

An Examination of the Role that Child Protection Professionals Play in an Identified Range of High Profile Cases in Britain: Some Criminal Justice and Historical Perspectives

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I. Introduction

Child abuse is a dominant social issue guaranteed to capture the headlines whenever there is an occurrence of it. Much of this reportage is sensational in style and superficial in content and has brought the problem into the open. A more disturbing factor of this has been the attendant public and media attacks on professionals, particularly individual social workers and the social work professional. This has resulted in a serious drop in morale and a crisis of confidence in child care practice. The attacks are sometimes vociferous and abusive and with that in mind it feel

necessary that as a trainee of the social work profession, the reasons behind this should be examined. The idea for this paper emerged out of an apparent atmosphere of blame and criticism surrounding public inquiries set up to investigate the deaths of children at surrounding public inquiries set up to investigate the deaths of children at the hands of their parents or carers. Latterly there has also been a plethora of cases involving false allegations of abuse, some of which have led to public trials and miscarriages of justice. Subsequently the last few decades has seen the British public bombarded with page after page of child protection disasters and this paper tries to make sense of the events which culminated in a selection of these notorious child deaths and tries to understand more about the behaviour of the families and professionals involved.

The UK has witnessed a growth in the definitions of what constitutes child abuse but for the purpose of this paper the definition will directly reflect on that given in the 2006 Working Together to Safeguard Children document. This formal definition states: “Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger. They may be abused by an adult or adults, or another child or children”.

There are two clear categories of individual child fatalities to be covered in this paper; tragedies for the children caused by deliberate abuse by carers and compounded by mistakes made by professionals and miscarriages of justice against parents who had suffered the tragic loss of a child, which was then compounded by professional accusations which arouse from professional mistakes. This gives two clear sections. However, there are other types of tragedies and mistakes that are identified as problematic in the UK; there is institutional abuse of children, which is perpetrated by the social care workers themselves and unresolved

cases where it is unclear who has suffered tragedy and who has made the mistake. Additional sections could have been included here but in this paper they will be ignored as it is felt that the underlying aim of this paper would be best achieved by focusing on the two types of tragedy specified so not to escalate the discussion and confuse the reader. Therefore the focus of this paper is of child fatalities, recognising its importance in shaping child protection policy and procedures, exploring its long and painful history and scrutinising the continuing dilemmas and problems it presents.

II. Literature Review: Historical Perspective

1. Child Abuse and Its History

While the practice of child abuse goes back to the roots of human history, it is only in the last century or so that it has been recognised as a distinct phenomenon, something that children have a right to be protected from. The existence of child mistreatment in history (infanticide, abandonment, severe physical chastisement, child prostitution and harsh labour) is indisputable. Maltreatment of children has been justified for many centuries by the belief that severe physical punishment was necessary either to maintain discipline, to transmit educational ideas, to please certain gods, or to expel evil spirits (Radbill 1968). It was considered necessary to literally beat the good into children and punish them severely when they were naughty. Kempe and Kempe (1978) have explained that parents, teachers and ministers alike believed that the only cure for 'foolishness bound up in the heart of a child' was repression by the rod. 'Spare the rod and spoil the child' was a dictum stretching back to

biblical times, which was a predominant social and religious ethic. 'Beating the devil out of him' is still a common expression used today (Cavanagh *et al.* 2007; Hien *et al.* 2010). Child abuse was obscured by widespread public ignorance and disinterest and it was merely seen as one of the tragic, if unintended consequences of normal life. Child exploitation was tolerated in much the same way, not least because child labour was cheap and versatile; children could carry out simple and repetitive jobs or crawl into spaces too small for adults. Children from five years of age upward were worked sixteen hours at a time, sometimes with irons riveted around their ankles. They were starved, beaten and in many other ways maltreated (Radbill 1968). The dreadful injuries suffered by many of these children, as well as the large numbers living as best they could on the streets drew the attention of such philanthropic figures as Shaftesbury and Barnardo who were to spearhead the great reform movements of the nineteenth century. During this time there was also a considerable social upheaval and numerous social crusades. Campaigns were led to improve the working conditions of children and novels by Dickens and Kingsley, such as *Oliver Twist*, aroused the national consciousness (Jones *et al.* 1982). It was only when social conditions began to improve that interest slowly came to focus on the abuse of children by their parents.

It was the view at the time that the role of the state in childcare should be a minimal one, and the privacy of a parent-child relationship should be respected: 'Laissez-faire'. Parental rights were paramount and it was thought that parents knew what was best for their own children, and they could delegate the responsibility to others if they chose. Physical punishment was essential to establish obedience - everybody knew that. The family was a sacred enclave into which no legislator dared to tread. Even as the impetus that led to the establishment of the Society for the Prevention of Cruelty to Children was taking off, a reformer Whatley Cooke-Taylor wrote: "I would far rather see even a higher rate of infant

mortality prevailing ... than intrude one iota on the sanctity of the domestic hearth”.

The right of parents to chastise their own children was still sacred and there was no law under which any agency could interfere; however the physical abuse of children in the form of what we now know as non-accidental injury was to come to the public eye and lead to public outcry through the well publicised case of Mary Ellen in 1874 (Calam and Franchi 1968). She was mistreated by her adoptive parents in New York and although there were attempts to take legal action against the parents, it was the Society for the Prevention of Cruelty to Animals (SPCA) who promptly took action and removed Mary Ellen, granting her protection. As a direct result of this incidence the Society for the Prevention of Cruelty to Children was founded in New York City, leading to the inspiration for the founding in Britain of the National Society for the prevention of Cruelty to Children (NSPCC) in 1889. The early NSPCC philanthropists argued that there were no statutory means of protecting children and relentlessly pursued changes to the law (Corby 2006). The outcome of all this pressure was the 1889 Prevention to Cruelty to Children Act. The responsibility for the care of children rested with non-medical personnel, whose concern was for the quality of life experienced by the child. This care had now become the responsibility of state and charity funded professionals such as social workers (Calam and Franchi 1968). It empowered police searches for children thought to be at risk and legalised removals to places of safety. Further acts followed but important changes in outlook and policy were shaped in part by an inquiry into the publicised death of Dennis O'Neill in 1945. He was a war evacuee who had been placed with foster parents who were later convicted of his murder. In the 1940's, interfamilial abuse was hardly top of the agenda but as Jones *et al.* (1982) explain, this case highlighted concern about the vulnerability of children living in substitute homes, which had grown with the wartime

experience of evacuation. The newly elected labour government of 1945 established the Curtis Committee to investigate these matters and its report led directly to the Children Act 1948. The Act created local authority children's departments and abolished the last remains of the much hated Poor Law. Parton states that this ushered a new, enlightened age in which families would be helped to stay together after the terrible experiences of war. This emphasis on a blood tie was to be contended following the death of Maria Colwell by her step father in 1973. a report at the time by the local authorities, stated: "there can be no question of automatic assumptions that a child is better off with any particular category of person, whether parent or substitute parent, it must depend on the circumstances of each individual case" (Colwell 1976).

2. Key Events During 1990's - 2010

During the end of the 1980's and into the early 1990's, social workers in the child protection field were operating with a much greater degree of uncertainty in relation to issues physical and sexual abuse within the family. However in response to Cleveland and some others inquires at the time, new child protection guidelines were produced in 1991; Working Together, outlining the need for more measured, planned and coordinated interventions. It provides definitions of child abuse and neglect and guidance on when a child's name should be added to the child protection register. It also includes guidance for agencies and professionals at a local level on more detailed ways of working together and includes information about roles and responsibilities for social services departments, local authorities, health professionals and organisations, schools and further education institutions, police, housing departments and voluntary and private sectors. In particular it makes requirements for social workers and

the police to conduct joint investigations into all cases of abuse (HM Government 2006). The Memorandum of Good Practice (1992) was also issued, bringing about child interviewing by means of video joint interviews so to ease the troubles of child witnesses in court. "It cannot be denied that the introduction of the Children Act and the new Working Together guidelines are having some impact on practice" (Corby 2006).

However the then Conservative government commissioned a range of research studies, summarised in *Child Protection: Messages from Research* (1995), in which the key message, as stated by the then conservative Health Minister, John Bovis, was that 'the spirit of the Children Act was not being adhered to' (Fawsett *et al.* 2004: 57-58). The general picture created was that child protection was 'too bureaucratic, too procedural and over-focused on overt incidents' (Corby 2006), John Bovis response was a recommendation for social workers to develop a 'lighter touch' approach in their work with families and children, however there was no forthcoming guidance on how best to achieve this so social workers retained their initial focus on what they saw as the most serious and concerning cases. The incoming Labour government concurred with much of this and supported the development of what was to be entitled the Framework for Assessing Children in Need and their Families implemented in 2001 (Cavanagh *et al.* 2007). In many respects, however, it seems that they took many issues and concerns forward in ways that had not been previously evident, primarily taking serious concern to the 'context' in which family life is lived and the welfare of the children more generally, tackling the legacy of child poverty left by conservative administration (Wilson and James 2002). Examples of this approach include SURE Start and the Children's Fund. Despite these new attempts to improve the existing child protection system, the first two years of the millennium witnessed yet more deaths by child abuse, which were widely reported in the press. Most notably was the death of Victoria Climbié in 2000 which resulted in a statutory inquiry

by the Secretary of State for Health Lord Lamming. It concluded that poor communication between agencies, lack of attention paid to the child in her own right and failure to follow up concerns had yet again led to disastrous consequences. Media coverage at the time seemed to suggest that it was 'somehow social workers that neglect abuse and kill children' (Hanvey 2003). The inquiry promised that her death would mark a turning point in the care of vulnerable children and this was also becoming more apparent to social workers. Following Climbie, Tony Blair (2003), in his speech on the launch of the Children's Green Paper 'Every Child Matters' explained that: "The failure of the existing system to keep children secure was tragically illustrated in the failures to protect Victoria Climbie ... child protection must therefore be our the top priority."

'Every Child Matters' was the response to the circumstances surrounding Victoria Climbie's death and legislation to enact this appeared in the Children Act 2004. Social workers have a legally binding duty under the Children Act to investigate any cause for concern they may have relating to child protection and Working Together to Safeguard Children and the Framework for assessment remain relevant and useful interpretations of how this role is to be carried out. In contemporary social work, child protection is still at risk because of its image. A survey for community care in 2004 found that just 3% of almost 300 social work students said they would want to go into child protection (Valios 2006; Cavanagh *et al.* 2007). Professionals are being put off due to the portrayal of it being extremely stressful work especially when in the firing line when things go wrong, but child protection is only a small part of services for children, which is embraced in 'Every Child Matters' (Everson *et al.* 2011).

III. Child Abuse Tragedies

1. Dennis O'Neill

One of the catalysts highlighting the sorry condition of children in care by the state during the period of the Second World War was the manslaughter of twelve year old Dennis O'Neill in 1945. The circumstances leading to the enquiry were that two boys, Dennis aged eleven and his brother Terence aged eight, were committed by court to the care and protection of Newport Borough Council who boarded them out with Mr Mrs Gough. Six months later Dennis suffered a heart attack following a brutal beating to his chest and back with a stick by his foster father, Reginald Gough. He had endured severe ill-treatment and under nourishment, identified by his weight of just under four stone, septic ulcers on his feet, severely chapped legs and an empty stomach (Hopkins 2007). Tom O'Neill, Dennis O'Neill's brother, published a book in 1981 after retiring as a residential social worker, the opening of which stated: "Studying The Times from 1945 one finds that the trial of Dennis O'Neill's foster-father for manslaughter received prominent coverage – so prominent that it took precedence over reports of the progress of the War. Not only that: on a strangely contemporary note, there was an outcry about lenient sentencing when Dennis O'Neill's foster-father was convicted".

Following this public outcry, Gough, who had been sentenced to six years for manslaughter, was re-sentenced receiving ten years for murder. His wife Esther was sentenced to six months for "exposing the said child in a manner likely to cause unnecessary injury to health" (Hopkins 2007). Their eventual fate and that of Terence O'Neill is not recorded but a government enquiry by Sir Walter Monckton ensued as a result of the case. Monckton's one-man, four day inquiry stated that there had been a

serious lack of supervision by the local authority. Making due allowance for the fact that the local authorities were understaffed and overworked in wartime, especially with the placing of evacuated children in homes. There had been a number of unfortunate slips in the way that letters had been handled in the filing systems of the local authorities. There had been too great a readiness to assume that all was well, without sufficient realisation of the direct and personal nature of the relationship between the supervising authority and the boarded-out children (Monkton 1945).

During the six months the boys were with ‘the Gouges’ they had never been medically examined and any visits made were deemed inadequate (Cavanagh *et al.* 2007). The last visit in December 1944 was made by a clerk concerned with administration duties in connection with boarding out allowances. Although the inquiry found she “had little experience to qualify her to undertake a visit to supervise the children in their foster home”, she knew that things were not right. In her report she recommended the “immediate removal” of the boys and commented that the “several times impressed upon Mrs Gough the necessity of calling in a doctor for Dennis” (Monckton 1945; Hopkins 2007). Neither authority responded with any urgency. In Shropshire, the report was put aside for an officer to deal with on his return from manual leave on the 10 January – Dennis died on 9 January.

The issues that contributed to his death – poor record – keeping and filing, unsuitable appointments, lack of partnership working, resource concerns, failing to ask on warning signs, weak supervision and “a lamentable failure of communication” – were not buried with Dennis O’Neill. These failings were to feature regularly in inquiries held into the death or abuse of children for the next 60 years. Back in 1945 Monckton’s findings led to the setting up of the Committee on the Care of Children which itself inspired the Children Act 1948. This advocated keeping children with their birth mothers where possible; this along with Bowlby’s influential work on

attachment and loss meant the importance of birth families was secure (Corby 2006; Hopkins 2007). However all this wisdom was knocked sideways in 1973 with the death of Maria Colwell by her mother's partner, providing a good example of how a preoccupation with the defence of the birth family can result in disastrous consequences (Corby and Cox 2000).

2. Jasmine Beckford

The year 1985 saw the publication of the Jasmine Beckford inquiry report. In 1984, in circumstances not that dissimilar to Maria Colwell, Jasmine aged four, died emaciated and horrifically beaten by her stepfather. Jasmine weighed just 23lbs when she died of a savage blow that dislodged her brain. During her brief life Jasmine had suffered leg fractures, broken ribs, burns and cuts. For her final months Jasmine had been chained to a bed in the attic, her death finally attributed to brain damage; although a further 40 injuries were found to be covering her face and body, resulting in a post mortem cataloguing seven pages of appalling abuse (Department of Health 1991). Both Jasmine and her sister had been made the subject of care orders to the London Borough of Brent in 1981 after both children had been admitted to hospital with severe injuries. Having been subsequently living with foster parents, Jasmine was returned home 'on trial' still subject to care orders (Parton 2006). Corby (2006) explains that the social services department supported the family somewhat spasmodically and Jasmine was seen only once by a social worker in the ten months leading up to her death. The 1985 inquiry report elaborates this. It explains that social workers monitoring Jasmine after she had been returned home to her abusive parents accepted a claim that all was well. The parents went to considerable efforts to stage-manage the social workers visit to hide the fact that Jasmine could not stand properly

because she had a broken leg (Munro 2002). No attempts were made to check this, for example, by seeing Jasmine herself or contacting the school. Social workers were also criticised for their apparent inability to confront Morris Beckford, Jasmine's stepfather, in what was thought to be fear of the stereotype of African Caribbean men being aggressive and threatening (Platt and Shemmings 1996). Whilst this was not seen as the sole reason for inaction it was thought to have played a part.

The inquiry report into the death of Jasmine Beckford highlighted a number of concerns regarding social work practice with families where child abuse was a feature and consequently it was the first inquiry which led to the dismissal of a social worker. At the trial which convicted Morris Beckford of manslaughter, the judge described social worker 'Gunn Wahlstrom' as 'naïve beyond belief' and in general both he and other professionals were condemned for putting the rights of the parents before the primary task of protecting the child (Parton 2006). There was little sign of good coordination within any of the services involved with this case the report of which paints a picture of social services going it alone without involving other agencies. The report into Jasmine's death concluded that: "On any conceivable version of the events under inquiry the death of Jasmine Beckford was both a predictable and preventable homicide. Even if it was not predicted, it was certainly preventable at the instance of those public authorities which had in their disparate ways individual and collective responsibility for her welfare. The blame must be shared by all these services".

The inquiry report made sixty eight recommendations relating to the tightening of monitoring procedures, the improvement of inter-agency collaboration and the need for more specialised training. Its conclusions echoed that of the Colwell findings regarding a lack of specialist knowledge and a lack of experience on the part of the key workers involved. The main response to the Beckford report were to be eventually incorporated

into the 1988 Working Together guidelines which re-emphasised the importance of concentrating on protecting children in serious cases, using the term 'child protection' for the first time. However, as Munro (2002) notes, there was a growing assumption in society that child abuse could be prevented by competent professionals, made apparent by the media attitude that a child's death was seen more as a failure of professionals than the fault of a parent who had actually killed the child. This general theme continued throughout the twelve child abuse inquiry reports between 1985 and 1989, and the pressure was on for professionals not to miss a single case of abuse.

3. Victoria Climbié

The Victoria Climbié case was the most horrific child abuse case seen in this country and did little to improve the negative portrayal of social workers in the media. Victoria Climbié died in February 2000 with 128 separate injuries on her body after months of child abuse at the hands of her great aunt Marie Therese Kouao and her boyfriend Carl Manning, later convicted of her murder. Victoria spent much of the last weeks of her life living and sleeping in a bath in an unheated bathroom, bound hand and foot inside a bin bag, lying in her own urine and faeces, eventually dying of severe hypothermia and multi-system failure in hospital (Laming 2003). Corby (2006) explains that the Climbié case was unlike many others inquired into; in that there was no ongoing involvement with Victoria on the part of the health, social care and police agencies based on agreed concern about her safety. In part this was thought to be the result of Victoria's unusual circumstances; she was born in the Ivory Coast and sent by her parents to live with her aunt, first in Paris and then in the United Kingdom. However, as the inquiry states, Victoria was not hidden away.

Laming goes on to say that: “It is deeply disturbing that during the days and months following her initial contact with Ealing Housing Department, Victoria was known to no less than two further housing authorities, four social services departments, two child protection teams of the Metropolitan Police Service, a specialist centre managed by the NSPCC and she was admitted to two different hospitals because of suspected deliberate harm”.

Tragically, this case required nothing more than basic good practice being put into operation but this never happened. The grotesque suffering of one vulnerable child remained unnoticed by an army of professionals. Victoria’s visits to hospital led many doctors and nurses to suspect that the injuries were non-accidental, however the consultant paediatrician and named child protection doctor, diagnosed scabies and decided that it was scratching that caused her injuries (Laming 2003). This diagnosis led to serious errors. Batty (2001) explains that the inquiry heard that the consultant’s diagnosis was decisive in police, social workers and junior doctors refraining from further investigating the possibility of child abuse. The doctor later admitted that she had made a mistake and that she had made the diagnosis without speaking to Victoria alone. Another doctor misleadingly wrote to social services saying there were no child protection issues. The social worker at the centre of the Victoria Climbié tragedy was suspended from her job and placed on the Protection of Children Act list in 2002. Speaking on a BBC Radio 4’s Today Programme, Ms Arthurworrey said: “I made many and serious mistakes. However, it is also true that I was badly let down by my employer and had I been working in a different environment maybe those mistakes would not have been made”. She goes on to say that “no one seemed to care and they just wanted us to get through cases”. Arthurworrey uses the term ‘conveyor belt social work’ to describe what the working conditions the time of Climbié was like. In 2005 a ruling by the care standards tribunal decided that Ms Arthurworrey should no longer be banned from working with children. Victoria’s parents,

Francis and Berthe Climbie, welcomed the decision to allow Ms Arthurworrey to work with children again because they felt she had been made a scapegoat for the failings of people in more senior posts whom they said should be held to account instead (Andalo 2005).

The Laming Report was written in an atmosphere of high emotion and moral outrage. It is a moral document written with vehemence and clarity, and dealing with questions of guilt, innocence, responsibility and blame. In general, it locates the causes of the tragedy on the organisations of social services and in the behaviour of particular people, rather than in general social conditions. Certainly, it identifies wider corporate failings: inadequate resources, poor organisation and poor leadership. In the main, however, and laid at the door of chief executives or other senior officers. This analysis influences the 108 recommendations Laming makes (Sinclair and Corden 2005; Laming 2003). In the wake of Victoria's death there was an echo down the decades with a chilling and depressing familiarity a picture emerged and was disseminated worldwide on the inquiry website, of inadequate or absent leadership, accountability, communication and preventative action in all of the key services (Gardner 2006). Victoria Climbie is still very much alive in the public and professional mind and it seems that she will remain so for some time to come. The Climbie inquiry promised that Victoria's death would mark a turning point in the care of vulnerable children and as a permanent memorial the Government launched 'Every Child Matters' which was to be centrally concerned with child abuse being a fundamental element across all public, private and voluntary organisations (Parton 2006). Child protection professionals still however need to get the basics of protection right and working together effectively has proven to be the core of this.

IV. Miscarriages of Criminal Justice

1. Sally Clark

Sally Clark, a solicitor, was jailed for life in November 1999 after being convicted of the murder of her two children. The jury found her guilty, by a majority verdict of ten to two, smothering her 11-week-old son Christopher in 1996, and of killing eight-week-old Harry in 1998 at the Cheshire home she shared with her husband, Stephen. Clark and her husband believed both the babies had suffered cot deaths (Batt 2004). Christopher's initial cause of death of lower respiratory tract infection was withdrawn and changed to asphyxia with smothering. Pathologist Dr Williams stated that if Harry had not died then he would have looked at Christopher's death again. At the trial, leading paediatrician Sir Roy Meadow said that there was a 1 in 73 million chance of two cot deaths happening in the same family; a figure he calculated from the Confidential Enquiry for Stillbirths and Deaths in Infancy Report (Criminal Case Review Commission 2003). During the trial Meadows stated that he could not think of any natural explanation for the death of Christopher or Harry Clark and even doubted professional observations. He claimed that police officers, when presented with a dead baby are immensely troubled and upset so it was common for them to overlook the bruising on Christopher's body (Batt 2004). This statistical and professional evidence was crucial in securing Sally Clark's conviction.

Her first appeal was thrown out in October 2000, but evidence began to mount, suggesting that she had been wrongly convicted. Stephen Clark discovered that Harry had had lethal levels of bacterial infection in his system, indicating he had died of infection rather than having been shaken (Batt 2004). For three years after the death of Harry Clark it was

believed that there was no evidence of any infection, but there was evidence of an infection which had been known to Doctor Williams (Home Office Pathologist) since 1998. The prosecution had not disclosed the tests done showing an infection in Harry's spinal cord, later decided by medical experts to be the only possible cause of death. The injuries are now believed to have happened when doctors tried to resuscitate the baby (Criminal Case Review Commission 2003). At the same time, the statistical basis of the 73 million to one odds used to convict Sally was being undermined. The Foundation for the Study of Infant Deaths provided evidence that second cot deaths in the same family occurred 'roughly once a year', and the Royal Statistical Society took the unprecedented step of writing to the Lord Chancellor stating there was no basis for the figure, and that the actual odds were much lower. To top it all, scientists at Manchester University found a genetic link among cot death cases, suggesting multiple deaths were much more likely than previously thought (Criminal Cases Review Commission 2003). The serious misuse of statistics in this case has alarmed many mathematicians, who believe that it casts grave doubts over the safety of the convictions. In an article by Roberts entitled "Trial by Numbers" in the February 2002 issue of 'New Scientist', it was revealed that the Clark's case was under consideration by the Criminal Cases Review Commission, the body which investigates possible miscarriages of justice in England. On 2 July 2002, the CCRC concluded: "... that there is a real possibility that the Court of Appeal will find that the new evidence renders Mrs Clark's convictions for the murders of Christopher and Harry unsafe."

Sally Clark's conviction of killing both her children was quashed in 2003 because of the failings by Dr Williams to disclose vital reports, but it was said that Meadow's error, described as "manifestly" and "grossly misleadingly" wrong, would have been enough to make the conviction unsafe. The professional errors made by both Williams and Meadows led to

disciplinary proceedings by the General Medical Council, however there is still another key figure that, due to professional misconduct, also made errors in the Clark case. Professor Southall was suspended from child protection work in 2004, having been censured after interfering in the Sally Clark case. He had accused Mrs. Clark's husband, Steve of murdering the two boys on the basis of a TV interview on Channel 4's Dispatches, and suggested that the couple's third child was at risk (Rose 2007). Dr Payne in an article entitled 'Paediatricians between a rock and a hard place (2008)' defends Dr Southall in what can only be seen as a professional concern: "My illusion of safe practice has been shattered by two recent GMC decisions about professional practice relating to the Paediatrician Dr David Southall. The GMC have adjudged that David Southall was wrong to share his concerns about a high profile child abuse case when he did not have the full information. But this is precisely what we are obliged to do under all Child Protection procedures, which use words to the effect that if you have concerns that a child MAY be suffering abuse you MUST refer".

However Mr Clark was completely exonerated. Sadly, the Clark's nightmare was not over. In a statement released by her family in 2007, it was revealed she had never fully recovered from the effects of such an appalling miscarriage of justice. She was found dead at her home on the morning of 16th March 2007, having died during the night. Sally Clark was found to have died from acute alcohol intoxication and there was no evidence she had intended to commit suicide.

2. Angela Canning's

The trial of Angela Cannings in April 2002 could not have come at a worse time. Sally Clark's first appeal had failed and Angela, a shop assistant from Wiltshire had lost three babies to sudden unexplained

deaths, though she was charged with the murder of only two of them. The medical evidence was even flimsier than in the Clark case but Angela was convicted of double murder by a unanimous verdict. Mrs Cannings was also originally also charged with the murder of her first baby Gemma, but the charges were dropped. Gemma and the two baby boys, Jason and Matthew, had died within weeks of their birth. Jason and the Cannings' surviving daughter Jade had also experienced acute life-threatening events. Matthew had suffered a 'worrying episode', in the appeal court's word, nine days before his death (Dyer 2005). The crown case was that on each occasion Mrs Cannings was smothering, or attempting to smother her babies. Professor Roy Meadow, retired paediatrician and prosecution witness certainly thought so. Even more sad and baffling is that Roy Meadows was called in as an expert at all after the derision aroused by his evidence at the trial of Mrs Sally Clark.

Following Sally Clark's case it was in agreement that there was to be no reference to Meadows 1:73 million statistics. However, it is still believed that Angela's conviction was based partly on the flawed evidence from Roy Meadows who asserted that "one sudden infant death is a tragedy, two is suspicious and three is murder, unless proven otherwise" (Batt 2004). In relation to this theory, Mr Cannings, in a BBC Radio Four programme (2005) stated that he believes Meadows evidence changed everything. He goes on to say that the authorities had been sympathetic until Meadows evidence came to light and then they were rapidly treated as murderers.

Angela Cannings was found guilty of murdering her two sons which was a verdict no-one expected. Batt (2004) stated that something very strange must have happened. He goes on to say that the only explanation for the conviction must be that the jury used knowledge from outside the trial, from newspapers and media surrounding Meadows' infamous 73 million to one statistic, to decide on a verdict. After serving 18 months in prison, Angela Cannings' conviction was quashed and she was freed by the Court

of Appeal in December 2003; her case making legal history. Mrs Cannings should never have been convicted on the basis of disputed medical testimony when there was no other evidence, as the court of appeal stated when it quashed her conviction (Dyer 2005). Her family tree was marred by cot deaths, which could suggest an unknown genetic problem. In a radio interview in 2005 (BBC Radio 4), Angela said that following her case and others alike: "Professionals and witnesses should be reprimanded and reviews should be made on all cases to make sure it never happens again".

The Cannings case did mark a turning point in the way that investigations of sudden infant deaths are handled. A joint working party at the Royal Colleges of Pediatrics and Pathology, has recommended a new national protocol to ensure that all unexpected baby deaths are thoroughly investigated and that expert witnesses opinions are based firmly on evidence, not on their past experience (Dyer 2005; Cannings 2006).

3. Case Discussions

The common feature in these cases and others alike was that the issue at stake was whether it could be shown - beyond reasonable doubt - which a death originally certified as due to natural causes had, in retrospect, been caused by a parent (Hey 2003; Huff 2007). In each case, suspicion only arose after a second child died. Only two of the most notable cases have been mentioned here but similar circumstances surrounded the conviction and later acquittal of Donna Anthony and the charge and acquittal of Trupti Patel, both of which receive mass media attention. The repetition of sudden deaths without explanation raised suspicion amongst professionals and, in the absence of any eye-witness evidence of harmful conduct, the police investigations relied upon medical expertise, particularly that of paediatricians and pathologists (The Royal College of Pathologists and The

Royal College of Paediatrics and Child Health 2004). That evidence, when placed under careful scrutiny, raised serious concerns about the role of the expert witness in the courts, about the standard of proof and the quality of evidence and about the procedures adopted for the investigation of sudden unexpected deaths of children (Hershkowitz 2011). The Presidents of The Royal College of Pathologists and The Royal College of Paediatrics and Child Health (2004) recognised the seriousness of the event that was unfolding and, even before the hearing of Angela Cannings' successful appeal, established a Working Group to consider the implications of these cases for the medical profession. The overriding concern was that steps should be taken to prevent miscarriages of justice while protecting the interests and safety of children. The Commons Science and Technology Committee (2005) have stated that: "The whole saga was nothing less than a 'systems failure'."

Also in 2000 the chief medical officer, Sir Liam Donaldson, in the course of a letter to every doctor in England and Wales, said that: "He doubted whether the public realised the extent to which 'when things go wrong, the true cause lies in weakness within the system rather than the culpable actions of an individual'."

However, the failings go much deeper and wider than the use of dubious statistical evidence. The Clark and Cannings cases and the 'shaken baby' cases now being heard in the court of appeal, have exposed just how uncertain, given the state of scientific knowledge, is the task of diagnosing whether a baby was smothered or shaken. The problem has been compounded by cursory post-mortems where deaths were not thought suspicious at the time. Yet some experts have been willing to pronounce themselves certain where, in reality, no certainty exists (Dyer 2005).

In 2004 the government declared that reviews would be carried out of 258 cases in which a parent was convicted of murder, manslaughter, or infanticide, to find out in which cases medical expert witnesses disagreed

and natural cases could not be ruled out as a possibility. In addition, thousands of children who were taken into care may also have their cases reopened (Gornall 2005). However Professor Craft (President of the Royal College of Paediatrics and Child Health) told the *BMJ* (2004) that paediatricians were demoralised by the General Medical Council's case against Professor Meadow. In a letter to the *Times* in 2004, Professor Craft acknowledged that there must be a review of any possible miscarriages of justice, but added: "Paediatricians are, not surprisingly, increasingly reluctant to act as expert witnesses in these complex cases. Unless confidence is restored, the present crisis in child-protection work will worsen. We therefore urge the government to support a high-level review of both the medical evidence with regard to child abuse and the legal processes by which these cases are managed."

Many paediatricians are becoming increasingly reluctant to become involved in such matters because a single genuine misjudgement can now trigger a heavy handed disciplinary inquiry and much adverse media publicity (Hershkowitz 2011). There is a resultant temptation to avoid all involvement and say that these things are a matter for social services or for the police (Hey 2003). Uncertainty as to where prime responsibility lies, has however been at the heart of many recent disasters, as previously discussed, and it is intelligible to say that there needs to be a robust system in place, in all our courts, to see that this does not result in a miscarriage of justice (Everson *et al.* 2011). Reading the literature for this section has introduced professional criticism that was not detected nor had little significance in the previous discussions in this paper. Although very complex in their nature, the professional errors made in the cases discussed have again identified that the professionals involved in child abuse / child death cases have to make difficult decisions and in this instance sometimes give flawed advice (Bader *et al.* 2008). The overturning of those verdicts discussed has left people with the impression

that such miscarriages of justice no longer occur. Unfortunately, that confidence seems to be misplaced, as more cases are arising all the time (Jardine 2004). Whilst writing this section it has been difficult to incorporate any reference to social workers, which have been the key profession to be criticised in the previous cases discussed. The only explanation to constitute this is that social workers and their colleagues often have rather less exalted status in court especially when there has been little or no previous involvement with a family (Valios 2006). A child does not have to die for parents to find themselves accused of abuse or neglect and this type of error is when social workers once again come to the forefront. This is a discussion not to delve into but it is necessary to state that research by Prosser and Lewis (1992) identified a number of perspectives by families who have been wrongly accused of child abuse, placing child protection professionals once again in a negative light.

V. Discussion

As section II indicated, much has happened in the development of contemporary professional practice in child protection, only an insight of which was explored. Child abuse concerns have expanded dramatically over the last fifteen years and this has led to a great shift in the legislation and practice concerning child protection. This journey has paved the way for documents such as 'Every Child Matters', 'Framework for the Assessment for Children in Need and their Families' and 'Working Together to Safeguard Children' (Bader *et al.* 2008). A considerable amount of tension has been displayed about how best to protect children within their families but it has been demonstrated that the current means of prevention and intervention has taken a more holistic approach to child abuse and is more

attuned to other problematic factors such as abuse outside the family. Over the discussed development it has been reflected that changes within the structuring of child protection systems has been a benefactor, coupled with the significant impact of the Children Act 1989. Social workers and professionals alike have recognised that every child needs to be heard and that the welfare, safety and protection of children are paramount. This continues to be at the forefront of child protection and a new shift towards early intervention, provided through programmes such as sure start, will hopefully reduce the occurrences of child abuse and bring child protection work into a new era. However, few could argue that the development of contemporary child protection work has been straightforward; it has been plagued by tragedy and scandal which has shaken the confidence of child protection professionals.

Child abuse inquiries provided the key catalyst for venting major criticisms of policy, practice and the competencies of social workers. Public inquiries were, and still are a major instrument in both assessing and conditioning response to child abuse practice. Whilst these inquiries were evident from the death of Dennis O'Neill in 1945, they gained a new level of intensity in the 1970's and Jasmine Beckford and more recently in 2000 following the death of Victoria Climbié (Leander 2010). It was public inquiries like these which provided the vehicles for political and professional debate about what to do regarding child abuse in a very public way and in full glare of the media. Inquiry reports illustrate the fallibility of professionals in child protection work and in all the cases discussed, the child was not adequately protected from harm. The child care professionals, particularly social workers, were perceived as having failed to protect the children resulting in horrendous consequences.

The death of Dennis O'Neill in 1945 highlighted the sorry condition of children in care, after he was killed by his foster father having been 'boarded out'. The issues that contributed to his death, namely

professional's errors, were not buried with Dennis and they featured regularly in future inquiries. The issues that contributed to Jasmine's death included poor record keeping and filing, unsuitable appointments, lack of partnership working, resource concerns, failing to act on warning signs, weak supervision and a lamentable failure of communication, all of which led to a repetition of recommendations in previous and subsequent inquiry reports. To put this problem in perspective, it may be useful to include the comments of the Hon. Barbara Castle, Secretary of State for Social Services, following the publication of the Colwell Inquiry Report: "It is right that we should feel shocked and angry at the social conditions which breed the circumstances in which she lived and died. Social work alone cannot solve these underlying problems. We as a society must recognise the very heavy burdens we lay on those whom we delegate to look after nearly 100,000 children in local authority care. We need to understand the very real difficulties they face and we need to help them to prevent this kind of tragedy."

Undoubtedly, such inquiries have had an impact but some things do continue to remain the same and inevitably it is the social work profession which continues to be held accountable. The Victoria Climbié inquiry was no different and the report explained that the extent of the failure to protect Victoria was lamentable. Tragically, it required nothing more than basic good practice being put into operation. This never happened.

All of the reports discussed have demonstrated continuing isolation and demoralisation of social workers, inadequate support, leadership and training and intolerable public pressure and seemingly unresolved conflicts of interest between the rights of the child and the rights of the parent. Crucially, professionals were seen as too naïve and sentimental (Leander 2010). The emphasis in recommendations was on encouraging social workers to use their legal mandate to intervene to protect children, to rationalise the multidisciplinary frameworks and to improve practitioner's

knowledge of the signs and symptoms of child abuse so it could be spotted in day to day practice. Each public inquiry into a preventable child death is an opportunity for the agencies mandated by society to grapple with this profound dilemma more openly – and thereby assist the professional task. Yet each is also in some measure an act of social displacement, for we know that cases not so dissimilar to Victoria Climbié's are being reported to the authorities on a regular basis, and yet do not become the object of public attention or political hand wringing (Cooper 2004). Although the history of child protection has been marked with terrible, memorable errors and omissions, these should not be allowed to obscure the very real and important gains won both at a national level through the work of reformers and on an individual level, with countless children's lives touched and improved by the dedicated work of thousands of social workers.

The controversy surrounding recent miscarriages of justice have again demonstrated problems within child protection (Bader *et al.* 2008). In the last few years a series of high profile child death trials have not only highlighted the difficulties surrounding expert witnesses at trial but has also continued to identify that professionals do make mistakes. This has subsequently knocked the confidence of the professionals involved. Sally Clarke and Angela Cannings not only suffered the tragic sudden death of two or more of their babies but were accused and convicted of their murders. Sir Roy Meadow, a senior paediatrician with a life-time's experience of investigating cases of suspected abuse, was an expert witness in both the murder trials. A comment about the likelihood of unexplained sudden death claiming two young children in a single family formed part of his testimony in the first case. It went unchallenged at the time, but has since attracted strong criticism. The media expressed much outrage at this particular lapse, but the banning of a defence expert for repeatedly expressing opinions unsupported by any objective evidence went almost completely unreported (Hey 2003). Many would accept that in a

criminal trial it is worse for expert evidence to result in wrongful conviction than wrongful acquittal. However Clarke and Cannings were both exonerated and it is overwhelmingly likely that others will follow. It is almost inevitable in such cases that there will be a media villain and these are no exception. It was of course, Professor Sir Roy Meadow. However Meadow's evidence has not always been so suspect. He was the first to recognise Munchausen syndrome by proxy, accepted as a condition in which parents deliberately harm their own children. A term which has come to be included in the Working Together guidelines under the definition of child abuse.

The medical evidence at both trials, which have been briefly described, makes clear that in any view these were difficult cases. There was a wide difference of views in respect of each death as to the conclusions that could properly be drawn from the available evidence (Criminal Cases Review Commission 2003). One obvious flaw in the handling of the Sally Clark case was the dearth of high quality forensic input into the initial investigation of the children's deaths. Dr Williams made no reference to microbiological results nor even to having submitted samples for examination in any of the three statements did he make for the trial. It was the fact that such tests could no longer be undertaken as a result of the failure by Dr Williams to disclose the information that lay at the heart of the Crown's decision not to seek a re-trial in Sally Clark's case (Criminal Cases Review Commission 2003). Following the errors and misleading evidence given in both of the trials, Meadows and Williams faced disciplinary hearings and were subsequently 'struck off' the medical register for abusing their professional positions. This has since been overturned. Paediatricians are now increasingly reluctant to become involved in child protection work for fear that this will trigger a formal complaint, a disciplinary hearing, and even litigation. Hey (2003) explains that there is now a resultant temptation to avoid all involvement and says

that such things are matter for social services or for the police to handle. However, it is dangerous to assume that just because one expert testimony has been found wanting, all convictions based on the person's testimony are unsafe. Conversely if our legal system allows people to be convicted on the basis of one expert's opinion, does this mean that something is badly wrong? Whilst it would also be naive to believe all experts are infallible, abandoning their testimony would also be a grave mistake for the future protection of vulnerable children. The opinions and questions that have been suggested here have come from a personal social work perspective as the miscarriages of justice that have been discussed have raised new issues and ideas not just to the reader but also on a personal level. The cases have been very complex but it has been identified that mistakes continue to occur and questions are asked in their more modern field of child protection work.

VI. Conclusion

This paper has tried to make sense of the events which culminated in a selection of notorious child deaths and has attempted to understand more about the behaviour of the families and professionals involved. The ideas and research that has been reviewed have made it clear that the notion of child abuse is a shifting and much contested one. The need for a governmental strategy to ensure that children's needs are met is obvious but this is not an easy task. The ebbs and flows of policy in the second half of the twentieth century were testimony to this and the knowledge we now have about the detrimental consequences and costs demands a concerted approach. A consensus about what needs to be done about child abuse seems to be well established, but those professionals who have

claimed the territory of child abuse as their domain are now faced with the daunting task of sharing it with other reluctant professionals to provide the child protection system that is needed; a factor which is embraced in the Working Together guidelines. It is important not to underestimate the considerable complexity that has come to characterise child protection work over the last thirty years. It is also clear that the nature of the responsibilities of the relevant agencies, particularly social services, has broadened and intensified considerably. If the history of the last thirty years demonstrates anything, surely it must be that there are no simple answers. It also demonstrates that the responsibilities of certain professionals, particularly social workers, are enormous.

Child abuse cannot be explained by a single factor, nor can it be attributed to the incompetence of professionals, however this paper has identified that mistakes by professionals are common features in cases of child fatalities. Child protection work is highly visible in both public and political arenas, and consequently there are high expectations of all the professionals involved. This pressure, added to the inherent responsibilities of the work and the limited resources available, make problems in the system even more significant than they might otherwise be. Among the problems highlighted in the literature, the most commonly noted were those associated with working in a multi-agency environment, particularly difficulties of coordination and communication. Although interagency and multidisciplinary management has been identified as the most effective method of working, it is recognised that many practice misunderstandings and conflicts still occur; recognised in both literature and practice. It is clear that there are still a number of criticisms and disagreements that will continue and need to be addressed.

The shame and degradation suffered by mothers, such as Clark and Cannings, wrongly convicted of murder, has shaken public and professionals confidence. This has been done due to the professional flaws; misleading

statistics and failures to disclose crucial reports. Due to such cases, this paper has highlighted the contrasting ways in which professional's can make mistakes, leading to dramatic and tragic consequences whether it is a child fatality or a miscarriage of justice. The atmosphere of blame that is created from such cases has been to some extent justified in the conclusions that have been presented but both professionals and the public need a clear understanding of the distinction between those avoidable and unavoidable errors that have been made. This said the fallibility of professionals in child death cases have led to improvements by changing the way we think, jolting accountability and improving practice. Such structures are imperfect both they demonstrate a continuing commitment to create a more efficient service. It has taken society a long time to recognise that the abuse of children in society is a serious problem. In looking towards the future, there are a number of problems which need to be addresses in order to achieve a more effective response. The whole area of child abuse needs greater research to measure and assess the problem fully so in future child fatalities from abuse and miscarriages of justice are prevented.

WORKS CITED

- Andalo, D. *Social Workers 'More Protected' After Climbie Care Worker Ruling*, 2005. [Online] Available From <http://www.guardian.co.uk/society/2005/jun/09/childprotection.uknews>. <Accessed 3rd January, 2010>.
- Bader, Shannon., Mario Scalora, Thomas Casady, and Shannon Black. "Female sexual abuse and criminal justice intervention: A comparison of child protective service and criminal justice samples." *Child Abuse and Neglect* 32.1 (2008): 111-19.
- Batt, John. *Stolen Innocence: The Story of Sally Clark*. London: Ebury, 2004.
- Batty, David. *Climbie Doctor Admits Errors put Girl at Risk*, 2001. Guardian Unlimited 12th October. [Online] Available From <http://society.guardian.co.uk/climbie/story/0,,573068,00.html>. < Accessed 2nd April 2007>.
- BBC Radio Four. *Women's Hour: Angela and Terry Cannings*, 2005. [Online] Available From http://www.bbc.co.uk/radio4/womanshour/2005-07_fir_03.shtml. <Accessed 15th January 2008>.
- Biair, Tony. *Prime Ministers Speech on the Launch of the Children's Green Paper 'Every Child Matters'*, 2003. [Online] Available From: <http://www.number-10.gov.uk/output/page4426.asp>. <Accessed 12 October 2006>.
- Calam, Rachel. and Franchi, Cristina. *Child Abuse and Its Consequences*. Cambridge: Cambridge UP, 1968.
- Cannings, Angela. *Against All Odds: A Mothers's Fight to Prove Her Innocence*. London: Time Warner Books, 2006.
- Cavanagh, Kate, Emerson Dobash, and Russell Dobash. "The murder of children by fathers in the context of child abuse." *Child Abuse and*

- Neglect* 31.7 (2007): 731-46.
- Colwell, Maria. *Children at Risk: Joint Report of the County Secretary and Director of Social Services*. Lewes: East Sussex County Council, 1976.
- Commons Science and Technology Committee. *The Use of Forensic Evidence in Court*, 2005. [Online] Available From <http://www.publications.parliament.uk/pa/cm200405/cmselect/cmsctech/96/9610.htm>. <Accessed 20 January 2010>.
- Cooper, Andrew. "Surface and Depth in the Victoria Climbié Inquiry Report." *Child and Family Social Work* 10 (2004): 1-9.
- Corby, Brian and Pat Cox. "Using Child Abuse Inquiries in Child Protection Education and Training." *Social Work Education* 19.3 (2000): 219-30.
- Corby, Brian. *Child Abuse: Towards a Knowledge Base*. Berkshire: Open UP, 2006.
- Criminal Case Review Commission. *Court of Appeal Citation*. London: Criminal Case Review Commission, 2003.
- Department of Health. *Child Abuse: A Study of Inquiry Report 1980-1989*. London: HMSO, 1991.
- Dyer, Clare. *Cherished*. London: British Medical Association, 2005.
- Everson, Mark, and Jose Miguel Sandoval. "Forensic child sexual abuse evaluations: Assessing subjectivity and bias in professional judgements." *Child Abuse and Neglect* 35.4 (2011): 287-98.
- Fawcett, Barbara, Brid Featherstone, and Jim Goddard. *Contemporary Child Care Policy and Practice*. Hampshire: Palgrave MacMillan, 2004.
- Gardner, Ruth. "The Challenges of Integrating Children's Services." *Child Abuse Review* 15 (2006): 373-79.
- Gornall, Jonathan. "Where Real Blame Lies for Scandal of Infant Deaths." *The Times* March 30, 2005. [Online] Available From http://www.timesonline.co.uk/tol/life_and_style/article439768.ece.

<Accessed 20th January 2010>.

- Hanvey, Chris. *The Lessons We never Learn*. Observer, 2003. 26 January [Online] Available From: <http://society.guardian.co.uk/climbie/comment/0,,882568,00.html>. <Accessed 12 October 2010>.
- Hershkowitz, Irit. "The effects of abuse history on sexually intrusive behaviour by children: An analysis of child justice records." *Child Abuse and Neglect* 35.1 (2011): 40-49.
- Hien, Denise, Lisa Cohen, Nathilee Caldeira, Peter Flom, and Gail Wasserman. "Depression and anger as risk factors underlying the relationship between maternal substance involvement and child abuse potential." *Child Abuse and Neglect* 34.2 (2010): 105-13.
- Hey, Edmund. "Suspected Child Abuse: The Potential for Justice to Miscarry." *British Medical Journal* 327 (2003): 299-309.
- HM Government. *Working Together to Safeguard Children*. London: Stationary Office, 2006.
- Hopkins, Graham. *What have We Learned/ Child Death Scandals Since 1944*, 2007. [Online] Available From <http://www.communitycare.co.uk/articles/2007/01/11/102713/what-have-we-learned-child-death-scandals-since-1944.html>. <Accessed 2nd January 2010>.
- Huff, Dany. *The Line Through Sally Clarks Life*, 2007. [Online] Available From <http://www.truecrimeblog.co.uk/2007/03/line-through-sally-clarks-like.html>. <Accessed 20th January 2010>.
- Jardine, Cassandra. *Its Getting Worse for Vulnerable Parents*, 2004. [Online] Available From <http://.telegraph.co.uk/health/main>. <Accessed 16th January 2010>.
- Jones, David, John Pickett, Margaret Oates, and Peter Barbor. *Understanding Child Abuse*. Hampshire: MacMillian, 1982.
- Kempe, Ruth and Henry Kempe. *Child Abuse*. London: Fontana/Open Books, 1978.
- Lamming, K. *The Victoria Climbié Inquiry: Report of an Inquiry*, 2003.

- [Online] Available From <http://www.victoria-climbie-inquiry.org.uk/finreport/finreport.htm>. <Accessed 3rd January 2010>.
- Leander, Lina. "Police interviews with child sexual abuse victims: Patterns of reporting, avoidance and denial." *Child Abuse and Neglect* 34.3 (2010): 192-205.
- Monckton, Walter. *Report by Sir Walter Monckton K.C.M.G., K.C.V.O., M.C., K.C. on the Circumstances which Led to the Boarding out of Dennis and Terence O'Neill at Bank Farm, Minsterley, and the Steps taken to Supervise their Welfare*, 1945. [Online] Available From <http://bopcris.ac.uk/bopall/ref9684.html>. <Accessed 2nd January 2010>.
- Munro, Eileen. *Effective Child Protection*. London: Sage, 2002.
- Parton, Nigel. *Safeguarding Childhood: Early Intervention and Surveillance in a Late Modern Society*. Hampshire: Palgrave MacMillan, 2006.
- Platt, Dendy. and David Shemmings. *Making Enquiries into Alleged Child Abuse and Neglect*. Chichester: John Wiley, 1996.
- Radbill, Samuel. "A History of Child Abuse and Infanticide." *The Battered Child*. Ed. R. E. Helfer and C. H. Kempe. London: London UP, 1968.
- Rose, Gallery. *Sally Clark Doctor, David Southall, Faced being Struck Off*, The Times, November 28th, 2007. [Online] Available From <http://business.timesonline.co.uk/tol/business/law/article2957762.ece> <Accessed 16th January 2010>.
- Sinclair, Ian. and John Cordon. *A Management Solution to Keeping Children Safe: Can Agencies on Their Own Achieve What Lord Laming Wants?*, 2005. [Online] Available From <http://www.jrf.org.uk/bookshop/details.asp?pubID=728>. <Accessed 3rd January 2010>.
- The Royal College of Pathologists and The Royal College of Paediatrics and Child Health. *Sudden Unexpected Death in Infancy*. 2004. [Online] Available From <http://www.rcpch.av.uk/publicaitons>. <Accessed 21st January 2010>.

Valios, N. *Do Not Knock the Experts*, 2006. [Online] Available From <http://www.communitycare.co.uk/articles/2004/02/26/43871/dont-knock-the-experts.html?key=DRUG%20RABUSE>. <Accessed 12 October 2010>.

Wilson, K. and A. James. *The Child Protection Handbook*. London: Bailliere Tindall, 2002.

Abstract

An Examination of the Role that Child Protection Professionals Play in an Identified Range of High Profile Cases in Britain: Some Criminal Justice and Historical Perspectives

Kwan Choi

Child abuse is a dominant social issue guaranteed to capture the headlines whenever it occurs. A disturbing factor of this has been the attendant public and media attacks on professionals, particularly individual social workers and the social work profession. The attacks are sometimes vociferous and abusive and with that in mind it felt necessary that as a trainee of the social work profession, the reasons behind this should be examined. There is an apparent atmosphere of blame and criticism surrounding public inquiries set up to investigate the deaths of children at the hands of their parents or carers. Latterly there has also been a plethora of cases involving false allegations of abuse, some of which have led to public trials and miscarriages of justice. Subsequently the last few decades has seen the British public bombarded with page after page of child protection disasters and this paper tries to make sense of the events which culminated in a selection of these notorious child deaths and tries to understand more about the behaviour of the families and professionals involved. There are two clear categories of individual child fatalities covered in this paper: tragedies for the children caused by deliberate abuse by carers and compounded by mistakes made by professionals and miscarriages of justice against parents who had suffered the tragic loss of

a child, which was then compounded by professional accusations which arose from professional mistakes. Therefore the focus of this paper is of child fatalities, recognising their importance in shaping child protection policies and procedures, exploring the long and painful history of child protection and scrutinising the continuing dilemmas and problems it presents.

Key words: Child Abuse, Death, Protection, Miscarriages of Criminal Justice, Britain

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