# FORENSIC EXPERTISE ELEMENTS IN INFANTICIDE, WITH VALUE TO JUSTICE

***Dan Perju-Dumbravă*** *
***Ovidiu-Sorin Chiroban*** **

Abstract

*This criminalization of infanticide generates theoretical controversies in judicial practice, due to difficulties in proving the elements of the offense. A decisive role in proving the crime of infanticide resides in the forensic expertise.*

Keywords: infanticide; risk factors; legal measures; prevention.

The crime of infanticide is provided by the art. 177 of the Romanian Penal Code and consists in killing the newborn child by the mother who is in a state of mental disorder occasioned by birth.

This criminalization of infanticide generates theoretical controversies in judicial practice, due to difficulties in proving the elements of the offense. A decisive role in proving the crime of infanticide resides in the forensic expertise. The mother's killing resolution must intervene spontaneously as a result of psycho-physiological effort led by the act of birth, which led to the diminution of discernment and the impulsive adopting of the aggression. The postpartum period in which the crime of infanticide should be retained corresponds to the period of time in which the diminution of discernment occurs due to the act of birth. This state of psycho-physiological influence resolves rather quickly after the act of birth, must by assessed from case to case, and could outlast minutes, hours, anyhow one cannot set exact time limits. This time variability is the one that raises real problems of appreciation, therefore the need to draw up uniform criteria in assessing the reality of mental disorder resulting from the act of childbirth.

In the Anglo-Saxon literature, neonaticide is usually described as the killing of a newborn within its first 24 h of life and is part of a larger concept, infanticide i.e. the killing of an infant of less than one year of age. The precise definition of the neonatal interval may depend on jurisdiction: this is usually the first 24 h, but sometimes extends to 28–30 days after birth. Finnish law defines neonaticide as a crime committed by a woman who, in a postpartum state of exhaustion or anxiety, kills her child and the punishment shall be not less than four months and not more than four years of imprisonment. According to other opinions, three types of infanticide could be distinguished: a group of "extended suicide", carried out mainly by psychotic or depressive mothers; "neonaticides", typically of concealed pregnancy in immature

* M. D., Ph. D., Professor at "Dimitrie Cantemir" Christian University, Faculty of Law Cluj-Napoca.
* * M. D., Resident Doctor at „Iuliu Hatieganu" University of Medicine and Farmacy Cluj-Napoca.

young women and "child abuse", with the death of the infant following severe battering and involving also the father of the child. Neonaticide is regarded as a crime of not only a low prevalence but also a hidden character; only few neonaticides are reported in each country annually.

Abandonment of newborn infants occurs throughout the world and often the outcome for the infant is death. Together with neonaticide it is felt to be one of the least preventable crimes. Because neonaticide is often a secret and hidden crime, the statistics referring to neonaticide may represent the tip of the iceberg. The hidden nature of neonaticide makes research, and consequently prevention, difficult. During the treatment of some mothers who had killed their children in the course of severe depression or psychosis, or during the forensic psychiatric examination of the mother, the impression arose that some of the homicides could have been prevented, although women at risk are considered rather unlikely to be identified before the event.

***Motives***

The practice of neonaticide dates back to prehistoric times and seems to have existed in every community and continent throughout history. Historically, the killing of newborns was most often the result of illegitimacy, gender selection, economic hardship, physical deformity religion, population control, ''deformity'' or just for being female. The most common motives in the nineteenth century were the shame of unwed motherhood and the poor economic situation of unwed women proposed that fear of rejection may still be a pronounced factor in the motivation for neonaticide in present society. Yet, even with modern civilization's contributions and social acceptance of contraception, illegitimacy, and single-mothers, this complex and poorly understood crime continues to occur. One study suggests that the most common reasons for neonaticide are extramarital paternity or incest. It has been suggested that the core motivation for neonaticides is the aim to eliminate an unwanted child.

Concealment and denial of pregnancy can result in consequences as tragic as neonaticide, or in newborn infant abandonment. Denying and concealing the pregnancy are characteristic of neonaticide, and preparations for birth and child care have usually been negligible if any. A further typical characteristic is a lack of social support for the pregnant mother pointed out that women guilty of neonaticide were of lower social classes and used contraception inadequately. Other motives claimed for concealment of pregnancy and neonaticide: fear of others' reactions, abandonment, inability to bring up the subject, riddance of problem without anyone's knowing, denial of pregnancy.

***Risk factors***

Postpartum psychosis is a serious disorder that can cause negative consequences for the mother, infant, and entire family. While reports of this condition date back for centuries, little is known about what interventions are most effective for this population. Research on interventions for women who experience postpartum psychosis has been limited due to barriers such as the relative rarity of

this disorder and exclusion from drug trials for safety concerns. Affecting one to two per 1,000 deliveries, postpartum psychosis can cause several negative consequences, including impaired mother–infant bonding, infant abuse and neglect, the risk of recurrent psychiatric illness, suicide, and infanticide. Postpartum psychosis is at times confused or used interchangeably with postpartum depression. Postpartum depression refers to a non-psychotic depressive episode that often requires treatment and affects approximately 13% of mothers within 12 weeks of giving birth. Postpartum psychosis is more severe than postpartum depression, often requiring hospitalization, and is characterized by delusions, hallucinations, bizarre behavior, depression, mania, and mood lability that usually presents within the first 2 weeks postpartum.

Puerperal disorder affects only women, has a clear temporal relationship to childbirth, characteristic clinical picture, a favourable short-term prognosis, a clear risk of recurrence with subsequent childbirth, and a long-term outcome similar to that of bipolar disorder. Puerperal psychosis is now generally considered to have its onset within the first 3 weeks following childbirth, although the first symptoms may arise within the first 3 days postpartum. These very early onset psychotic symptoms may be a factor in the tragedy of neonaticide. Careful observation is required over this period to ensure that the earliest symptoms are promptly treated to prevent escalation of the psychosis. It is wise to ensure that stress is minimised and a regular sleep wake cycle is maintained as sleep disruption can trigger the onset. Two of the proposed triggers are environmental stressors and hormone dysregulation. While hormone dysregulation can occur at other times in a woman's life, there are major hormonal changes following childbirth.

While mothers can have hallucinations and delusions (that often focus on the infant and can put it at risk), they exhibit many atypical symptoms such as catatonic features, and appearing confused or perplexed with a fluctuating course (suggesting delirium). In addition, they show a predominance of manic, rather than schizophrenic symptoms, although some will present with a more melancholic picture. Studies suggest that postpartum psychosis is often a manifestation of a bipolar disorder condition that is triggered by childbirth. Research on the prevention of postpartum psychosis has focused on the effects of mood stabilizers, antipsychotics, and hormone therapy. The well-established risk factors (e.g., bipolar disorder) and potentially severe consequences (e.g., suicide and infanticide) of postpartum psychosis point to the importance of preventive measures.

There are different theories about what the motives for abandonment or neonaticide are. For example, it has been suggested that the mothers' motive for neonaticide and abandonment is that the child is unwanted, or that they have suppressed the notion of their pregnancy to such a degree that when they give birth they panic. Stone et al. have proposed that "evolutionary theory predicts that very young mothers would be more likely to kill an infant than older women, given that the younger mother has a much greater ability to replace the dead child through subsequent pregnancies".

Various researchers have reported that a mother's delivery in a nonmedical setting is a significant risk factor for neonaticide. The mothers are often young,

unmarried and primiparous, and the denial of pregnancy or concealment often extends to even the closest family members. Also, not surprisingly, they often give birth outside a hospital setting. Researchers concluded that some of other risk factors are the following: relatively young age, lack of support from the father-to-be and dependency on others. Some mothers take action to conceal their body's physical changes to include wearing baggy clothing, decreasing visits with family and/or friends or hiding out in their bedrooms. Their deliberate physical isolation may lead to emotional isolation where the lack of meaningful and supportive relationships prevents the offender from confiding in another. Attempts to conceal the birth range from immediate disposal of the infant's body to long term storage of the body in the mother's personal surroundings. Once the infant is discovered, offenders often attempt to obscure their culpability by attributing the death to a heavy menstruation, miscarriage, an accident, or natural causes.

***Childbirth***

Childbirth is a severe physical ordeal and may be followed by exhaustion, fainting and shock, and (rarely) confusion or stupor. Hypovolaemic shock can follow haemorrhage, though this is rare in hospital deliveries. In the first half of the 19th century, before anaesthetics were introduced, it was recognized that, in the crisis of severe labour, a woman could suddenly become confused. This clouding of consciousness lasted for a few minutes or hours. The exhausted mother may be unable to play any part in events. During the labor and delivery, women often describe dissociative-like experiences, characterized by the inability to remember details, limited amnesia (e.g., flashes of memory), blacking out, and/or viewing themselves outside of their bodies. Once the newborn is delivered, the offenders experience intense panic, having made no plans for the birth or care of the child. With the arrival of the baby the mother now becomes focused on silencing the infant and finding a way to "get it away" from her, suggested that the actual act of neonaticide is not premeditated, but rather the offender reacts based on fear, shock, and guilt. This lack of premeditation can be reflected in the fact that many offenders equate labor pains with defecation, constipation, or menstrual cramps.

When the baby is delivered (often directly into the toilet) the mother typically attends to herself and does not assess the condition of the baby for some time. The mother may cut the umbilical cord with a makeshift tool (e.g., scissors, razor blade, nail file) and the baby is typically placed in some type of container (e.g., plastic bag or towel). The blood is cleaned up and the young woman often resumes her normal, daily activities. For example: a woman gave birth standing up and then fainted. She came to half an hour later, and went to wake up the householders. She returned to find the child still living and hit it with a piece of wood.

In the agony of delivery, there have been acts of desperation – autoepisiotomy, auto-Caesarean section or suicide. In addition, several specific mental disorders have been attested by many case descriptions. They are an essential background to any consideration of childbirth's forensic complication – neonaticide. Many neonaticidal women who deny their pregnancy often recover quickly from the

delivery and may go back to their daily lives as if nothing had happened. These early postpartum states have forensic importance, because the infant often needs resuscitation, and can suffocate in mucus or blood. They are relevant to 'infanticide by neglect'.

There is another literature about unconscious delivery. There is one factor that might be relevant to aetiology – hyperventilation. Researchers showed that paroxysms of pain corresponded to a high respiratory rate. Overbreathing is known to constrict the cerebral arteries, and lead to slowing of the electroencephalogram and impaired consciousness. Women can give birth without knowing it, not only when anaesthetised, but also when profoundly drunk. Any medical cause of coma can have this effect, including head injury, antepartum haemorrhage and other causes of syncope and apoplexy. The commonest cause, however, is eclampsia.

Since investigators are often unfamiliar with this exceptional crime, they may be perplexed when faced with certain case dynamics: variation in offender characteristics, intermittent denial of pregnancy, the physical and emotional resiliency of the offender, and the lack of documented mental illness and criminal history. Further complicating these cases is an offender's altered perception of the birth and homicide. By conducting interviews with neonaticide offenders, investigators highlighted the behavioral and psychological responses integral to the act of neonaticide: fear, concealment, emotional isolation, denial, dissociation, panic, and homicide. Neonaticide offenders typically have difficulty remembering details and have lapses in their memory due to fear, anxiety, pain, and loss of control. A variety of terms have been used when describing this response to childbirth, including mental disconnect, depersonalization, detachment, cognitive separation, limited amnesia, and dissociation.

***Methods***

Methods of killing a newborn can be divided into active and passive ones. In active methods direct violence is used against the body of the newborn, whereas in passive methods, proper care is neglected or the infant is abandoned in a panicked state. Suffocation has been the most frequently used method of active killing. Newborns are killed in a variety of ways; however, it is more likely for the deaths to be a result of inaction by the mother, as opposed to a violent action that is more often seen in the killing of older infants. Although some newborns are simply abandoned, or die from blunt or sharp force injury, asphyxiation appears to be the most commonly reported. Asphyxiation is most often accomplished through suffocation, smothering, or drowning. Common instruments include the mother's hands, containers, bags or towels, or toilet water.

Other methods of killing a newborn: stabbing, drowning, burning, being thrown to pigs, buried alive, being thrown from a high building, and such unusual means as inserting needles inside the cranium.

***Conclusions***

Neonaticide has its cultural connotations and, therefore, no global preventive strategies can exist. Women who kill their newborns are something of a mystery to present-day culture even with the advances in the medical, psychological, and behavioral fields. In response to what many find inexplicable, society tends to think of mothers who kill their newborns as irrational and pathological, labels that encompass a variety of explanations including mental illness, menstruation, poor socialization, domestic pressures, or a broken home. In reality, neonaticide offenders are rarely psychotic, but often are perceived as less culpable by the criminal justice system.

Furthermore, prevention might be heightened. We call for international joint projects for enlarged material to enable grouping, as well as education and discussion among the public and the professionals to prevent neonaticide, unify its jurisprudence and improve the treatment of the offenders. Sex education of the young and education of the parents and school nurses may prevent neonaticide in the younger offender group. In some countries better societal support for single parents, anonymous childbirth, or more liberal attitudes toward abortion or adoption may prevent neonaticide.

Evaluation of the period before the killing yielded evidence of "warning signals" in some cases. Especially mothers who killed their child before an attempted suicide (extended suicide) gave numerous signals to their partners, parents, siblings, friends or members of the social services. They reported depressive symptoms, suicidal thoughts, feelings of insufficiency, strain and problems in the relationship. Therefore, understanding the symptoms advocating for a possible change in the nature of mental depressed discernment, could lead to prevention of infanticide by family members, social workers and also medical staff. This could be achieved by compulsory hospitalization of all mothers in hospital units, where they receive specialized care, namely the proper education of carers and mothers for fortuitous circumstances in which they would give birth at home or outside a hospital, thus, in this sense more efficient legal norms would be welcomed.

In cases of psychosis or depression, medical treatment - if necessary in a hospital and even against the will of the patient- has to be considered in an early stage of illness, while in the group of young couple with signals of psychic decompensation, financial problems and child battering, mainly social help with intensive support and in some cases stricter legal measures are required. These cases also generate much attention in the media and often raise the question about whether so-called "safe havens", or a type of ''deposit box'', where a mother can leave her unwanted newborn baby anonymously, should be instituted.

Neonaticide may always remain an area of some uncertainty but there is still much to be done. General knowledge and discussion are essential and should be improved to bring consistency into the handling of neonaticide cases, refine treatment of perpetrators, and most of all, to prevent new heartbreaking cases.