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Introduction

1. On 19th January this year, on the day that the Court of Appeal published its judgment allowing the appeal of Angela Cannings against conviction, I announced that I had established a review of all cases of convictions in the last 10 years of a parent for the unlawful killing of babies and infants under 2. At the same time I asked the Crown Prosecution Service to review the current cases involving an unexplained infant death. A copy of my statement to the House is attached as **Annex A**.

2. The judgment came at a time of growing concern about the safety of convictions of parents for so-called cot deaths. This judgment had serious and far-reaching implications and showed clear unease about the safety of certain convictions. I shared the unease of the Court of Appeal. Young and vulnerable children need the protection of the law. Yet if unfair accusations or, worse still, convictions for the death of a child occur, it increases the tragedy of what is already a devastating event. This is the background against which I decided to establish this review.

3. I have since provided interim reports on the progress of that review on 5 February, 5 May and 22 July. This is the report of that review. For the reasons explained below, in relation to one category of cases, shaken baby syndrome cases, the review awaits a further clarification from the Court of Appeal. Otherwise my review is now complete.

Background

4. This review arose out of the growing concern that miscarriages of justice had occurred in relation to cases of prosecutions of mothers for killing their infant children in Sudden Infant Death Syndrome Cases ("SIDS") so called "cot death cases". Three particular cases led to this concern: the convictions and subsequent appeals of Sally Clark and Angela Cannings and the acquittal of Trupti Patel.

5. Sally Clark had been convicted of the murder of her two infant children. Her two very young children had died suddenly and for no immediately obvious reason. The prosecution's case that she had murdered them relied heavily on expert evidence to show that the children had died from harm caused to them by their mother and not from natural causes.

6. After a long campaign to overturn that conviction, the Court of Appeal eventually found that Sally Clark's conviction was unsafe and should be overturned. The Court of Appeal's

reasons for allowing the appeal were contained in its judgment of 11 April 2003. The Court was particularly concerned that certain potentially relevant evidence had not been disclosed to the defence at the trial or prior to the first appeal and particularly criticised the pathologist, Dr. Alan Williams, for the non-disclosure of potentially relevant evidence. There was also criticism of one piece of evidence given by Professor Sir Roy Meadow.

7. I was concerned at the implications of that judgment and acted swiftly to establish an Interdepartmental Group ("IDG"), consisting of members of the police, Crown Prosecution Service, and Home Office together with representatives of the Law Society and Criminal Cases Review Commission.

8. The remit of the Group was initially to examine other cases involving Dr Williams as expert, in order to determine whether similar instances of non-disclosure had, or were likely to have taken place. The ambit of that review was informed by the advice of independent Counsel.

9. I also met with the Director of Public Prosecutions and other members of the Crown Prosecution Service. The CPS agreed to identify all current cases involving Dr Williams as prosecution expert. A package of material for disclosure to the defence was to be prepared and served on the defence.

10. The work of the Interdepartmental Group into cases involving Dr Williams was overtaken by the later and larger review which I announced on 19th January this year. The specific Williams review has, however, almost concluded: 49 cases were identified for consideration and 44 reports so far written. The Interdepartmental Group will consider the remaining reports very shortly. I will report on the outcome of that review when concluded. These are not restricted to homicide cases where the victim was an infant and accordingly some would fall outside the scope of the Cannings review.

11. Shortly after the Sally Clark judgment, Trupti Patel was acquitted of charges of murdering her three infant children. The prosecution case against her involved no evidence from Dr Williams though it did involve evidence from Professor Meadow. However, it had the similarity that it concerned sudden deaths of infant children, establishment of the cause of which depended on the increasingly controversial expert evidence as to the cause of unexplained cot deaths.

12. This case increased public unease in this category of case. Whilst I understood the reasons for the CPS decision to proceed with that case, I was also concerned. The CPS issued further internal guidance on such cases on 17th June 2003.

13. It was against this background of increasing concern by the public as well as criminal justice professionals that on the 19th January 2004 the Court of Appeal gave its detailed reasons for the decision announced in December 2003 that it was allowing the appeal of Angela Cannings against her conviction for the murder of her two children.

14. In its reasons the Court expressed the view that, in the light of present medical knowledge, where there was a sudden and unexplained infant death; where there had been a prior unexplained infant death in the family; where there was a dispute between medical experts as to whether the infant had been unlawfully killed; and where there was no extraneous evidence of physical harm, convictions for those deaths were likely to be unsafe. The Court of Appeal reached this judgment in the light of an extensive review of the substantial medical research into SIDS, including recent new evidence. This tended to show that multiple unexplained infant deaths could be compatible with an innocent explanation.

15. The judgment therefore showed that, in relation to unexplained infant deaths, where the outcome depends exclusively, or almost exclusively, on a serious disagreement between distinguished and reputable experts and natural causes cannot be excluded as a cause of death, it will often be unsafe to proceed.

Scope of the Cannings Review

16. My statement on 19 January (the same day as the Cannings judgment was handed down) set out the aims of my review. The aim was to identify whether other cases of infant homicide bore the hallmarks described by the Court of Appeal as making a conviction potentially unsafe.

17. The first step was to identify the potentially relevant cases. I had asked, shortly after the conclusion of the hearing in the Cannings appeal, for all potentially relevant cases to be identified. I asked the Interdepartmental Group to assist. Their view was that the only practicable way of identifying all potentially relevant cases was to identify all recent cases of homicide of an infant by a parent. There was no way otherwise to identify all cases which were sudden infant death cases, let alone other cases which otherwise raised concerns about medical evidence.

18. The first matter that the IDG needed to agree was the scope of the review in relation to both the age of convictions and the age of the deceased child. For the age of the conviction, it was agreed that 10 years was both practicable and realisable and should ensure that all persons still in custody were included in the review. Secondly, the IDG

agreed that the age of the deceased child should be put at up to 2 years which is double the medically accepted maximum age of children susceptible to SIDS. This allowed for the maximum capture of suitable cases and ensured the review was not unreasonably confined to a small number of cases.

19. Having agreed the scope of the review the Home Office from its homicide index urgently identified all convictions for the murder, manslaughter or infanticide of a child less than 2 years of age by a parent or foster parent. Some 258 convictions were identified. This was the figure I was able to include in my 19th January statement.

20. Thereafter, in order to ensure that all relevant cases had been included three further steps were agreed to. The CPS agreed to contact each of its Areas asking for identification of all cases falling within the scope of the review. Likewise the individual police forces would also be asked to identify cases. Additionally the Law Society wrote to solicitors inviting them to notify my office of any suitable cases. Following consultation with me, it was decided to include convictions of carers in the review as the same issues could arise as in the case of parents. A small number of cases which did not fall strictly within the parameters of the review were also included at the request of defendants or their solicitors. The total number of cases reviewed finally rose to 297.

Current Cases

21. Before returning to the details of the review process, I should deal with the question of current cases. Following consultation with me the Director of Public Prosecutions took steps to review personally all current cases of SIDS deaths. 15 such cases had been identified at the date of my 19th January statement. A further 5 were subsequently identified by the police. As a result of the review of these cases by CPS Areas 14 transpired not to be SIDS cases. The remainder were considered by the Director[1]. As a result, in 3 cases the prosecution was abandoned on the grounds that it was not safe to proceed.

[1]In one case, the final review was conducted by the CPS Director of Casework because of a potential conflict of interest.

Review Process

22. Review of each of the cases required detailed examination of the papers in each case by experienced lawyers.

23. This was a very substantial exercise. In order to review each case as expeditiously as possible I established the Central Review Team: a small group of highly experienced lawyers to work on the reviews themselves led by a project manager. These staff were prosecutors, with substantial relevant background expertise. I am grateful to the Director of Public Prosecutions for making their services available to me. The Review Team looked at all the cases. In order to simplify the process an initial examination of all cases was made by the CPS Area from which the case came. This was not to provide any form of filter but to enable information to be assembled so that the CRT lawyers' task would be eased.

24. I should emphasise that in performing the review task the Central Review Team were answerable to me for their conduct of the review and not to the Crown Prosecution Service or the Director. My review is distinct from the consideration which the CPS may have to give in relation to any case which is the subject of an appeal. It was important therefore that the lawyers working on the review were clear that they were not reviewing as prosecutors responding to a possible appeal. This independence was further reinforced by two further safeguards. Firstly, all cases which the CRT considered might require review were considered by the Interdepartmental Group. Secondly, highly experienced and independent Counsel, Nicholas Price QC, was engaged to provide me with advice throughout the review. He looked at a number of cases where there were difficult issues arising, where the cases were borderline and to provide assurance as to the quality of the review.

25. More details of the process by which the files were retrieved for all these cases and the review are set out in a report to me by the Project manager, a copy of which is annexed to the Report (**Annex C**).

26. The nature of the review which I required was to identify cases where the conviction gives rise to concern for the reasons explained in the Cannings case. I instructed the Team to take a broad, rather than a narrow, approach to those issues so that they would identify any cases where there was concern even if not strictly a SIDS case.

27. I discussed with the Criminal Cases Review Commission at the outset of this review how to proceed once a case had been identified as potentially unsafe. I did not consider it

appropriate to take on the role of finally deciding whether the conviction was in fact unsafe. That would have been to usurp the role of the Court of Appeal. In any event without interrogating the defendant for his case (which it would not have been appropriate for me to do) it would not have been possible to reach a concluded view. Once a case had been identified as potentially of concern, therefore, it would be passed, if the defendant wanted, to the Criminal Cases Review Commission to take up the case and, if appropriate, present an appeal to the Court of Appeal. The defendant would be able, in some cases, where he or she had not previously appealed to the Court of Appeal, to be able to appeal directly to the Court of Appeal if the help of the CCRC was not desired. I should make it clear that I have no power to present a case directly to the Court of Appeal nor to the Criminal Cases Review Commission without consent of the defendant.

28. It follows that the fact that a case has been referred as potentially of concern does not amount to a concluded decision that it is unsafe. Equally, the fact that a case has not been identified for referral does not conclusively mean that there can be no issue in relation to the conviction. There may, for example, be other issues which were not apparent to the reviewers on sight of the papers. In all cases it is open to a defendant whose case has not been identified to exercise the right he or she has always had: to ask the CCRC to take up the case in any event.

29. The letter sent to the legal representatives of convicted defendants in each case made these points clear. A copy of the standard letter is included at **Annex B**. Where a defendant **does** indicate that he/she wishes a case to be taken up by the CCRC, the review papers would be handed across to the CCRC.

30. The review of individual cases was based on the evidence used to convict each defendant, together with any defence evidence served on the prosecution before or during trial. Those who represented defendants subject to this review possess the best possible knowledge concerning the circumstances of their client's conviction or plea of guilty. Whilst the CRT may have concerns about specific convictions, those who ultimately represent defendants may well have no concerns precisely due to the information they possess to which the CRT was not privy. By identifying those cases which either fall squarely within the ambit of the Angela Cannings judgment, or contain features which make it essential that further review is necessary, the clear concerns expressed as a result of the Cannings judgment are met. Therefore the referring letter made clear that no determination had been made on the safety of the conviction and furthermore the CCRC would decide independently whether to appeal the conviction.

31. The review of infant homicide convictions is not a CPS review. Consequently the CPS will decide in each case referred whether to contest the cases. In some they may well decide not to but in others the Director will consider it right and proper to contest appeals. It is a matter for the CPS to reach those decisions. My office will retain its files so that appropriate material can be sent to the CCRC when requested.

32. During the early stages of the review 5 cases were referred to the IDG following recommendation from the CRT that they be looked at further. Letters in the terms detailed above were sent to each of those offenders. Some have already lodged applications for appeal out of time and in others the letter has generated further counsel's advice prior to any decisions taken on whether to lodge an appeal. It should be stressed it is for the defendant alone to appeal or invite the CCRC to look at his or her case. To hold otherwise would be fundamentally wrong irrespective of concerns over the conviction.

33. Given the age of some convictions, in 9 cases legal representatives have not been able to contact their clients immediately given the lack of a current address. I remain committed to ensuring that offenders are informed of the views of the Central Review Team so that with the guidance of their legal representatives they can decide on the best course of action. As a result, my office continues to make necessary enquiries to ascertain information of assistance in locating those defendants. Once obtained, the information is passed to the legal representatives to pursue

34. The review recognised that concerns have been raised about the evidence of certain expert medical witnesses for the prosecution. In relation to each case the question for the review was; having regard to the evidence in that case, including what is now known or suspected about the expert medical evidence, was the conviction unsafe?

Results of Review

Cases considered

35. Some 294 cases have been identified as falling within the scope of the review. We have also, on request, considered a further 3 cases which strictly fell outside the time frame of the review. The vast majority, 247, of the cases were identified from a Home Office database. A further 27 were added as a result of my decision to consider homicides which resulted in the conviction of the carer of the deceased child. A further 20 were identified by the police, or others.

Cases finalised

36. Of the 297 cases, all have been finalised. All cases where the offender remains in custody, or have been the subject of a hospital order, have been identified. Of these 'custody cases', 9 have been referred.

37. The review only identified 3 cases where there were convictions precisely analogous to that of Angela Cannings, i.e. SIDS cases. These cases appear to fall four square within the Cannings judgment. All of them were referred to the defendants' advisers. These are identified in the CRT report as Category 1 cases.

38. As well as SIDS cases, the CRT identified a number of cases where detailed consideration of the case papers gave sufficient cause for concern in relation to the medical evidence relied upon at trial so as to warrant further consideration.

39. There were in all 25 of these cases. All have been referred to representatives of the defendants in the same way as the 3 SIDS cases. It is now for them and the defendants to decide what, if any, further steps to take. It should be noted that referring such a case does not mean that it is an unsafe conviction. It may indicate only that there is an issue which merits further consideration by a defendant's representative. That may or may not lead to an appeal. We do not know, also, if these concerns had already been considered and dismissed by a defendant and a defendant's representative. They are known as Category 3 cases in the CRT report to me.

40. The CRT identified to the IDG 34 cases for possible referral to the defendant. All but 6 of those cases identified were accepted for referral. As to the remaining 6, after careful consideration by Nicholas Price QC, the members of the IDG and myself, it was decided that they did not give sufficient cause for concern to justify referral.

41. In another 175 cases no concerns about the safety of the conviction arose after careful examination of the papers by CRT. Nor were they shaken baby cases. These are termed Category 4 cases in the CRT report.

42. That leaves as a final category, which I asked the team to identify as a separate category, all cases of "shaken baby syndrome". 97 cases were so categorised; in 9 of those cases the CRT identified them as category 3 cases and 8 were subsequently referred.

43. The term "shaken baby syndrome" has become very widely used throughout the world to describe a category of non-accidental injury believed to result from severe shaking of

a baby or small infant, associated for some commentators with impact of the head. This term is open to objection; it is not so much a medical diagnosis as an explanation for an injury. There is not agreement on exactly what injury patterns do or do not fall into this category. There is a particular debate over the issue whether the injuries can be the result of shaking alone or whether shaking with impact is involved (although the view can be held that this may be a sterile debate as all shaking is likely to involve some impact (chin on chest wall or back of head on spine). As a result, other terms are also in use, including shaken impact syndrome, whiplash shaking syndrome and abusive head trauma.

44. However, the term "shaken baby syndrome" ("SBS" for short) is one that has become familiar not only to health care and child protection professionals but also to the wider public. I will, therefore, use that term in this report for convenience. I do not intend by so doing to be taken as expressing agreement with any particular school of medical thought.

45. SBS cases differ in a number of respects from sudden infant death syndrome cases. In particular a SIDS case involves the sudden death of a healthy baby where there may be no physical signs of the cause of death. In an SBS case, on the other hand, there will be clear physical evidence of the cause of death. This will commonly, though not exclusively, be subdural bleeding, retinal haemorrhaging and axonal injury (injuries to the axons in the brain) which may be associated with other injuries, such as fractures of the ribs or fractures of the long bones. The issue in these cases is rather what was the cause of the elements said to show SBS and, in particular whether they were due to non-accidental injury.

46. There is, however, this similarity with SIDS cases: there has been a growing medical controversy about the identification of the cause of these injuries. It was for this reason that I asked the team to identify these cases separately. In understanding the nature of this controversy I have been much assisted by Professor Tim David, Professor of Child Health and Paediatrics at the University of Manchester and I have read some of the voluminous medical literature myself, including the key studies which lie at the centre of it.

47. It may be helpful to explain that controversy in very broad terms. In the early 1970's Guthkelch noted that not all infants with subdural haematoma had external marks of injury on the head and postulated that they could be produced by shaking rather than being struck. In 1972 Caffey suggested that the cause of the haematoma in cases where there was no sign of external trauma to the scalp was whiplash shaking and he coined the term "whiplash shaken infant syndrome". The view was, and still is, held by many that the forces needed to create such injuries are very substantial and are not consistent with normal handling or accidental treatment. The existence of these injuries is therefore taken

as evidence of criminal behaviour by inflicting deliberate, violent and obviously inappropriate shaking of the child. It is worth noting that they may very well not be the only evidence and there could be, and in some cases is, strong evidence of abuse from other evidence, such as witnessed abuse or the presence of other injuries. This is a further difference from the SIDS cases.

48. Another school of thought, of which Dr Jennian Geddes and Prof Helen Whitwell are especially well known proponents, holds that the symptoms which have been taken as indicative of criminal behaviour can in fact be caused by less trauma than had previously been thought[2], or more recently, by no trauma at all. A central feature of the hypothesis is the proposition that the subdural haematoma typical of the SBS diagnosis may be caused by lack of oxygen, and not just physical trauma, and that the lack of oxygen can itself be caused by less severe trauma to the brain stem or, as I have noted, more recently, no trauma at all[3]. The basis on which this is proposed is hotly disputed. For example, in a recent article by Punt et al[4] the authors mount a vigorous and detailed attack on the methodology, the logic and the evidential base for the Geddes approach. Geddes responded[5] with a robust defence in which the conclusion is maintained that a lack of oxygen can cause a subdural haemorrhage. I do not think it unfair to say that the Geddes theory has not been proven.

49. The issue which arises is whether this material, in the form of the views of Dr Geddes and others, casts doubt on convictions in SBS cases particularly where the verdict was obtained prior to the publication of the Geddes work in 2001.

50. This is not an issue on which the Courts have yet given a definitive view in the criminal context. In A Local Authority v (1) A (2) D in 2001 the President of the Family Division, having heard a number of experts, noted that "..all the experts ... came round to the opinion that the degree of force required to cause subdural haematomas need not be as great as previously believed.." But she went on to say, notwithstanding the evidence given by Professor Whitwell, that, "It remains equally clear that the force used must be out of the normal rough and tumble of family life and must be unacceptable and inappropriate and obviously so.". In Stacey[6] the Court of Appeal heard fresh medical evidence which included material based on the Geddes theory. The Court declined to accept that it was anything other than the appellant's actions which caused the fatal damage to the child

[2] See especially Geddes et al Neuropathology of inflicted head injury in children I and II Brain 124, 1290-8 and 1299-1306 2001
[3] Geddes et al: Dural haemorrhages in non traumatic infant deaths: does it explain the bleeding in shaken baby syndrome Neuropathology and Applied Neurobiology 29: 14-22,2003
[4] "The unified hypothesis of Geddes et al is not supported by the data" Paediatric Rehabilitation 2004 Vol 7 no 4 173-184.
[5] "Violence is not necessary to produce subdural and retinal haemorrhage": a reply to Punt et al; Paediatric Rehabilitation, 2004 Vol.7, No.4, 261-265
[6] [2001] EWCA Crim 2031

but did substitute a verdict of manslaughter for that of murder on the grounds that there was insufficient evidence of an intention to do really serious harm.

51. It is clear that this difficult area will receive continued careful thought by the medical and scientific community in the future. That is to be very much welcomed. SBS will also continue to be a feature in some cases which come before the Courts.

52. I also recognise the importance of the role played by the Court of Appeal in its consideration of such cases. I became aware that the Court of Appeal had granted leave to appeal in a case referred to it by the CCRC which contained SBS features. I discussed this case with Professor Zellick of the CCRC. It was not a case of fatality and, therefore, did not fall within the ambit of my review. The case was due to be heard originally in October. I thought it right that I await the results of the Court's consideration of that case before announcing the results of the review, as it is possible that the Court may issue general guidance on the issue of whether convictions in SBS cases are generally safe or unsafe.

53. However, since then the hearing date of this case has been put back more than once. It has now been joined with 3 other SBS cases, all of which are cases which have been considered in this review. This increases the prospect that the Court of Appeal will give general guidance on SBS issues. However, the cases will now not be heard before summer 2005 at the earliest. In these circumstances I have considered it right not to wait any longer but to issue the report now.

54. Knowledge of SBS will continue to grow over time and I appreciate that any determination I make on these cases is based on current knowledge alone. Nevertheless, I am satisfied that it is appropriate to issue my report at this time. Once the Court of Appeal has had an opportunity to consider the cases which contain SBS features, it may well decide to issue guidance. If that is the case then I will of course consider very carefully what conclusions the Court draws from its consideration of these cases. This decision in no way affects the ability of any defendant whose conviction falls within this category of homicides to take legal advice on the possibility of appealing his or her conviction.

55. This is subject to two caveats.

56. First, in relation to 8 of these cases the detailed review of the files indicated other areas for concern apart from the core question of SBS diagnosis. Those 8 cases have therefore been included in what I have termed the "referred cases". There are therefore 89 cases which remain for further consideration in the light of the Court of Appeal judgment.

57. Second, it is of course open to any convicted person himself to seek a further appeal, either directly if that route is still open to him, or through the Commission.

58. Nonetheless, if the Court of Appeal's decision carries implications for the safety of homicide convictions in the generality of cases where SBS is an issue, or in a subset of those cases, I would of course reconsider my conclusions in the light of that decision.

59. It should be noted that none of these cases was a SIDS case and thus did not fall within the strict terms of the Court of Appeal's decision in *Cannings.*

Progress to date

60. In relation to the 3 cases which I have identified are broadly similar to the Cannings case, one of them is presently being considered by the CCRC. In relation to another, instructions are being sought by legal advisers on whether to appeal.

61. In relation to the 25 other cases which have been referred on the grounds that there is a genuine concern surrounding their convictions, one is already listed for a further directions hearing before the Court of Appeal in February 2005. There are a further 4 where I have been made aware that work preparatory to an appeal or CCRC referral is already underway. In another 2 cases, I have been requested to refer the case papers to the CCRC.

62. The process of deciding whether to appeal or refer to the CCRC is likely to be lengthy in a number of cases, and it is expected that the numbers given above will rise over the next few months. I should stress that the decision in question is for the defendant alone. I am aware of 2 cases at present where the defendant has instructed his legal representatives not to pursue an appeal.

Acknowledgments

63. Finally, I would like to repeat the thanks and acknowledgments to all who have assisted in this review as set out in chapter 9 of the CRT report to me and also to Howard Cohen, CRT Project Manager

21 December 2004

ATTORNEY GENERAL
R v Angela Cannings

The Attorney-General (Lord Goldsmith): Today's Judgment in the Court of Appeal in the appeal against conviction of Angela Cannings has serious and far-reaching implications. The Judgment has demonstrated that, in relation to unexplained infant deaths, where the outcome of the trial depends exclusively, or almost exclusively, on a serious disagreement between distinguished and reputable experts, it will often be unsafe to proceed. I share the unease expressed by the Court of Appeal in relation to such convictions.

Following similar reported comments of concern by the Court of Appeal at the conclusion of the hearing of this tragic case in December, I asked for all cases potentially involving Sudden Infant Death Syndrome to be identified as quickly as practicable. To date, some 258 convictions over the past 10 years have been identified involving the murder, manslaughter or infanticide of an infant aged under 2 years of age by its parent. These cases will be considered further as a matter of urgency to establish whether they bear the hallmarks of a conviction which the Court of Appeal Judgment today has indicated may be unsafe. I expect this process to be completed swiftly over the coming weeks. I propose that in all cases which appear to meet the criteria laid down by the Court of Appeal the convicted person will be informed of these developments as soon as possible. The possibility then will be for the case to be referred to the Criminal Cases Review Commission (CCRC) or for the convicted person, with legal advice, to consider an appeal out of time to the Court of Appeal. The CCRC has the power under the Criminal Appeals Act 1995 to consider whether the convictions should be referred to the Court of Appeal.

I am particularly concerned about cases where the defendant has been sentenced to a term of imprisonment which is still being served. We have so far identified 54 such cases which may involve Sudden Infant Death Syndrome. These will be accorded the highest priority.
I have already spoken to the Chairman of the CCRC and will be meeting him in the coming week to discuss how the review of these cases can be expedited.

I have also asked the Crown Prosecution Service to conduct a review of the 15 ongoing cases involving an unexplained infant death of the sort described in today's Judgment.

R v xxxxxxxxxxxx CROWN COURT xxxxxxxxxxxxx xxxxx 19xx

As you may know, as a result of the Court of Appeal's judgement in Angela Cannings the Attorney General invited an Interdepartmental Group to review previous cases of murder, manslaughter or infanticide of a child under 2 years of age by a parent, foster parent or carer.

According to records held by us, you represented the above defendant who was convicted of xxxxxx for xxxxx at xxxxx Crown Court on xxxxx 19xx. His/her case was one of those examined by the Interdepartmental Group. As a result you are advised that it may be appropriate for the safety of your client's conviction to be considered further by the Court of Appeal or, if appropriate, the Criminal Cases Review Commission.

You will wish to give your client advice as a result of this letter. It may be the case that your client previously had an appeal against conviction considered by the Court of Appeal. In those circumstances it will not be open to him/her to make an application out of time to the Court of Appeal. The only option would be to apply to the Criminal Cases Review Commission for that body to investigate the conviction and if it is appropriate for them to then refer it to the Court of Appeal. This office is prepared to assist by bringing your client's conviction to the attention of the CCRC by sending the case papers. **Please let us know whether your client consents to this and we will undertake to do so without delay**. Bringing your client's case to the attention of the CCRC does not in any way mean that the CCRC will refer your client's conviction to the Court of Appeal. It will be a matter for that body to investigate the case and arrive at an independent decision on whether or not to refer your client's case.

I should stress that the Interdepartmental Group has not made any determination on the safety of any relevant conviction and this letter does not mean that your clients' conviction is unsafe. Should any appeal take place the Crown Prosecution Service will independently decide whether to contest the appeal.

Finally, please acknowledge by return receipt of this letter return and confirm that you are acting or intend to act for the named defendant. If that is not the case you must notify us immediately of that fact.

Should you have any queries in relation to this letter please contact Stefan Peyton at the Legal Secretariat to the Law Officers, 9, Buckingham Gate, London SW1E 6JP, (020) 7271 2428, email: stefan.peyton@lslo.x.gsi.gov.uk.

A copy of this letter is being forwarded to the Registrar of Criminal Appeals and to the Criminal Cases Review Commission.

REPORT OF THE CRT TEAM

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LETTER TO THE ATTORNEY GENERAL

Re: The Review of Past and Current Infant Death Cases following the decision of the Court of Appeal (Criminal Division) in R. v. Angela Cannings (2004)

On 19 January 2004, you asked that a review of past infant death cases take place in order to identify if in the light of the Cannings judgment there were other previous potential miscarriages of justice so that appropriate action could be taken to remedy them.

I am pleased to enclose a report detailing the findings of the Central Review Team established under your supervision. In addition I have included a few remarks about the possible lessons to be learnt from this exercise based on my experiences in managing this project.

I take personal responsibility for all that is set out in the report.

Howard Cohen
Project Manager

EXECUTIVE SUMMARY

Chapter 1 – Introduction

The introduction sets out the chronology of events from the point where the Court of Appeal overturned the convictions against Angela Cannings on 10 December 2003. An overview of the process of planning to the point of the implementation of the project is provided giving specific details of the announcements made by the Attorney General and the Director of Public Prosecutions.

Chapter 2 – Objectives

This chapter sets out the main objectives of the project namely:

I. To establish in accordance with the Attorney General's announcement whether any features identified in the Cannings judgment made the convictions obtained in past cases potentially unsafe; and

II. To oversee the review of current SIDS prosecutions by the Director of Public Prosecutions (DPP).

In addition further details are provided about the extension of the scope of the project and the reasons for this.

Chapter 3 – Outline of Process

An overview of the process by which the cases were reviewed is provided. Further expansion of the 4 main stages (as listed below) identified for the review is provided with appropriate explanations of the reasons for these steps being taken. In addition details of quality and time controls are set out.

The 4 main stages of the review process were:

- Identification and locating of case papers;
- Initial consideration by CPS Areas;
- Detailed review by Central Review Team (CRT) who recommended to the Inter Departmental Group (IDG) whether or not to notify defence and CCRC; and
- Validation process by the IDG who would carry out notification to the defence and CCRC. (This subsequently was extended to include a review by independent counsel of the cases before cases were referred to the IDG).

Chapter 4 – Controls

Further details are provided on the control measures used during the project with explanations where appropriate. The controls stated are:

- Standardisation of instructions;
- Use of Counsel;
- The filtering of work through the process of a single countersignature;
- The provision of deadlines and diarised action for failures to comply with them;
- The use of briefings and highlight reports; and
- The independence of review by use of the IDG.

Chapter 5 – Results Achieved

In relation to the past case review this chapter highlights the main results achieved in the project. The headline figures provided are:

- Total number of cases for review: 297
- Total cases finalised by CRT Project Manager: 297
- Total cases still outstanding: 0

Regarding the current case review, the headline figures are:

- Total cases notified to the DPP – 15 by CPS Areas and 5 by police
- Total Cases wrongly notified or resolved by CPS Area – 14
- Total cases considered by the DPP* – 6

*One case was not reviewed by the DPP but by the Director, Casework Directorate due to a possible conflict of interest.

Chapter 6 – Benefits Delivered

The main benefits are identified as being:

- The identification of past cases which are potentially unsafe and notification to the defence;
- Restoring public confidence in the CJS; and
- Consideration of the impact of Cannings to current cases.

Chapter 7 – Learning Points

This chapter set out the main learning points that were thought to be of possible benefit in the future. The issues highlighted were mainly practical and included the need to review the RMU retention policy, the use of counsel, the centralisation of cases to ensure consistency and the need to plan for delay.

CHAPTER 1 – INTRODUCTION

1.1 On 10 December 2003, the Court of Appeal overturned Angela Cannings' convictions for the murder of her infant children. The Court reserved judgment, but asserted that the case raised issues of general public interest in relation to infant deaths.

1.2 Pursuant to a request by the Attorney General, on 16 January 2004 a notice was sent to all CPS Areas requesting that they identify all current Sudden Infant Death (SIDS) cases in anticipation of the imminent Court of Appeal judgment. As a result CPS Areas identified 15 cases. In addition the police provided some information about a further 5 cases.

1.3 On 19 January 2004, the Court of Appeal provided its reasons for the judgment in R v Cannings. In summary the Court stated that a conviction is likely to be unsafe where there is any sudden unexplained infant death where there has been a prior unexplained infant death in the family, where there is a dispute between medical experts as to whether the victim was unlawfully killed, and where there was no extraneous evidence of deliberate harm.

1.4 On the same day the Attorney General made a statement indicating that some 258 convictions had been identified over the past 10 years involving murder, manslaughter or infanticide of an infant aged under 2 by its parent. This figure was obtained from the Home Office Homicide Index. The Attorney General indicated that he wanted these cases considered to establish whether they contained features identified by the Court of Appeal in the Cannings case, which could potentially make the conviction unsafe. **The review's function was not to establish whether any conviction was unsafe and the CPS would completely independently decide whether to contest any appeal, which may subsequently be made.** Priority was to be given to those cases where offenders were still in custody. In those cases that fell within the scope of the Cannings judgment, the defence would be notified in order for them to consider appealing or referring the case to the Criminal Cases Review Commission (CCRC).

ANNEX C – REPORT OF THE CRT TEAM

1.5 On 20 January 2004, an instruction was sent by the Director of Public Prosecutions (DPP) to all CPS Areas requesting that they review all current cases within 28 days. If a decision to proceed were taken then the case would be reviewed by the DPP personally. In addition the DPP issued a press notice highlighting that this review was underway (see **Annex 1**).

1.6 On 22 January 2004 the Attorney General requested that the Interdepartmental Group (IDG) reviewing Dr Williams' cases following the Sally Clark judgment should meet. The IDG consisted of representatives from a number of CJS agencies namely CPS, Home Office, ACPO, The Law Society and the CCRC. The representative of the Attorney General from the Legal Secretariat To The Law Officers chaired it. The purpose of the meeting was to extend the role of the IDG to handle the review of cases following the Cannings judgment.

1.7 The IDG agreed to the review having the following key stages:

- Identification and locating of case papers;
- Initial consideration by CPS Areas;
- Detailed review by central review team (CRT) who recommend whether or not to notify defence and CCRC; and
- Validation process by the IDG in relation to those cases identified by CRT as potentially being ones which should be considered further by the Court of Appeal or CCRC. Once the recommendation has been ratified by the IDG, the Deputy Legal Secretary, as Chair would write to those offenders' legal representatives and notify the Court of Appeal and CCRC. (This subsequently was extended to include a review by a highly experienced independent Queen's Counsel of the cases before cases were referred to the IDG).

1.8 On 30 January 2004 further and detailed guidance was sent by the DPP to CPS Areas setting out the process of review and seeking their assistance to identify unlocated files; to review current and past cases; and to provide regular progress updates.

1.9 The purpose of this report is to detail the findings and the process by which the results were achieved. In addition observations are provided regarding the learning points for all agencies involved, positive and negative, which may assist in developing best practice should such a review be necessary in the future.

CHAPTER 2 – OBJECTIVES

2.1 The main objectives of this project were:

I. To establish in accordance with the Attorney General's announcement whether any previous cases of infant homicide contained features identified in the Cannings judgment which could make the convictions potentially unsafe; and

II. To oversee the review of current SIDS prosecutions by the Director of Public Prosecutions (DPP).

III. To make recommendations to the IDG in accordance with the agreed categorisation as set out in Paragraph 3.11 below.

2.2 It was also intended to demonstrate to the public that the Criminal Justice System (CJS) was capable of identifying potential miscarriages rapidly and take appropriate steps to correct them, thus maintaining confidence in the CJS as a whole.

2.3 The initial scope of the project was restricted to contested cases over the past 10 years (taken from 10 December 2003) involving murder, manslaughter or infanticide of an infant aged under 2 by its parent. The two-year age restriction was based upon scientific findings that SIDS cases were effectively not found in infants over the age of 2.

2.4 During the course of the implementation of the Project its scope was extended to cover:

- Uncontested (guilty plea) cases;
- Cases involving carers as well as parents;
- Cases over 10 years old that appeared on the Home Office list or where notification of concern about safety was raised by defence solicitors or defendants directly.

These extensions ensured that the review of infant homicides was as comprehensive as possible. As the review covered all infant homicides within a 10-year period it additionally captured those cases of murder, manslaughter or infanticide which are commonly termed "shaken baby syndrome" cases.

2.5 In order to achieve the objectives it was necessary to ensure that a robust and efficient process was established.

CHAPTER 3 – OUTLINE OF PROCESS

Current Cases

3.1 The system of overseeing the review of current cases was straightforward. CPS Areas and police had already identified the current cases and a database was prepared to monitor progress on these.

3.2 On 20 January 2004 CPS Areas were instructed urgently to review cases within 28 days and where a decision was taken to continue with a prosecution, to refer the case to the DPP for his personal consideration.

3.3 Following the expiry of the 28 days, CPS Areas where cases remained outstanding for review were asked to provide an explanation for the delay.

Past Cases

3.4 The system for the consideration of past cases was much more involved (**see Annex 2**). The first stage of the process required the identification and location of case papers. In order to ensure that as many cases as possible were identified the following steps were taken:

- The Home Office provided details of cases on their Homicide index;
- The Law Society wrote to defence firms requesting that they identify cases to the CRT;
- ACPO informed police Areas to report cases to CRT;
- CPS Areas were asked to identify cases not listed on the Homicide Index.

3.5 Once cases had been identified the more difficult task of locating case files was commenced. The primary source for case files was to be the CPS Records Management Unit (RMU). Most of the cases were located by RMU. However there were a significant number which could not be located due to a number of reasons including their retention policy, retention by CPS Areas or due to insufficient details being provided to identify the case papers.

3.6 It was anticipated that some files were unlikely to be located and, as a result, provision for locating files with the aid of other sources was made. ACPO agreed to provide an experienced police officer to assist in locating these papers. The police secondee was unable to commence work until 4 May 2004, some time into the review process, although attempts were made by the CRT to locate cases in the interim, including

writing to all Crown Court locations in England and Wales. The absence of the police secondee earlier in the project did cause some delay. Fortunately, after the police secondee did commence work, virtually all the case papers were located within a period of 5 weeks. The sources for the case papers included the archive units, central and local, of Crown Courts and CPS Areas.

3.7 Once case papers were located they were sent to the relevant CPS Area to provide specific information for the Central Review Team. In accordance with the Attorney General's announcement, RMU sent custody cases (where the offender was still serving a custodial sentence) first and CPS Areas were instructed to deal with such cases as a priority over non-custodial cases. CPS Areas were required to complete a pro-forma reporting the required information to the CRT and attaching supporting papers for the CRT to consider the case independently.

3.8 In addition Chief Crown Prosecutors were required to provide weekly updates of progress to the CRT using another pro-forma .

3.9 On completing this exercise, the case papers were retained by the Area unless they were covered by the RMU retention policy in which case they were returned to RMU.

3.10 The completed pro-forma and supporting documents were sent to the CRT where the manager then allocated these papers to the CRT lawyers for their consideration. The CRT consisted of a Project Manager, a project officer, one administrative support and a team of 4 senior CPS current or former lawyers based in London, Manchester, Chester and Northamptonshire. This ensured that the CRT lawyer considered cases from a different geographical area from their own practice so as to avoid potential conflicts of interest. Two lawyers had returned from retirement and all were highly experienced in the area of infant homicides.

3.11 On receipt of papers from the Project Manager, CRT Lawyers considered them and prepared their own report classifying the case into one of 4 categories.

A set criterion for the review of cases was vital to consistent and effective reviews. An independent Queen's Counsel's advice was sought on the type of features that the CRT should attempt to identify when reviewing the cases. The IDG then agreed a system of categorisation of each case taking into account the type of features each case possessed. These are:

Category 1: Unexplained deaths in accordance with the Cannings judgment;

Category 2: Shaken Baby Syndrome cases. The CRT provided their views on a case-by-case basis regarding whether these types of cases are affected by the judgment in R v Cannings;

Category 3: Cases where there was a genuine concern about the conviction, for example:

- The veracity of the confession and/or plea; and/or
- Serious challenges to the Prosecution medical evidence; and

Category 4: Cases where there was no genuine concern about the conviction.

Reviews were undertaken on the papers provided by the CPS that would have formed part of the original prosecution file. They would usually comprise the statement of facts, counsel's summary or opening together with any relevant statements such as medical or post mortem reports. Further documentation would not be obtained unless the supporting documentation were found to be deficient for a proper consideration of the case, CRT Lawyers were instructed to obtain further and better supporting papers, including requesting the whole set of case papers, before preparing their report or finalising their consideration.

3.12 Having considered the cases and completed their report, CRT Lawyers then returned the papers and their report to the CRT Project Manager for countersignature. The counter signatory process provided a further independent consideration of the case and also ensured consistency of approach in terms of classification between the separate CRT Lawyers.

3.13 Having considered the CPS Area report, supporting documents and the CRT Lawyer report, the Project Manager established the final categorisation of the cases.

3.14 Independent counsel was instructed to review a sample of cases as an additional quality control mechanism and to make where appropriate specific recommendations to be considered by the IDG. In order to assist counsel was provided with a full list of cases and the observations of the Project Manager on these cases. This sample included all cases identified in Category 3 and a selection of cases from Category 2.

3.15 Those cases, in which the CRT recommended that further consideration should be given, were then reported to the IDG for appropriate consideration and decision as to further referral by them. Where the IDG agreed further action was necessary, a letter was written to the defence solicitors or the defendant directly where no defence solicitor could be identified.

3.16 Communication on progress was made regularly to the Attorney General. In the initial stages of the Project, reporting occurred on a fortnightly basis but this was then changed to weekly reporting from March 2004. This in turn was used to provide updates to the public .

CHAPTER 4 – CONTROLS

4.1 The establishment of set criteria for review was of paramount importance to ensuring each case was reviewed in a qualitative and consistent way. Additionally, a number of other controls were implemented into the process.

4.2 CPS Areas were given standardised instructions on the method by which they should report the required information and provided with pro-formas for completion. In addition they were also given a separate pro-forma for providing progress updates. The use of the instructions coupled with the pro-formas ensured that a level of consistency was maintained over what was provided to the CRT and ease of reference for the CRT when they assessed a case. This in turn ensured that each reviewer possessed the same basic information from areas when commencing a review.

4.3 Similarly the process used by RMU and the CRT were agreed and standardised by a preliminary meeting between them and subsequently having further ad hoc discussions to maintain the consistency when issues arose requiring some change in approach.

4.4 As stated earlier, before implementing the process of review, counsel's advice was sought on the efficacy of the approach.

4.5 Counsel was also used to affirm the independence of the project by having a sample of cases finalised further considered.

4.6 The countersignature by the Project Manager of all cases examined by CPS Areas and then considered by the CRT Lawyers, was a very useful control. It ensured that there was a consistency in approach as well as identifying any failures in the process quickly so that immediate remedial action could be taken.

4.7 In terms of timeliness a number of timescales were provided in the instructions to Areas and to CRT Lawyers to ensure swift progress was made in all cases. When the timescales expired, the CRT requested explanations and also diarised further checks in 7 days unless other deadlines had been agreed. The main timescales used were:

- 28 days to review current cases;
- 14 days for CPS Areas to review past cases from receipt of file;
- 14 days for CRT lawyers to consider papers from date sent to them; and
- 7 day CPS Area progress updates.

4.8 In deciding the application of resources regular meetings between the Project Manager and Project Officer coupled with the preparation of the progress updates for the Attorney General and DPP were effective methods for stock taking on the progress and highlighting issues for resolution.

4.9 The final, and possibly most significant control on the project, was the removal of the final decision making process from the CRT to a multi-agency body, namely the IDG. This ensured that independence was retained throughout the project as a whole.

CHAPTER 5 – RESULTS ACHIEVED

5.1 The main results are set out in the schedule of results from the project (**attached at Annex 3**).

5.2 However on a wider perspective the results achieved include:

- The identification of cases suitable for review via the use of a number of CJS agencies;
- The creation of a process to allow for review to occur in a timeous and qualitative manner;
- The extension of the wider implications of R v Cannings to other forms of infant death such as deaths by carers.

5.3 In relation to the current cases, early reconsideration of the evidence in the light of the Cannings judgment has resulted in cases not being prosecuted such that the harm to the wrongly suspected parents has been minimised. In other cases the prosecution continued, as these cases were not affected by the Cannings decision. By ensuring that proper consideration of the impact of the Cannings judgment was made before a prosecution was pursued or continued, the confidence of the CJS was retained in the CPS's ability to only bring cases that merited a prosecution.

5.4 The nature of the defendants and charges which were subject to the review are set out in Annex 4.

CHAPTER 6 – BENEFITS DELIVERED

6.1 The Project established whether any features identified in the Cannings judgment made the convictions obtained in past cases potentially unsafe.

6.2 The Project ensured that due consideration was given to the effect of Cannings in current cases swiftly and cases were either pursued or withdrawn as appropriate following consideration either at CPS Area level or following a review by the DPP.

6.3 By carrying out this exercise, public confidence in the CJS should be improved by demonstrating that despite serious concerns raised by the Cannings decision concerning the use made of expert evidence in criminal cases, the CJS is capable of taking appropriate steps to identify and correct any possible miscarriages of justice quickly, independently and effectively.

CHAPTER 7 – LEARNING POINTS

7.1 The RMU process in general was found to be very efficient in locating case papers and subsequently sending them to the CPS Areas in a timely manner. Major difficulties were only identified where the retention policy used by the RMU was found to distinguish between cases charged as murder from those where the charge was manslaughter or infanticide. In the former category, although there were some inconsistencies, the cases were retained for life whereas in the latter the retention policy seemed to suggest that papers did not have to be sent to RMU for retention and even if retained could be destroyed after the expiry of 5 years from sentence. This anomaly was pointed out to RMU and a change of the retention policy is planned imminently.

7.2 The CRT found the use of experienced counsel throughout the process a valuable asset in ensuring the Project was based on correct principles and applied the correct standards. The use of counsel to sample check the work of the CRT added a level of independence. However to a certain extent that was already present in the presence of the IDG. This additional step in this context could be considered as a 'belts and braces' approach.

7.3 During the course of the Project changes were made to its scope. These were based upon information received following the commencement and were rightly made and unavoidable. They do highlight the need for ensuring that the planning of any such project needs to focus not only on the specific issue but also the wider context as this will minimise the extent of the changes required following the commencement of a project.

It was in general found that the making of changes, once the undertaking was underway, was more difficult to implement and resulted in delays to the finalisation of the Project.

7.4 The anticipated difficulties with locating case files, resulted in the police indicating that a police secondee to the CRT would assist. After commencing work. the police secondee was tremendously efficient and successful in locating case papers within a matter of 5 weeks. There was some delay in a police secondee bring able to commence work and is a factor to take into account for future projects. The need to have staff in post quickly is critical to the ability of a project being able to meet its projected timescales.

7.5 The ability of having a small CRT with all cases passing through a single person countersigning all cases was a useful method in co-ordinating the project and ensured that consistency of approach was maintained despite the number of different persons used to review cases at the CPS Area level and the CRT lawyer level.

7.6 The use of the CPS Areas to carry out the initial stage of the review was beneficial as it spread the workload over a much larger group of professionals and thus ensured that challenging timescales could be met. On the whole, the Areas were very good at meeting the timescales set and in providing the requisite information for the CRT lawyers to further consider the cases. This was not consistent throughout the Areas and it is believed that consistency could be improved if personal links and responsibility were applied at the local level.

CHAPTER 8 – TRANSFERABILITY

8.1 The experience of having considered so many infant death cases is unique and this expertise is now capable of providing assistance to current and future prosecutions. It may be possible to disseminate this information by way of guidance on the issues that are likely to be met in prosecuting such cases, on the appropriate level of charging and on the situations when a plea to lower charges is acceptable.

8.2 The devised project and the foundations for it are capable of adoption to other situations where there is a need for a prompt review of a high volume of cases. It is difficult for any generic process to suit all situations and no doubt some adaptation will be necessary to meet the needs of a new project.

8.3 The process of obtaining files via RMU and then sending them to Areas worked extremely well and is commended to future situations where this may be necessary.

CHAPTER 9 – ACKNOWLEDGMENTS

9.1 The scale of this project and the timescales has been challenging. In order to achieve this work a considerable amount of work was put into the organisation and implementation of the project by a large group of people. The Attorney General and CRT would like this opportunity to thank all these people involved for their efforts. In particular thanks are due to:

- CPS Area administrative and legal staff for their concerted efforts in ensuring that cases were reviewed swiftly, professionally and efficiently, despite their considerable day-to-day workload;

- RMU staff for the efficient location and delivery of case papers. Particular thanks to Richard Peirce and Narinder Shergill for their organisation of this aspect of the project;

- CPS Policy Directorate (Angela Deal, Karen Kneller, Anne Murphy and Janet Pooley) for their early work in co-ordinating the project at the outset;

- Stephannie Huzziff – for her tireless work in providing administrative support to the CRT and the stock taking of the project;

- Glyn Eynon – police secondee for his extremely successful efforts in locating the case papers rapidly;

- CRT Lawyers (Claire Ward, Glynn Rankin, Brian Crebbin and Raymond Wildsmith) – for their efforts in considering a high volume of cases with integrity and professionalism;

- The individual members of the IDG for agreeing to extend their role to consider these cases on top of their other commitments; and

- The staff of the Legal Secretariat to the Law Officers.

- Counsel, Nicholas Price QC

- Professor Tim David, who provided particular assistance to the Attorney General as detailed in his report.

ANNEXES

DPP's Press Announcement 20 January 2004

Director of Public Prosecutions to take personal charge of Cot Death cases
Released: 04/02/04

Ken Macdonald QC, Director of Public Prosecutions, said today that he would personally review all Sudden Infant Death Syndrome cases that have yet to come to trial.

Mr Macdonald said: "I have asked all the Chief Crown Prosecutors who have identified cases involving an unexplained infant death of the sort described in yesterday's judgment in their Area to review them within 28 days.

"I will then personally review any cases that the CCP wishes to pursue before making a final decision on whether to prosecute."

In the full judgment handed down by the Court of Appeal yesterday, which quashed the convictions of Angela Cannings for the murder of her two children, it said new evidence had come to light which was not available to the jury, suggesting that the children may have inherited a genetic flaw which could have contributed to their deaths.

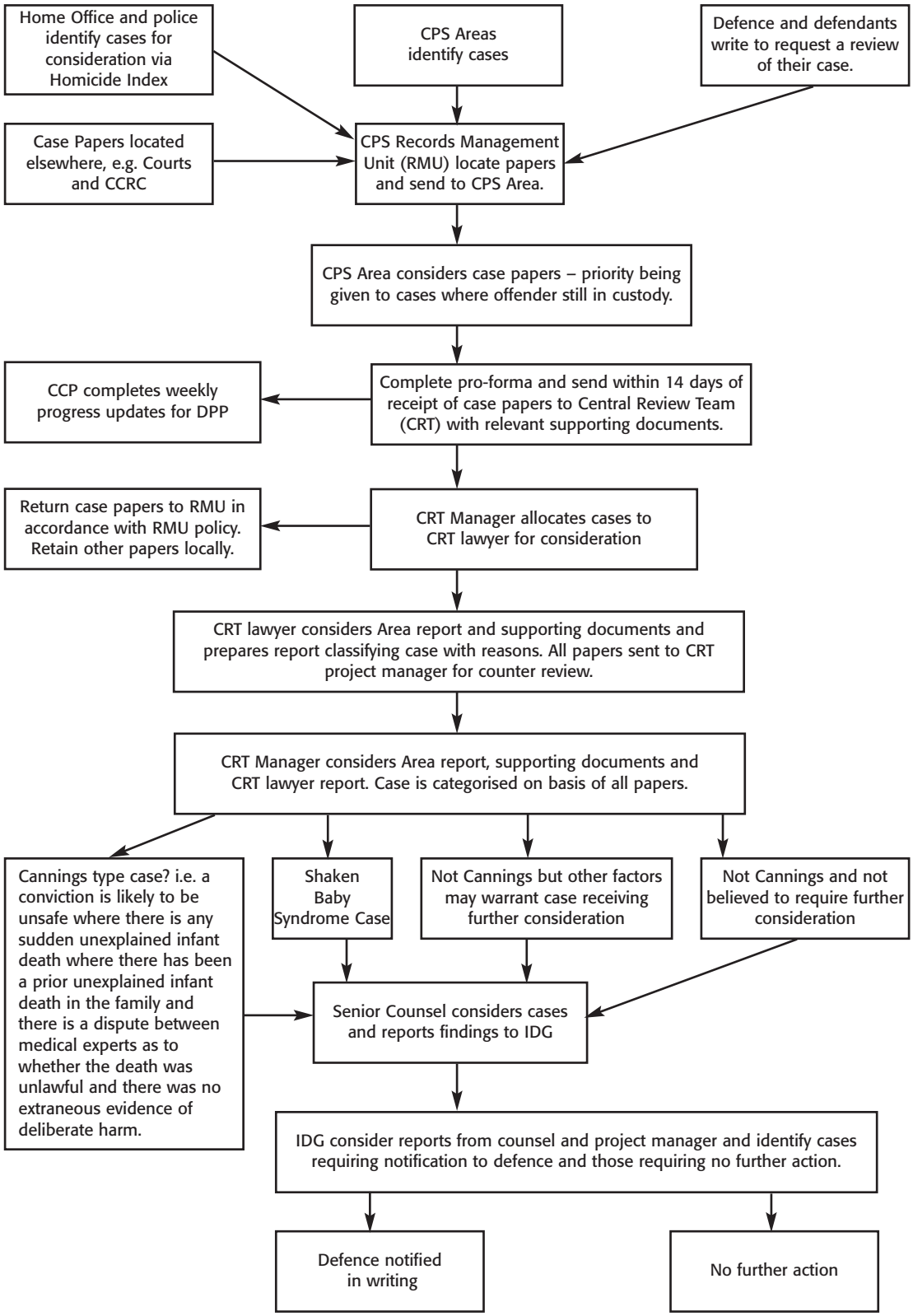
Mr Macdonald said: "It is clear that the Court of Appeal accepted that this was a matter that required a thorough examination and investigation and that the original trial was a fair one, conducted fairly.

"The Court said in its general observations that with unexplained infant deaths, in many important respects, we are still at the frontiers of knowledge and that, for the time being, where there is a serious disagreement about the cause of death between reputable experts a prosecution should not be started or continued unless there is additional compelling evidence.

"In the light of this, I decided that the review of the pending cases should be treated as a matter of utmost urgency and that I, as Director of Public Prosecutions, should take the final decision as to whether a case continues or not.

"The Crown Prosecution Service understands the great public concern in this area and is determined to act decisively."

Project Process Chart



Project Results Table

Review of Current Sudden Infant Deaths Cases

Cases notified to DPP by CPS Areas	15
Cases notified to DPP by police	5
Cases resolved by CPS Areas or wrongly notified	14
Cases considered by DPP	6*
Case(s) still under consideration	0

* one case was not reviewed by the DPP but by the Director, Casework Directorate due to a possible conflict of interest.

Review of Past infant Death Cases

The figures stated below are as at 13 September 2004.

Total cases identified for review	297
Total reviewed and finalised by CRT	297
Number of cases identified as 'Cannings 1' category	3
Number of cases identified as 'Cannings 2' category	88
Number of cases identified as 'Cannings 3' category	31
Number of cases identified as 'Cannings 4' category	175
Number of cases still requiring review	0

Nature of Defendants and Charges

Overview

1. In accordance with the Cannings judgment, the Central Review Team (CRT) identified and reviewed a total of 297 cases, comprising 311 defendants, categorising each case into one of four categories. These 297 cases were made up of:

a. 3 Category 1 cases, (consisting of 3 defendants);

b. 88 Category 2 cases, (consisting of 89 defendants);

c. 31 Category 3 cases, (consisting of 31 defendants including 9 defendants categorised as Shaken Baby Syndrome cases, but not included in the Category 2 totals);

d. 175 Category 4 cases, (consisting of 188 defendants).

Category 1 Cases

2. The CRT identified 3 Category 1 defendants. All category 1 defendants involved females; 2 of the defendants were prosecuted with multiple charges of murder and infanticide.

3. All 3 defendants were convicted of different offences. 1 defendant pleaded guilty to infanticide, the other 2 defendants were both convicted, 1 of murder and the other of manslaughter.

Category 2 Cases

4. The CRT identified 89 Category 2 defendants; these were cases of Shaken Baby Syndrome, excluding some 9 defendants included in the Category 3 list as where the CRT had a genuine concern about the conviction.

5. Of these 89 defendants, 8 were female and 81 of them involved males.

6. 50 of the defendants pleaded guilty to manslaughter and it was noted that a very high proportion, that is 46 of those 50, were male and only 4 female.

7. Cases where the defendants were convicted of manslaughter were of a similar high proportion with 19 of the 21 convicted cases being male.

8. Where the defendants were charged with murder, all 16 were male, 3 of who pleaded guilty; the other 13 being convicted.

9. Only 2 of the Category 2 defendants involved women pleading guilty to Infanticide. Therefore as a whole there were 55 cases where the defendant pleaded guilty, and 34 where the defendant was convicted.

10. Of the 55 guilty pleas, these can be further classified into 3 defendants pleading guilty to gross negligence manslaughter, 4 defendants pleading guilty arguing diminished responsibility and 1 defendant to child cruelty.

11. Of the 9 defendants identified as Category 3 (Shaken Baby Syndrome Cases), 5 of those involved women and 4 were identified where the defendant was male.

12. Of these 9 defendants, only 1 of the 5 involving a female defendant pleaded guilty to manslaughter, the remainder being convicted. Of the 4 cases involving a male defendant, all were convicted of manslaughter.

Category 3 Cases (excluding Shaken Baby Syndrome Cases)

13. The CRT identified 22 defendants as being Category 3 cases (non-Shaken Baby Syndrome cases). Of these, 12 involved females and 10 males.

14. Of the 12 females, 5 pleaded guilty to Infanticide, and 5 pleaded guilty to manslaughter. Of the 5 pleading guilty to manslaughter, where shown, 2 defendants pleaded guilty to manslaughter with diminished responsibility, 1 of gross negligence and 1 of unlawful conduct.

15. Only 1 case involved a male pleading guilty to manslaughter, while 3 cases occurred where the male defendant was convicted. There were a further 6 cases involving males where the defendant was convicted and 1 Category 3 Shaken Baby Case Syndrome case where a female defendant was convicted of murder and 1 female defendant was convicted of manslaughter.

16. Therefore there were a total of 11 cases where the defendant pleaded guilty to manslaughter or Infanticide and 11 were the defendant was convicted of manslaughter or murder.

Category 4 Cases

17. Of the 188 defendants identified as Category 4 there were 31 males and 30 females whom pleaded guilty to manslaughter. There were 26 males convicted of manslaughter and 12 females. Of the guilty pleas to manslaughter, 9 of the male defendants pleaded guilty with diminished responsibility whereas 15 female defendants pleaded to this charge.

18. One male and one female defendant each pleaded guilty to manslaughter by gross negligence and one male defendant and one female defendant pleaded guilty to neglect.

19. Of the defendants who faced murder charges there was a total of 11 cases, all male, where the defendant pleaded guilty. Where the defendants were convicted of murder there were 37 involving males and one involving a female defendant.

20. There were 25 defendants where a female pleaded guilty to infanticide, and one where a female was convicted of Infanticide.

21. Therefore there were 97 defendants where the pleas of guilty were entered; of these, 42 were male and 55 female.

22. There were 77 defendants convicted, of manslaughter and murder. Of these, 63 defendants involved males and 14 involved females.

23. There were a further 14 defendants who were either not charged, or were acquitted of any offence coming within the scope of the Review.

24. It was found that 2 of the defendants died while in the process of trial, and 6 defendants where the defendant was not charged, or not charged with a homicide related offence.

25. There were 4 defendants who were charged with child cruelty, 2 of whom were convicted and 2 of whom were acquitted.

26. A further 2 defendants were investigated, where it was determined that the defendant was unfit to plea and received a hospital order.

ANNEX C