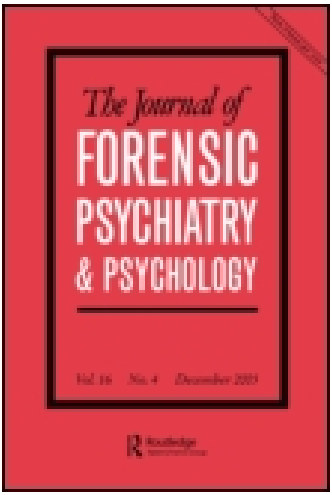

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ARTICLES

Suicide and murder in child murderers and child sexual abusers

COLIN PRITCHARD and CHRISTOPHER BAGLEY

ABSTRACT A better understanding of the child protection–forensic psychiatric interface could contribute to prevention of child homicide and suicide. Assailant rates in potential 'risk' groups (1986–95) and the suicide of assailants and male sex abusers (1995–6) were calculated, based upon an epidemiological analysis of police and official records, from within a population of 2.4 million people. There were 27 murderers. Of the murders, 81% were intra-familial. In the group of murderers 55% were 'mentally ill', 27% were 'child neglecters' and 18% were 'violent offenders'. All extra-familial assailants were child sex abusers (CSA). The homicide rate of 'mentally ill mothers' (MIM) was 10 per 100,000 (pht) p.a. of those estimated to be at risk. The 'violent offenders' rate was 44 pht p.a.; 'neglecting' mothers rate, 83 pht p.a.; and violent 'multi-criminal child sex abusers' (MCCSA) rate, 870 pht p.a. Half the 'mentally ill' murderers committed suicide, but none of the violent 'MCCSA' assailants. In the CSA cohort of 374, 3.2% of 'sex offences only' (SOO) abusers killed themselves. The violent MCCSA killed at more than 80+ times the rate of MIM; while the suicide rate of SOO abusers was 200 times the general population rate, highlighting the possibilities for the forensic psychiatric–child protection interface in prevention strategies.

Keywords: homicide, suicide, child sex abuse, psychiatry

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Perhaps the crime that causes the greatest public outcry in a civilized society is that of child homicide (Atmore, 1999; Doyle, 1996; Lamhars-Winkleman, 1994), though in statistical terms it is very rare (Prins, 1991; McDonald, 1995; World Health Organization, 1998). Moreover, with one or two notable exceptions, over the past two decades child homicide has declined in the majority of western countries, including Britain (Pritchard, 1996; World Health Organization, annual statistics 1974–98). None the less, the public's disquiet continues and centres upon the 'lurking stranger' perceived of as the stereotypical child molester (Bagley, 1997; Atmore, 1999). However, international research shows that murders and sexual assaults of children predominately occur within the family, rather than by an extra-familial assailant. In the case of intra-familial homicide, almost invariably the psychiatric dimension is very prominent in the parent who kills (D'Orban, 1990; Somander and Rammer, 1991; Bourget and Labelle, 1992; Falkov, 1996; Wilczynski and Morris, 1993; De Silva and Oates, 1993; Stroud, 1997).

Child sexual abuse also occurs more often within the family, rather than being extra-familial, as found in research from agency reports and from adult survivors and recall studies (e.g. Finkelhor, 1994; Bagley and Thurston, 1996; Fischer and McDonald, 1998; Pritchard and Bagley, 2000). However, 'extra-family' offenders are more likely to be prosecuted, partly because of the difficulty in bringing intra-family offences to successful prosecution (Cox and Pritchard, 1997; Fischer and McDonald, 1998; Pritchard and Bagley, 2000). Despite the relative hiatus between psychiatric and child protection research there is a convergence of findings around the adult sequelae of child sex abuse, with suicidal behaviour as an extreme outcome (Hawton *et al*., 1985; Famularo *et al*., 1992; Bagley and Ramsay, 1997; Stanley and Penhale, 1999).

With respect to suicidal behaviour of child sex assailants, with a few notable exceptions (Wild, 1988; Walford *et al*., 1990) there has been virtually nothing in the literature, though in regard to child murderers, suicide following murder is a well-known sequence (West, 1965; Coid, 1983; Stroud, 1997; Appleby *et al*., 1999). This reflects the problem of trying to study such assailants as, relatively, it is much easier to study the victims, for whom there is immediate sympathy and concern, than the perpetrators, who are an elusive and unattractive group. Yet there could be important lessons that could contribute to both improved child protection and suicide prevention if there were a better appreciation of this child protection–forensic psychiatry interface.

The present study builds upon earlier pilot work on male child sex abusers (CSA) (Cox and Pritchard, 1997), and explores, from within a general population of two English counties (population 2.4 million people), a 2-year cohort of men charged with a sexual offence against a child. This is juxtaposed against

a decade of child homicide from the same counties, to examine the profile of the child murderers and to compare any subsequent suicide rates in the assailant groups.

METHODOLOGY

An epidemiological approach

It has been argued that because child homicide is such a statistically rare event there is little to be gained from the study of such small numbers (Lindsey and Trocme, 1994; McDonald, 1995). However, as Grubin showed (1994) in a study of adult sex murders, there is important information to be gleaned from studies on samples as small as 20 assailants. Moreover, the majority of child murderers come from small 'special' groups of people rather than, as it were, the 'normal' general population (Somander and Rammer, 1991; Wilczynski and Morris, 1993; Stroud, 1997). For example, in Falkov's (1996) national study of child homicides, all the assailants were recognized as having severe psychosocial problems before the event while Stroud (1997), in a comprehensive 20-year international review, confirmed the prior psychosocial 'pathology' in those who kill children, emphasizing the disproportionately frequent psychiatric problems of many assailants. Thus, in determining an epidemiological rate of child homicide, one is using as potential perpetrators not the general population, but rather the much smaller groups of four potential 'special samples'. These are: mentally ill assailants; 'neglecting and abusing' parents; men with history of criminal violence; and male child sex abusers (Somander and Rammer, 1991; Block and Tilson, 1994; Stroud, 1997; Wilczynski, 1997).

The standard epidemiological approach calculates death rates by dividing the number of events by the actual or potential population. The following formula is used to estimate mortality rates per hundred thousand (pht) per annum (p.a.) for each particular cohort:

$$\frac{d}{p} \times \frac{100,000}{y}$$

where d is the total number of murders (deaths), occurring in y years, and p is the estimated population for each cohort.

For illustrative purposes only, it will be assumed that all murdered children in England and Wales in 1995 were murdered by a male who killed only one child. Extrapolating from the mortality statistics (WHO, 1998) there were 43 child homicides, and 15,950,000 men aged 19–64 years – the age range of our assailants; the estimated General Population Rate (GPR) for child homicide assailants would be as follows:

$$\text{GPR} = \frac{43}{15,950,000} \times \frac{100,000}{1} = 0.27 \text{ pht}$$

Thus a sample of 370,930 men would be required to reach the estimated statistical 'expected' rate of one child murderer. Such numbers need to be borne in mind when considering the size of the special groups and the number of child murderers they contained.

Data

The data for the study were drawn from three sources relating to the same general population in two English counties. All cases of child murder and assailant suicide (in the murderers and/or the child sex abusers) were cross-verified from different data sources. These data sources were as follows:

1 the complete police records on a decade of child homicide assailants; and comprehensive police and Central Criminal Records Office data on a 2-year cohort of 374 men found guilty of a sexual offence against children, and of 1,802 men convicted of an 'offence-against-the-person' (violence) in the same period, in the two counties;
2 Social Services records from the same counties abstracted in respect of people on the 'At Risk of Abuse' register (average, 723 a year) over a 5-year period, to check whether any of the child murderers were previously known to Social Services;
3 a current suicide register covering the two counties over the period (King, 1996), which made it possible to identify suicides among the child homicide assailants who were on the 'At Risk of Abuse' register and from among the child sex abuse cohort.

While there may have been 'false negatives' in respect of the suicides who may have died outside the region, and of those who killed outside of the two counties, there were unlikely to be false positives in respect of either homicide or subsequent suicides, all being confirmed by crown or coroner's court.

Child homicides

Data were drawn from police records on all cases of child homicide victims (0–16 years) between 1985 and 1994, irrespective of whether the original murder charge was reduced to 'manslaughter' because of the 'diminished responsibility' of the assailant. However, undetected homicides, of which there was one in the decade, could not be included in the study as nothing certain was known about the perpetrator. Over the period there were 27 assailants, 13 men and 14 women, who between them killed a total of 33 children.

Assailant categories

'Mentally abnormal'

From the police files, all assailants in the present study were ascribed to one of several mutually exclusive categories, including the 'mentally ill'. However, as Falkov (1996) reported, data on exact diagnoses are extremely difficult to obtain even from a variety of psychiatric sources. Consequently, 'mentally ill' status in this study referred to an assailant who had a known referral to a consultant psychiatrist within 3 months either prior to or after the arrest. In the latter cases, 'psychiatric status' was inferred by the person's being committed to a secure psychiatric hospital or unit; 8 people were so referred. In the event, 8 out of 12 murder charges were reduced to manslaughter because of diminished responsibility. Moreover, half the parents associated with a prior psychiatric referral committed suicide coincident with the murder, which included 4 fathers, who of course could not then be tried. On these various criteria 12 assailants were designated as 'mentally ill'. As Taylor and Gunn (1999) point out, while this does not necessarily mean they were mentally ill, it is probable that they were so. Though no firm diagnosis was always available, a reading of the files of the 12 people categorized as 'mentally ill' appeared to show that they were suffering predominately from schizophrenia or, in three cases, severe depression. This was in accord with the international research on child homicide (Somander and Rammer, 1991; Bourget and Labelle, 1992; Block and Tilson, 1994; Stroud, 1997).

Estimating epidemiological murder rates

'Mentally ill'

The potential psychiatric population to be used in calculating epidemiological child murder rates is based upon recent detailed analyses by the Department of Health of the prevalence and incidence of mental disorder in the British population (Meltzer *et al*., 1995; Jenkins *et al*., 1998). We took the cautious approach of including only the more serious forms of mental disorder as the basis for our estimate, namely psychosis and severe depression, because these are the psychiatric conditions most often associated with child homicide (e.g. D'Orban, 1990; Somander and Rammer, 1991; Falkov, 1996; Stroud, 1997). According to Jenkins *et al.* (1998) there is an estimated annual prevalence rate of serious psychiatric disorder in 2.1% of men and 2.9% of women in the general population. To provide firmer parameters for this group, we took the ages of the actual assailants as the boundaries upon which to estimate the at-risk population of potential psychiatric assailants within county

populations. Based upon the 1991 general population census, this yielded an estimate of 13,419 men and 8,022 women who were seriously mentally ill in the two counties who matched the age of the actual assailants (Office of Population and Census Surveys, 1993).

'Violent males'

The violent male population providing the relevant risk pool was relatively easy to estimate, being based upon a 2-year average of the number of men who had a criminal conviction for violence in the two police areas. They averaged 901 p.a.

'Neglecting mothers'

Again this was a fairly simple estimate, which was based upon the average number of women known to Social Services on the 'At Risk of Abuse Register' over 2 years, which averaged 723 p.a. As the majority of child murderers have had contact with a range of agencies prior to the fatal event, this is a logical source of potential 'neglecting' assailants (Wilczynski, 1997).

'The child sex abuser population'

Based upon a total 2-year cohort, which provided an estimated annual rate of *convicted* child sex abusers over the period, this averaged 187 men p.a.

Sub-types

As Soothill *et al.* (2000) have shown, it is possible to demonstrate sub-types within a cohort of sex offenders. In earlier work we also were able to differentiate typological sub-groups within the child sex offender cohort ($n = 374$) (Cox and Pritchard, 1997; Pritchard and Bagley, 2000), which was similar to results from the USA (Abel *et al.*, 1987; Simon *et al.*, 1992; Knight *et al.*, 1994; Firestone *et al.*, 1998).

The offenders could be differentiated by distinguishing between those men who committed only sexual crimes, designated the 'sex only' offences (SOO) group, which averaged 92 men p.a., and 'multi-criminal child sex abusers' (MCCSA), so called because they had more non-sex than sexual crimes. These, however, consisted of two distinct sub-sets: 49 men p.a. who had sexual and other convictions, but not convictions for violent crime; and the remaining 46 men, 24% of the cohort, who had convictions for violence in addition to their other and sexual offences and were designated the 'violent MCCSA' group. These three sub-groups of child sex abusers provided estimates of the actual number of *substantiated* potential assailants.

These 'estimated' numbers of people belonging to the 'special' groups of potential assailants will become the 'denominators' to calculate proportional child homicide rates stemming from each group's actual event 'numerator'.

Subsequent suicides of child killers and child sex offenders

Finally, it was possible to confirm independently from the regional suicide register any subsequent suicides of assailants both in the 10-year homicide and in the 2-year sex abuser populations.

Limits of the study

It is readily acknowledged that one weakness of the methodology is that the 'denominator' numbers can only be an approximate estimate of potential assailants. However, the 'violent men', 'neglecting mothers' and 'child sex abusers' are based upon substantiated numbers confirmed in official records, the former two being independently confirmed by the judicial process of a trial and conviction. On the other hand, the mentally ill potential cohort errs on the side of caution, and may underestimate the number of seriously mentally ill in the general population. If this were so, however, this would mean that the child homicide of the 'mentally ill' was an overestimate. Of course, it would have been extremely valuable to have had the formal psychiatric diagnoses of the assailants, but in the event this was not possible, and is readily acknowledged. Hence it is argued that the method provides indicative rather than definitive signifiers of broad trends. It supplies relatively hard data in a field that, almost by definition, will contain many grey and ill-defined areas.

RESULTS AND DISCUSSION

Patterns of child homicide assailants

General

There were 33 children killed in the two counties, which is equivalent to a rate of 0.6 per 100,000 per annum (pht p.a.), slightly higher than the UK rate of 0.5 pht p.a. (WHO, 1998). There were 27 assailants, a figure that included four cases of joint defendants (the natural mother and her male cohabitee). The majority (21) of the murderous events were intra-family, with the five extra-familial murders being committed by men not related to the victim. Four intra-familial assailants killed more than one child in the same event and two also killed their wives.

Victims

Details on the victims (0–16 years) are shown in Table 1: there were 20 boys and 13 girls. It was statistically significant that 92% of the intra-family murders were young children, < 7 years, whereas no victims among the extra-familial murders were under 7 years old ($p < 0.001$).

Intra-familial deaths

Table 2 lists the assailants. All assailants were adults, occupying a parental role. Mothers, including one stepmother, were responsible for 67% of the deaths (14), although four others were jointly convicted with their male cohabitee. The mothers' ages ranged from 18 to 34 years. Of the four father assailants, all were mentally disordered, but they had a much wider age range, from 24 to 69 years.

Of the four stepfathers/cohabitees, four were co-defendants with the deceased child's mother, all having a record of previous violence. Their ages ranged from 18 to 37 years. However, from our reading of the police records, the co-defendant's presence often compounded the mother's previous instability.

Extra-familial deaths

There were five such victims, all at the hands of men with a prior history of child sex abuse, whose ages ranged from 22 to 30 years.

Epidemiological rates of child homicide

In terms of absolute frequency, parents killed substantially more often than strangers. Of the parents, 55% were mentally disordered, which is 22 times

Table 1 A decade of child homicide: the victims and their ages (0–16 years)

Category	*Boys*	*Girls*	*Total*
Victims	20	13	33
Intra-family			
Aged 0–7 years	15	11	26
8–16 years	1	1	2
Extra-family			
Aged 0–7 years	0	0	0
8–16 years	4	1	5**

Key **Age by intra-family and extra-family: chi-squared = 16.6842, 1 df Yates correction $p < 0.0001$

Table 2 Ten years of child homicide by gender, 'status' and number of assailants

Category	*Males*	*Females*	*Total*
All assailants	13	14	27
Intra-family (22)			
Mothers	0	14*	14
(*1 stepmother)			
Fathers	4	0	4
Step-parent	4	0	4
Cohabitee (joint)			
Extra-family (5)			
'Not relative'	5	0	5
Intra-family			
Mentally ill (age [M] 24–69, [F] 18–34)	4	8	12
'Neglect and abuse'	0	6 (4 joint)	6
(age [F] 18–24)			
Violent offenders	4 (all joint)	0	4
(age [M] 18–37)			
Extra-family (Child sex abuser)			
CSA only	0		0
Multi-criminal CSA	5		5

the rate of the severely mentally ill in the general population (Jenkins *et al.*, 1998). However, when applying the epidemiological measures a very different picture emerges, seen in Table 3.

The mentally disordered

Based upon 2.1% and 2.9% of men and women respectively being severely mentally disordered in the general population, we estimate a homicide rate of 3 pht p.a. for men and 10 pht p.a. for women among the seriously mentally ill. This was 21 times the notional rate of 'ordinary' mothers killing their children.

Violent offenders

Based upon the 901 men p.a. with convictions for 'violence-against-the-person' in the area, the child murder rate of men with a prior history of

Table 3 Estimated frequency of child homicide assailants by 'status', rates per 100,000 (pht)

Assailants by age	*Males estimated population**	*Females estimated population**	*Assailant rates per 100,000 p.a.*
Est: mentally ill[1]			
Male: 24–69 years	Pop. 13,419	Pop. 8,022	3 pht p.a.
2.1%	4 assailants	8 assailants	
Female: 18–34 years			10 pht p.a.
2.9%			
Est: neglect[2]			
(SSD)		723 p.a.	
With cohabitee		6 assailants	83 pht p.a.
Without cohabitee			28 pht p.a.
Violent offender[3]	901 p.a.		44 pht p.a.
(police)	4 assailants		
All male CSA[4]	187 p.a.		267 pht p.a.
	(5 assailants)		
Sex only CSA	93 p.a.		
Multi-crime CSA	49 p.a.		204 pht p.a.
	(1 assailant)		
Violent and multi-crime CSA	46 p.a.		869 pht p.a.
	4 assailants		

Sources 1 Jenkins *et al*., 1998
2 Social Services Department register
3 Police records
4 CSA study

Key *1991 General population 18–75+: males 750,890; females 853,399 (Office of Population and Census Surveys, 1993)

violence was an estimated 44 pht p.a., 4.4 times the mentally ill mother assailant rate.

Neglectful mothers

There were on average 723 p.a. women on the 'At Risk of Abuse' registers in the two counties. The six acts of killing a child by women from this group yield an estimated rate of 83 pht p.a. However, if the rate were calculated separately for the non-joint deaths (i.e. in collusion with a partner) the mothers alone

would have killed at a rate of 28 pht p.a., suggesting that this category of assailant is more dangerous when living with a male with a history of violence.

Child sex abusers

Based on an annual rate of all 187 men convicted for an offence against a child, the five extra-familial deaths for which these prior sexual offenders were responsible would yield an annual estimated rate of 267 pht in this population. In reality, however, no man with a prior sexual offence but no history of other violent criminality was involved in any of the child murders, i.e. half the sex abuser sample, the 'sex offences only' (SOO) offenders. All the assaults were carried out by 'multi-criminal child sex abusers' (MCCSA). In the event all but one of the five murders were committed by an MCCSA with a history of violence, yielding an estimated rate of 870 pht p.a.

Subsequent suicide of homicide assailants

Table 4 lists the categories of those assailants known to have committed subsequent suicide.

Intra-familial assailants

Within the cohort of child homicides, six of the mentally ill parents killed themselves either at the time of the murder or shortly afterwards. This was a real suicide rate of 100% of the fathers and 25% of the mothers. This obviously exceeds the suicide rate of the general population; the rate in the Wessex region was 0.016% of all males and 0.005% of all females in the relevant age groups. These findings reflect the well-established pattern of suicide following murder (West, 1965; Coid, 1983; Stroud, 1997).

Extra-familial assailants

Not one of the five extra-familial murderers, all MCCSAs, had killed themselves. This is in marked contrast to the subsequent suicide of the CSA offenders who had neither killed their victims nor been convicted of a prior violent offence.

Suicide of CSA offenders

In the 2-year cohort there were seven suicides among the 374 convicted child sex abusers (but men who had not murdered their victims), i.e. a rate of 1.87%. All occurred either around disclosure or shortly after the trial, which is a real suicide rate of more than 110 times the average male population rate.

Table 4 Completed suicides among a decade of child murderers and a 2-year cohort of child sex abusers

Category	*Male suicides*	*Female suicides*	*Suicide rate %*
Child killer			25% biological mothers
Mentally ill (all < 54)	4	2	100% biological fathers
Neglect and abuse	0	1	17% p.a.
Violent offender	0		0
Multi-criminal child sex abuser	0		0
2-Year child sex abuse cohort			
Multi-criminal and violent (n = 46 p.a.)	0		0
Multi-criminal with no violence (n = 49 p.a.)	1		1.02% p.a.
Child sex abuse offence only (n = 92 p.a.)	6	0	3.23% p.a.
Regional suicides in general population*	134 p.a.	45 p.a.	Male 0.016% p.a. Female 0.005% p.a.

Key *Source, Wessex Regional Suicide Register (King, 1996)

Six of the seven suicides were committed by the SOO men, who had no history of violence; their suicide rate was 3.2% p.a, some 24 times the expected rate for males in this age group.

Suicide and typologies of child abusers

The estimated suicide rate for all the child abusers is 934 pht p.a., which is actually higher than the violent MCCSA child homicide rate of 869 pht. Yet there were no suicides among the most dangerous sex abusers, the violent MCCSA group, and only one among the non-violent MCCSA. Thus it is the least physically dangerous child sex abusers, the SOO group, who have a remarkably high suicide rate of 3,226 pht p.a., many times the average general male population rate.

CONCLUSIONS

There is a need for caution in considering our estimates of the potential 'at-risk' populations, which while drawn from samples known to the authorities,

cannot account for any 'false negatives'. Therefore the epidemiological assailant rates for the specialist groups may in fact be underestimates of the true rates of risk. Moreover, the data came from official records and not from direct interviews, which can be so revealing in these problematic and rare client groups (Grubin, 1994). None the less, the data were essentially independently validated, being based upon judicial procedures of crown courts and coroners' courts and upon information from different kinds of case-register: hence we can have a degree of confidence in these indicative findings. Moreover, although child murder is a rare event, it is also one of profound symbolic importance (Atmore, 1999) and challenges those at the child protection–forensic psychiatric interface to engage in interdisciplinary research and clinical co-operation to identify those most at risk.

With a few exceptions, most research in this area has emerged from the child protection field (Finkelhor, 1994; Leventhal, 1998; Wyatt *et al*., 1999; Grubin, 1999). Although these authors stress that the extreme consequence of child abuse can be a dead child (Kempe and Kempe, 1978; de Silva and Oates, 1993), the 'psychiatric dimension' is seldom acknowledged, to the extent that recent texts failed to mention mental disorder at all (Doyle, 1996; Munro, 1998). This probably reflects the influence of the original work of Kempe *et al*. (1962), Kempe and Kempe (1978) and subsequent workers who tended to emphasize the ubiquitous nature of child abuse and played down the psychiatric element. Thus, in many countries, the core responsibility to protect children against the extreme outcomes of abuse lies foremost with the child protection services, with relatively limited psychiatric input, despite the fact that parents who maltreat children often have treatable mental illness. There has evolved an 'anti-psychiatric' ideology in many social work systems, with the tendency to emphasize adverse social circumstances surrounding the incidents of neglect and abuse rather than any psychiatric factors (Lindsey and Trocme, 1994; Gillham *et al*., 1998; Krishnam and Morrison, 1995).

Conversely, it is not uncommon for those in child protection teams to encounter adult psychiatrists who pay relatively little attention to children's issues or to such problems as poor housing, poverty, unemployment, or partner violence – despite the urgings for interdisciplinary collaboration and training (Department of Health, 1995; Falkov, 1998). This has resulted in an unfortunate split between psychiatry and child protection work, which it is hoped that this study will help to correct.

Child homicide assailants

The method appears to have successfully produced a clearly delineated typology of child murders which is mutually exclusive in its categorization, namely intra-familial parents who are 'mentally ill', 'neglecting' parents, or

'criminally violent' men; and the extra-familial multi-criminal child sex abuser (MCCSA). This typology enabled us to differentiate between the homicide and suicide rates in the potential risk groups. The high prevalence of psychiatrically ill parental assailants was expected from previous research (Somander and Rammer, 1991; Falkov, 1996; Stroud, 1997).

Within this decade of child murderers, the males with a prior history of violence killed at about four times the rate of the psychiatrically ill mothers; but the 'neglectful and abusing' male partner killed at a rate eight times higher than that of the mentally ill mother. However, it was the MCCSA man with a history of violence who proportionally killed at more than 87 times the rate of the mentally disturbed mother. It is the violent multi-criminal child sex abuser who poses the most formidable physical risk to children. Based upon our estimated male murder rate in England and Wales, 43 children by 15.9 million men, to 'find' one child murderer would require a random sample of 370,930 men. Thus to have four child murderers from among this group of violent MCCSA males highlights just how potentially dangerous is this combination of violence, criminality and sexual assault against children. Clearly the work requires replication but the implications if the result were confirmed would be profound.

Suicide amongst assailants

The obverse side of the assailant coin, their subsequent suicide, was, as might be expected from previous research, highest among the mentally ill parents who had killed their child (Coid, 1983; Stroud, 1997). What was unexpected, was the high suicide rate among those child abusers with no history of prior physical violence. Wild (1988) in Britain and Walford *et al.* (1990) in Ireland have reported suicide following disclosure of child sexual abuse, but what has never been examined before is the suicide in a whole cohort of sex abusers, which had the benefit of cross-verification from police records and a suicide register. Paradoxically, it was the least physically threatening men, the men with convictions only for sexual offences, the SOO group, who killed themselves at double the violent MCCSA child homicide rate. Bearing in mind that 3.2% of the SOO group killed themselves, mainly around the time of disclosure or during the trial, it would seem that many of these suicides were perhaps preventable.

Conversely, there was no record of suicide being linked to any of the violent child sex abuse homicide assailants. This may be indicative of the degree to which the violent MCCSA are not remorseful, and are a substantially greater violent threat to children in their potential for reoffending.

Although child murder is a rare event, it is also one of profound symbolic importance (Atmore, 1999), especially when compounded by the associated crime of child sex abuse. This profoundly important problem in forensic

psychiatry requires better understanding (Bagley and Thurston, 1996; Grubin, 1999).

There are four major findings highlighting the importance of the child protection–forensic psychiatric interface:

1 All extra-familial murderers were multi-criminal child sex abusers.
2 While mentally ill parents were the most frequent assailants, male cohabitees with histories of personal violence and 'neglecting' mothers killed proportionately more often.
3 All male mentally ill assailants killed themselves, as did a quarter of the mentally ill mother assailants.
4 There was no suicide among the violent multi-criminal assailants but very high rates among the 'sexual offence only' child abusers.

These findings support the need for interdisciplinary research and clinical co-operation to identify those most at risk of committing such crimes (Falkov, 1998). Clearly more work is required to refine the categorizations of the present research in the search for a more individually orientated risk assessment. In the meantime there is an overwhelming case for further interdisciplinary collaboration and information-sharing in the pursuit of improved child protection.

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