPO) 2014 Investigating Child Death Guidance. Although I am the author of both of these pieces of guidance, I am not sure that I can claim full credit in terms of impact here. Both sets of guidance were widely consulted on across all agencies, and all parties agreed to this inclusion.

The article on the other hand is cited in the Cook & Tattersall second and third editions of the Senior Investigators Officers handbook. I know that the SIO handbook was circulated at the national SIO conference. It is also seen as the text book for the national police SIO training course, so has a wide reaching impact.

Both the journals and articles within them are widely read by investigators. The acknowledgement from others, like Tony Cook wanted to include details from within his

and Andy Tatterstall books, means that the article did achieve the wider audience that I hoped for and consequentially impacts on the working practices of many officers.

CPS issued guidance in 2011 on dealing with abusive head trauma (Shaken baby syndrome) and they included this journal article, as one of the only two areas for further reading within the section of this Journal article. The author of the guidance Squibb-Williams (2011:1) also highlighted in the launch press release, the help she had from others in compiling the guidance, one of the investigators she mentions being myself.

> *"It is important to recognise that although the medical evidence is crucial to prosecutions in NAHI cases; other non-medical facts are important and can provide appropriate supporting evidence in addition to the triad of injuries. These additional factors or areas that could support NAHI may include: … For further reading, see: Wate, R and Marshall, D. (2009). 'Effective Investigation of Intra Familial Child Homicide and Suspicious Death'. The Journal of Homicide and Major Incident Investigation, volume 5, issue 2. ACPO/NPIA: London". (CPS, 2011, p.5)*

4. Reflections and new challenges

'Serious Case Reviews present a lasting testimony and memorial to children who die in horrific circumstances. This must be remembered in the deliberations about learning from these reviews'. (Brandon et al, 2010, p.V)

I probably haven't answered explicitly the questions below that I posed to myself in the first two sections of this context statement.

I often sit and reflect, asking myself, how, and why is it, that my area of professional specialist practice is within such a sad area? Why couldn't it be in a less emotionally demanding specialist area than the investigation of child death? I have often wondered how I ended up being the Association of Chief Police Officer (ACPO) lead for investigating child deaths.

I am pretty sure though, that any reader of this context statement, would be absolutely certain, that I had gained the depth, and range of necessary knowledge and practical experience, to be a person who can be considered as a specialist in this area. I also believe, that I have portrayed that I demonstrated the requisite responsibility, and appropriate leadership skills, to make a difference to the police response to child deaths. I have also been able to present, and communicate and make a difference to the critical communities, as well as to multi-agency partner's responses, as to how they deal with a child death.

I have critiqued within section three, the public works I have relied upon to demonstrate my original contribution to this knowledge, including the impact on practice, to be able to successfully investigate child deaths. The public works of national police guidance, development of the training course and articles relating to child deaths, clearly show my leadership to national policing in this area.

The process of reflection I have engaged in, as part of this doctorate programme, has allowed me to realise that my contribution to influence practice is richer, and has had a greater impact than I had initially realised. In summary, my broader contribution can include as follows:

- Investigation of the deaths of Holly Wells and Jessica Chapman;

- The ‘Pink’ Investigation;
- The Bichard Public Inquiry;
- Membership of ACPO Child abuse investigation working group;
- ACPO lead for Investigating child death;
- Representing the police service on the implementation of government guidance on rapid response to child deaths;
- Author of child deaths inputs to Family Liaison and Child abuse guidance;
- Team member for government guidance on safeguarding children 2010;
- Team member of the ‘Munro review’ of child protection;
- Team member to make amendments to legislation on causing or allowing serious injury to a child or vulnerable adult.

I could add many more instances of my involvement, and leadership, across a range of different areas where I have sort to develop and influence others.

This doctorate process has given me the chance to look in detail at what I did, why I did it, and now, to reflect on what I am sure would be seen as a successful period of leadership. I believe I have demonstrated autonomy of leadership and the responsibility for myself, and others, in the specialism of investigating child deaths.

On evaluation, and analysis of my actions using the public works of the guidance as an example, I have found a real maturing and development of my approach as time went on. The first guidance I produced as a lone author, with consultation. The second set of guidance I used what could be described as a co-creation model. Finally, the third set of guidance, a trans disciplinary partner (Lawyer) helped to author a section of the guidance. However, I would on reflection do some things differently. The specialism of dealing with child protection and child deaths is not an easy one, with no straightforward answer, as Munro (2011b) states below.

> *“Determining how to improve the child protection system is a difficult task as the system is inherently complex. The problems faced by children are complicated and the cost of failure high. The sometimes limited understanding amongst the public and policy makers of the unavoidable degree of uncertainty involved in making*

child protection decisions and the impossibility of eradicating that uncertainty". (Munro, 2011b, p.14, 15)

I would have put together at the earliest stage, my sub-group of members from around the UK. I believe, that probably the biggest change that I would have made, was to ensure the composition of the sub-group was multi-agency based. After the Baroness Kennedy group and the Working Together to prevent future deaths finished, there was a void that still exists today. As Rose and Barnes (2008) state when quoting Hudson (2000):

> *"There is a paradox here, with 'collaboration' seen as both problem and solution – failure to work together is the problem, therefore the solution is to work together better! (Hudson 2000, p.253) Hudson firmly asserts the importance of recognising that 'inter-organisational relationships are largely built upon human relationships' (Hudson 2000:254). Building up trust and nurturing fragile relationships with practitioner colleagues from other agencies are two key components of working together effectively".* (Rose and Barnes, 2008:43)

I already had in place this inter-agency group, albeit virtual, whom I used for consulting on various cases, and in particular each issue of the national police guidance. I would have made this a formal group. The next area I would change is after issuing the first guidance, to have in place a learning package to go with it. This, I know now, would have improved our take-up, albeit as the reconvened Kennedy group informed the police they were ahead of health and social care. Finally, most of my engagement was with the leading specialists in each force area. I am not sure I influenced the Chief Officers, or their heads of crime, as much as I should have done. As Lord Laming (2003) states below, the Chief officers are the ones to ensure changes take place.

> *"Recommendation: Chief constables must ensure that the investigation of crime against children is as important as the investigation of any other form of serious crime. Any suggestion that child protection policing is of a lower status than other forms of policing, must be eradicated". (Laming, 2003, p.311)*

New challenges

The process of this doctorate programme has been of great benefit to my self-appraisal and critical reflection on my practice. Below is a personal case study which was a part of my self-directed learning, whilst at the same time making use of the expertise of others, for example, an associate and my academic advisor.

Personal case study

For the last three years I have delivered a three hour presentation on the investigation of child deaths. These presentations are delivered to detectives on a specialist child abuse course.

I originally put together three power point presentations to cover three different aspects of these deaths. The first presentation was on the history of child deaths. This detailed how we arrived where we are today and how we, as multi-agency partnerships investigate them. This is an abridged version of the opening presentation that I use on the national four day investigating child death course. (The course is one of my public works.) The second presentation is on the ACPO guidance for investigating child deaths; this presentation is based on the guidance of which I was the author in 2011. This guidance, along with the first version in 2006, plus the update to the 2011 version, is now the College of Policing Approved Professional Practice guidance 2014. My third presentation is on the investigation of abusive head trauma (shaken baby syndrome). Again, an abridged version from the ACPO training course.

The first question I might ask, would be, why they would want me to be the person to deliver this as a subject matter expert? The answer is quite straightforward. For five years I was the ACPO lead for investigating child deaths. I had written the ACPO guidance, I have worked with Government to deliver how we, in England, dealt with child deaths, and had developed with others and with myself as the lead, the national training course. Probably, and most importantly in my opinion, I have dealt with, as an investigator, a number of these offences. I can demonstrate not only to the course, but to any independent observer, that I have the depth, and range of knowledge required, to be a subject matter expert. This is a sensitive and complex area, of not only police work, but multi-agency practice. Through my involvement in being the author of the 2014 guidance, and dealing with serious case reviews I am still knowledgeable of practice in the country.

So, my approach to the presentations with this mind set in place, I am the expert. I have been where they are now, I had similar uncertainty and concerns when dealing with child deaths, and they just want to hear from me. Therefore, I was able to speak for just over three hours on these three subjects. My colleague, Dave Keech, who runs the courses, and is a very experienced and qualified trainer, gave me feedback that students had really valued my inputs. I deliver these presentations on approximately six courses a year. I also deliver parts of the presentations a number of times a year to multi-agency professionals. Stice (1987) re-enforced for me that providing lectures can be really beneficial to the

student.

> *"The lecture method can be used for teaching facts and concepts and for showing how to apply them in a more or less straightforward situation. If lectures are well done, they are an excellent way for a teacher to model professional behaviour and to use enthusiasm to motivate the listener to want to know more about the subject. (For many people seeing a play performed has far more impact than reading the play.)"(Stice, 1987, p.102)*

After about 18 months of delivering these presentations, Dave provided feedback, not just to me, but he considered that all of his subject matter experts were using too many power point slides. The students felt that they were trying to read the slides, and at the same time listen to what we were saying, which was a challenge. He sent us all a link to a critique by Rutledge (2011) on the use of power point, and asked us to reflect on the content of our slides.

> *"The first reason most people cite is that it helps them remember what it is that they want to say. They can look at the slides and use them as a prompt for their presentation. The most obvious manifestation of this is the presenters who helpfully read the slides to their audience and then wonder why people are losing the will to live. Problem is I can read silently quicker than you can read out loud and the repetition isn't helping it stick. The less obvious manifestation is that the PowerPoint system becomes the entire template for the presentation." (Rutledge,2011, p.1)*

I was able to resonate with the some of the comments above, and there is no doubt that I was using the power points as a template for my presentation. I used images, visual recordings and also had a story to tell. The feedback confirmed I was delivering a useful product for the students; but suggested that I needed to modify some of the slides.

Dave also asked if I could not deliver the history section. Much of this was covered at the beginning of the course. The course is two weeks long, and my input is on the second week. The Social Worker input, at the end of the first week, covers a lot of the high profile cases that I focus on. At first my thoughts were that no one else would be able to deliver this history any better than I could. However, it made sense for me to cover something else and not to duplicate. On reading Elder L (2013), and using critical thinking to assist in my practice, I was quite happy to change and develop my practice.

> *"A hallmark of a critical thinker is the disposition to change his or her mind when given a good reason to change. Good thinker wants to change their thinking when*

they discover better thinking. In other words, they can and want to be moved by reason". (Elder and Paul,2013, p.73)

The input that he asked me to substitute was on Familial Homicide, which I was very confident and happy to deliver. I had recently helped Sir Paul Beresford MP, David Marshall and Lord Laming to bring about some changes in legislation connected with familial homicide, so was completely up to date with this subject matter.

I did review and delete a number of slides as requested. After reading a number of books and articles for this doctorate course, and reflecting on my practice, I have grown to understand that to develop my practice further, I need to reflect on what I had done in the past, and to be able to move forward and improve in the future. Tarrant P (2013) describes this purpose of reflection well.

It is well documented that to develop as professionals we need to be able to reflect on our practice and to learn from this reflection. Donald Schón (1983) suggested that the capacity to reflect on action is to engage in the process of continuous learning and that this is one of the defining characteristics of professional practice. (Tarrant ,2013:2)

My academic adviser, Brian Sutton, (2012) has written an article that helped me look at how I could make my presentation more successful in the future.

"On average we only remember 10% of what we read. This is quite alarming given that the dominant form of information transfer in our organisations is the written word and even in e-learning, reading is the primary activity. We remember around 30% of what we hear but combining seeing and hearing together can raise retention to levels close to 50%, this is why we emphasise the use of visual aids in classroom training; it also explains why audio is more than just a gimmick when added to an e-learning package. In order to achieve retention levels of over 70%, it is necessary to introduce collaboration and individual or collective practice." (Sutton , 2012, p.3)

The date for the next presentation of the specialist child abuse investigators course was on the 24th of March 2014. I knew I needed to take account of both Dave and Brian's comments, if I was going to develop any improvement in my practice. I decided that I needed to ensure that I produced a key point sheet. I had compiled one in the past, so I improved the focus of this, so the students had a key point sheet and were not concerned with making lots of notes.

I then reflected on the comments of Covey (2013)

"The early Greeks had a magnificent philosophy which is embodied in three sequentially arranged words: ethos, pathos, and lagos… These three words contain the essence of seeking first to understand and making effective presentations. Ethos is your personal credibility, the faith people have in your integrity and competency. It's the trust that you inspire. Pathos means that you are in alignment with the emotional thrust of another person's communication. Lagos is the logic the reasoning part of the presentation." (Covey, 2013, p.267)

At the start of the input I spent time finding out what the students actually knew already, then what they wanted to learn from the session, rather than just what I wanted to deliver. I made sure I listened, so I understood what their needs actually were. I outlined more of my experience at their level, and how I had progressed to being able to be the author of the ACPO guidance.

One of the students on the course was a Detective Sergeant who was quite experienced, and had dealt with a few child deaths. He had also completed the full course that I had played the lead role in developing. The course he had already attended, however, was not one that either myself or David Marshall had delivered. I was conscious of needing him to feel that he had a lot to contribute to the group learning, as well as ensuring I gave him some points to learn from, and reflect on, to improve his personal future practice. Taking time at the start, to listen to the students really enabled this interaction to take place more successfully.

The feedback, which has always been very good, was equally as good for this presentation. I spoke to the Detective Sergeant; he informed me that he had learnt a lot more from my input than he had on the course which he had completed. I am now looking forward to the next course and constantly review how I can continue to improve my practice for the benefit of the students.

I believe the case study above, does show, that the doctoral process is helping me to continue to develop my knowledge, and redefine new approaches in the works of investigating child deaths. I have carried out the presentation a few times now, and although I have to take much more time in the delivery of it, I feel that the students are able to understand the concept that I am trying to get them to consider much better.

In section two, I have discussed some of the new directions I have taken since leaving the police service. I took retirement, on a full pension, so that I could focus on the activities that I wanted to be involved in.

Sir Stuart Rose (ex CEO M&S) made the following comment, when being interviewed in The Times, talking about the work he does in retirement.

> *"I came up with four rules: I don't want to work with people I don't like; I don't work in a business I either don't like or understand; I don't want to work in business where I can't have fun; I don't work in a business where I can't have some upside." (Rose S, 2014, p.13)*

Although I should take notice of someone who has been as successful as Stuart Rose, I actually believe that at least one, or more, of these rules are different for me. One of my rules would read, 'I want to work in a business where I can make a difference to the lives of children'.

Whilst working through this doctorate process, I felt hugely inspired by the commentary below taken from the Evangelical Alliance: Friday Night Theology (2014) of a young man Stephen Sutton, who died (aged 19yrs) after developing cancer as a boy.

> *"First, he had a driving passion to make the most of the life he had. Creating a bucket list of 46 things he wanted to do. These varied from raising money for charities to skydiving and writing a book. He was no longer content to be a spectator but wanted to participate fully. Second (I think this overtook his bucket list), he wanted to help as many people as possible. Whether this was by raising money for the Teenage Cancer Trust, raising over four million pounds, or simply encouraging people to live beyond themselves. Third, people were drawn to Stephen because he displayed a positive outlook and attitude in the midst of tragic circumstances. He didn't feel sorry for himself and didn't want other people's pity. He is reported to have said: "I am not bitter about leaving the party early, just happy that I was ever invited." (FNT 30/05/14)*

The two phrases from this commentary that I feel encompass my work are 'that I have never wanted to be a spectator but wanted to participate fully'. I am sure this context statement shows that 'want' by me to always be involved in influencing and developing policy, practice and individuals. Reflecting on the other phrase, I am also am 'just happy

that I have been invited' to carry out all of the public works that I have been able to carry out concerning investigating child deaths.

One of the areas that has been new to me is my authoring of serious case reviews. These are reviews into when a child dies, or is seriously harmed and abuse and neglect is suspected. The quote at the start of this section is by Professor Marion Brandon, who analyses the reviews on behalf of Government. I agree completely with her thoughts, and I always have as my goal, to keep the child at the centre of my reviews.

I am now, to a certain extent, regarded nationally as very experienced in conducting these reviews. At the time of writing this context statement I am currently involved in nine reviews around the UK. A review I conducted whilst I was the chair for Hammersmith & Fulham LSCB, was evaluated by Ofsted, who made the following comments about the quality of this review.

> *"The serious case review has been assessed against the criteria for conducting reviews as set out in 'Working Together to safeguard children (Chapter 8)' Our evaluation is that the review is outstanding." (Ofsted, 2011, p.1)*

I could sit back and feel that I have 'got it cracked' after receiving such positive comments from Ofsted. However, this is not my nature. I try continually to work out ways to better analyse, and synthesise, the complex information that you receive from agencies, in relation to their involvement with the child who had died. It is important to try and constantly develop knowledge so that we can improve how we protect children.

As an overview author of SCRs it is important for me to be balanced in my analysis and comments that relate to all partners, and to try and not let my police background dominate my reviews. Ray Jones (2014) in his book on the Baby P story makes the below comments. Ray is a social worker by profession, and he makes a strong point.

> *"Why were the Metropolitan Police and Great Ormond Street Hospital both of which played a critical part in Peter's story, so quickly airbrushed out of the picture? The police largely stayed on the margins of the story' 'The police are on the margins throughout, and especially so in the 2nd serious case review report, in which, for periods the police disappear from view."* (Jones R, 2014, p. E 121, 145, 753)

The lead statutory responsibility (Children Act 2004) does sit with the Local Authority and their Children's Services Departments through section 10 of the Act. Davies & Ward (2012:120) in 'Messages from Research' found very little evidence that responsibilities were equitably shared. However, as I have mentioned earlier in this context statement through Section 11, all agencies and individuals from those agencies, have a duty to protect children. I see this section as important to ensure that my reviews are multi-agency in focus, and not just Social Services based.

To a certain extent the trigger event (death or serious harm to a child) is a critical incident. Tripp (1993) describes below that this thereby creates a real opportunity to learn from them.

> *"Critical incidents are an excellent way to develop an increasing understanding of and control over professional judgement, and thereby over practice. Critical incidents should question the way things normally operate." (Tripp, 1993, p.24, 28)*

As a member of the 'Munro review' of child protection in England, I was introduced to double loop learning. Professor Munro was a great believer of the use of this in re-defining child protection. I must admit that at the time I didn't really understand what this term meant, or how I could use it to influence either mine, or others practice, through recommendations from SCRs. Professor Munro (2010) stated in her part one report:

> *"In child protection terms...double loop learning leaves space for professional judgement and the questioning of set targets if a given situation does not conform to the technocratic model." (Munro, 2010, p.14)*

Whilst using this doctoral process to develop and broaden my thinking I read Hayes (2013) on change management. The section below helped me to make sense on how important it is to come up with recommendations that make people do things differently and do different things.

> *"Double loop learning is more cognitive processes; it occurs when the assumptions and principles that constitute the governing variables that underpin the shared mental model are examined and challenged. This kind of learning challenges accepted ways of thinking and could produce a new understanding of situations and events, which in turn can lead to the development of new rules that require organisational members to change their behaviour and do things differently or even do different things." (Hayes, 2010, p.306)*

One of the clear learning experiences for me, whilst being a member of the 'Munro review', was that SCRs shouldn't follow the old format that I, for example ,used in the review that was highly rated by Ofsted. I should adopt a 'systems' approach to my reviews in the future, that will allow me to find out why things happen, and then how to put in place measures to resolve them.

> *"The systems approach can address the problems with the current methods of SCRs. Critically, it explicitly focuses on a deeper understanding of why professionals have acted in the way they have, so that any resulting changes are grounded in practice realities." (Munro, 2011b, p.61)*

Whilst studying during this doctoral process, I have seen a number of different ways to carry out 'systems' type methodologies to my reviews. I have been quite taken with Root Cause Analysis from the Health sector, but also as Rose and Barnes (2008) highlight in their SCRs biennial analysis, the appreciative enquiry.

> *"Appreciative Inquiry (Cooperrider et al 2001) is a radical way of learning and building on existing good practice and is undertaken in a positive environment of collaborative inquiry. It can be applied to safeguarding practice." (Rose and Barnes, 2008, p.66)*

I have now had a chance to trial this system twice. The first time was in Wales, where I carried out an inspection of child protection arrangements. It worked out very successfully as I highlighted their strengths and then what areas needed improvement. The second time was recently (November 2014) in Jersey for a SCR, it was not as successful, but still seemed to work. I highlighted what didn't work well for the time period of the review, but continually moved it forward to what do we now do differently, or will do differently. This helped us to not dwell on past failures but to be encouraged on what happens now, and want to do more.

After discussions with my consultant, Malcolm Ross, who is very experienced in the completion of SCRs, he advised me on the importance of keeping up to date with developments. He often includes the latest learning from the child abuse review publications in his SCRs. I have just been asked to join the child abuse review editorial team. Although I try, I find it difficult to keep as up to date as I should. Tarrant (2013) comments on this:

> *"Many professionals lament the lack of time for reading about the latest thinking and new ideas about their practice. For many the longer they are in the job the less they have the opportunity to stop and look at how the theory is changing. Another problem is that most of us get so involved in the day-to-day pressures of the job that we do not have the 'space' to consider what is going on in the development of our profession." (Tarrant, 2013, p.170)*

This emphasises for me, that I must create this space to enable myself to remain at the cutting edge of developments in my professional practice.

Covey (2013) coins the below phrase:

> *"Habit 7: Sharpen the saw. "(Covey, 2013, p.5)*

He is talking in broader terms than just sharpening your professional knowledge, but also applies this to your physical and spiritual strength. These areas are frequently overlooked in the busyness of day to day work. I realise that I must also work on this holistically, if not, I will be unable to sustain the impetus and professional credibility which I have achieved.

Professor Munro (2011b) highlights some research that she feels important for practitioners to consider, this failure to take time to think and keep up to date, and was completed by Oakeshott (1989:33).

> *"Michael Oakeshott draws attention to the limitations of a 'crowded' life where people are continually occupied and engaged but have no time to stand back and think. A working life given over to distracted involvement does not allow for the integration of experience." (Munro, 2011b, p.87)*

During a meeting with my academic adviser, Dr Brian Sutton, he mentioned a previous student, J. Andres Coca-Stefaniak, who is now the author of a professional journal. Below is a comment taken from his context statement (2012).

> *"In July 2008, four months after taking up my appointment as Senior Lecturer at London College of Communication (University of the Arts London), I was approached by Henry Stewart Publishers with a challenging offer: they wanted me to lead a journal on city management by helping them to build it from scratch, including the design of its editorial board and editorial objectives." (Coca-Stefaniak, 2012, p.57-58)*

After discussing this with Dr Sutton I really felt inspired by this concept of a Journal. I had just seen the feedback from the ACPO child death conference. I reflected that there had only been 200 people present, yet there were thousands of officers around the country who would have benefitted from some of the inputs at the conference. I put together a proposal to commence the 'National Journal of Investigating Child Deaths' with myself as the editor. I could have spent time talking to others or working through ideas, but I have always been one to take action. Paul McGee (2008) sums this up for me, that thinking is only good if action takes place from it.

> *"In a nutshell; great ideas, great goals and great intentions are meaningless without great actions. People achieve success in life not just because they take charge of their thinking, but because their thinking propels them into taking action." (McGee, 2008, p.137)*

I submitted my proposal to the ACPO child death working group. Maybe this was because I had initiated this group and this would be another development for the group. I already had a target audience for the journal consisting of professionals from all the multi-disciplinary partners. I could have easily approached others to publish the journal, but decided instead, to enlist journal article authors. I am co-author of a book 'Multi-agency Safeguarding in Public Protection' A practitioners handbook. The publishing company for the book are very experienced and publish a number of journals. I could have received a fee for being the editor of the journal. However, I decided not to. I ethically felt that the majority of contributors would have been from the public sector, and I wanted no questions of fees or intellectual property rights and use of a private sector publishing company could create difficulties. The journal is now on its way to becoming a reality, with the first publication due winter 2014/15. One thing I didn't envisage was how hard this would be, in terms of getting people to keep to timescales, word counts and difficulties in getting permissions to publish works.

The golden thread that has run though this context statement is the principle 'Investigating child deaths the balanced approach between sensitivity and the investigative mindset'. Before I develop further how this came about and how it encapsulates being professional in these investigations, I would first like to explore the knowledge bases that underpins not just my approach, but for all professionals in their protection of children.

Almost 25 years ago the United Nations formally introduced a convention for the rights of children, the Convention for the Rights of Children (CRC), which the UK ratified in 1991. One of the main principles that form the core of the convention is:

> *'Life, survival and development (article 6): All children have a right to life, and to survive and develop – physically, mentally, spiritually, morally, psychologically and socially – to their full potential.'*(UNCRC 1989, Article 6)

The Human Rights Act 1998 at Article 2 states: *'Everyone's right to life will be protected by law.'* (Human Rights Act 1998, Article 2)

Baroness Kennedy in her report and already mentioned by me within this context statement states:

> *'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, 2004, pg 6)

Finally Section 11 of the Children Act 2004 states:

> *'Each person and body to whom this section applies must make arrangements for ensuring that – (a) Their functions are discharged having regard to the need to safeguard and promote the welfare of children.'* (Children Act 2004, Section 11a)

In all three versions of the guidance I have mentioned a series of principles for officers to follow. These were also mentioned in the 2002 guidance and followed up by a mention in the Kennedy report. In both the 2002 and then my 2006 guidance, they mention keeping an open mind, being sympathetic and sensitive to grieving parents.

It was not until I led on developing the training course, and in fact delivered the course myself as a trainer, that I felt the need to tighten these principles. I came up with the first principle being 'balanced approach between sensitivity and the investigative mindset.' The investigative mindset phrase was originally developed and comes from ACPO Core Investigative doctrine (2005). This says.

> *'The application of the investigative mindset will bring some order to the way in which investigators examine material and make decisions. There is no process map that will assist the investigator to develop the mindset, it is a state of mind or*

attitude that investigators adopt and which can be developed over time through continued use. It involves applying a set of principles to the investigation process. This will enable investigators to develop a disciplined approach which ensures that the decisions they make are appropriate to the case, are reasonable and can be explained to others.' (ACPO, 2005, pg.60)

The above definition almost sums up exactly how I would want an investigator to deal with child deaths, and I thought it essential to include this within the principles. However, due to the emotional nature of child deaths, and the vast majority being not suspicious, I wanted as mentioned in the two previous versions of the guidance to include the need for officers to also act with sensitivity.

The police service up until 2014 didn't have in place a formal code of ethics. Whilst I was writing all of the public works this code of ethics was absent. I felt then and now that the guiding principles helped to give police investigators an ethical approach when dealing with child deaths.

The five common principles that I have included in the current set of guidance (2014) states:

- *Balanced approach between sensitivity and the investigative mindset;*
- *a multi-agency response;*
- *sharing of information;*
- *appropriate response to the circumstances;*
- *preservation of evidence. (ACPO, 2014, Pg. 6)*

The knowledge base for my approach to the public works does derive from the statutory directions I have stated earlier, but also from a moral perspective. I have made mention earlier in this context statement of a strong faith, and to use just one quote from The Bible '*Defend the children of the poor and punish the wrongdoer*' which is inscribed above the front door of the Old Bailey Court house in central London. This aptly describes for me the action I should take for all children.

A further basis for my approach is other professionals with whom I have worked within this field who do have a code of ethics, for example pediatricians. My engagement with them as I dealt with my first cases of infant deaths helped me to develop a more balanced approach and to develop a greater personal understanding of the situated nature of ethical behaviour. A good example of this is the explanation to me by pediatricians, of the importance of taking mementos.

One of the most significant contributions to the formulating of the guidance and the principles, and in particular the first principle is my personal experience. I had learnt, whilst dealing with child deaths how complex and emotionally demanding they are. The learning from the personal experiences of yourself, and others, I believe, is crucial in leading with child deaths. Boud and Walker (1990) wrote a paper on 'Making the most of experience'. Within this paper they state:

> *'Being attentive to feelings makes learners aware of their emotional responses to the event. This is important as it involves being sensitive to the situation, seeking to detect the nuances and affective tone, as well as the ostensible content. While it may be necessary at times to play down feelings in the immediate situation, neglect of emotional responses can lead to a build up of stress and a numbing of awareness which can inhibit the ability to act and distort learning.'* (Boud and Walker, 1990, pg67)

I have found it a real challenge to get others to realise and accept that to have feelings when they are dealing with child deaths is natural. As Boud and Walker say above, to fail to take notice of feelings can affect how you act. This is why the principles and the training course was/is an essential component to enable officers to learn how to act in stressful situations.

The police now have a code of ethics formulated by the College of Policing, who are the professional body for policing. This code of ethics should be at the core of officer's decision making. It is a code of practice for the principles, and standards, of professional behaviour for the policing profession of England and Wales. I do not believe the absence of this code, when I compiled the guidance stopped me wanting to ensure it had at its heart ethical/professional behavior.

The code (2014) states in order to do the right thing, the right way, the following principles are to be used:

'Policing principles

Accountability -*You are answerable for your decisions, actions and omissions.*

Fairness -*You treat people fairly.*

Honesty - *You are truthful and trustworthy.*

Integrity -*You always do the right thing.*

Leadership -*You lead by good example.*

Objectivity -*You make choices on evidence and your best professional judgement.*

Openness -*You are open and transparent in your actions and decisions.*

Respect-*You treat everyone with respect.*

Selflessness -*You act in the public interest' (College of Policing, 2014, pg.3)*

I wouldn't want to say that I, or the others that have worked with me, were ahead of our time, but if we look at the nine principles above, it is clear that almost all of them are encapsulated within my first principle for dealing with child death.

I see one of the main changes to the thoughts on what makes a professional, moves from where you come from eg the medical profession to what and how you do things. This, I feel is very important in dealing with child deaths. This encapsulates what my first principle is all about. It is the way in which you act and how you do your job that is being professional rather than, you are a professional. Lester (2007) within his paper on 'professions and being professionals' states:

> *'Professional knowledge is seen as evolving more quickly, created in the practice setting as well as through academic research, and changed through the contexts in which it is applied. The idea of a monolithic 'body of knowledge' owned by the profession becomes less important than the idea of knowledgeable and knowledge-generating practitioners who are able to reflect on practice and produce knowledge from it, as well as being able to critique and contextualise externally-generated knowledge and research'*(Lester, 2007, pg.4)

This, I believe, widens the argument that practitioners are the ones who help to generate the knowledge from the learning of their practice. The combination of knowledge, some of

it from being a practitioner, with the theory of why we deal with child deaths, helped me to not only write the guidance, but also to change officers, and our partners views of them, to be more professional in how they deal with the deaths of children.

Brandon et al (2008) in their end note of the 3rd biennial analysis of SCRs (2003-2005) made the following comments:

> *"Our argument throughout this study has been for the need for practitioners and managers to be curious, to be sceptical; to think critically and systematically but to act compassionately. It is not helpful to be sceptical in the absence of compassion."* (Brandon et al, 2008, p.106)

This in essence describes my core principle of balancing the investigative mind set with sensitivity. The above analysis from Brandon, I believe adds evidence and support to my comments.

I hope, that thorough this context statement, I have demonstrated through all of my public works that we ensure that all professionals, from whatever discipline, but the police in particular, **'Investigate child deaths- achieving a balanced approach between sensitivity and the investigative mind set'.**

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5.2 Glossary of Acronyms

ACPO - Association of Chief Police Officers

APP - Approved Professional Practice

CEO- Chief Executive Officer

CID- Criminal Investigation Department

CP - Child Protection

CPD - Continuous Professional Development

CPS- Crown Prosecution Service

CRC- Convention for the Rights of Children

CSE- Child Sexual Exploitation

DCS- Detective Chief Superintendent

DCSF- Department for Children, Schools and Families

DfE- Department for Education

DI - Detective Inspector

DPP- Director of Public Prosecution

FLO- Family Liaison Officer

FSID - Foundation for the Study of Infant Death

HWG- Homicide Working Group

JAA - Joint Agency Approach

LSCB - Local Safeguarding Children Board

MIM- Murder Investigation Manual

NAHI - Non Accidental Head Injury

NPIA - National Policing Improvement Agency

NCA- National Crime Agency

NSDU- National Safeguarding Delivery Unit

NSPCC- National Society for the Prevention of Cruelty to Children

PM- Post Mortem

QPM- Queens Police Medal

SCR- Serious Case Review

SIDS- Sudden Infant Death Syndrome

SIO- Senior Investigating Officer

SOCO- Scenes of Crime Officer

SUDC - Sudden Unexplained Death in Childhood

SUDI- Sudden Unexplained Death in Infancy

5.3 Research Questionnaires

The training questions were:

Q. The feedback from the students on the courses has always been really good. What for you was the highlight of the course?
A.
Q. This course has been a new venture for the police. It was designed to equip both the SIO and a first responder whether DI or Ds with some practical knowledge of the investigation of child deaths. This is whether the death is suspicious or not. Do you think it achieves this?
A.
Q. Is this the right target audience for the course?
A.
Q. What are the three points that you now remember or have used since the course?
A.
Q. Is there anything on reflection that you feel that we need to add or change to the course?
A.
Q. Is it worth considering making the course a multi-agency one?

A.
Q. Any other comments you wish to add?
A.

The questions I posed to sub-group were:

Q. When I started in the role, my predecessor had carried it out by himself. I just continued this for the first year; however I felt that I could not be the voice for the whole service on investigating child deaths? Do you agree that the sub-group approach I developed was the right approach? If so why?
A.
Q. Did you feel that during the meetings and outside of them you were given ample opportunity to contribute and develop the work of the police in investigating child deaths?
A.
Q. Did you feel you had the freedom to represent your region or for Sonya the NPIA/NCA?
A.
Q. Did you get any feedback from the officers and staff in both your region and the country that we were the voice of investigating child death and able to influence the national agenda?

A.
Q. What would you say were the highlights that we achieved? What else could we have, or can we achieve?
A.
Q. Is it worth considering making the group a multi-agency one? (albeit I had a virtual one with DfE, paediatricians, pathologists and FSID)
A.
Q. Any other comments you wish to add?
A.

The in force D/Supt questions were:

Q. As you may remember, I was involved in four groups for ACPO nationally CP, FLO , HWG and the lead for investigating child deaths. Did you feel that being so heavily involved nationally impacted on my role as head of CID for Cambs?
A.
Q. Did you feel at any time I neglected the role of being your line manager, or playing an adequate part of our Team?

A.
Q. Did you feel I gave you the freedom to manage your area of business adequately, without being distracted by my other commitments to not be there if you required me to be?
A.
Q. What advice would you give to anyone that you work with either now or in the future who has a national role as well as a key in force role, on how to manage the balance after working with me for all those years doing this?
A.
Q. We certainly achieved within force a huge amount of success. Do you think this was down to our mutually supportive team approach? Or was it something different?
A.
Q. Did you feel by my involvement in ACPO groups that this also allowed you access into a world outside of Cambridgeshire policing, whether this was through your own endeavors with my total support, or through linking up with me?
A.
Q. Any other comments you wish to add? In particular from Mark and Jeff who are also involved in national ACPO and NCA working groups.
A.

6. Supporting Evidence - Public Works

1) ACPO Guidance on investigating child deaths: Publication 2006

2) ACPO Guidance on investigating child deaths: Publication 2011

3) ACPO Guidance on investigating child deaths: Publication 2014

4) ACPO national training course on investigating child deaths

5) Articles from Journal of Homicide and Major Incident Investigation

6) Responding to Public Inquiries: Lessons learnt from the Bichard Inquiry

7) Deposition sites

8) The effective investigation of Intra-familial child homicide and suspicious death.