

## **Annotations**

# **Infanticide, filicide, and cot death**

The 'suppression' of unwanted babies seems to have been commonplace in antiquity. Early travellers to New Zealand, while remarking on how fond the Maoris were of their children and how well they looked after them, noted that infanticide was openly practised. The most favoured methods were squeezing the nose between the fingers, pressing the fontanel, or putting a wet cloth over the baby's head—practices that time perhaps had shown would enable a child to die without a struggle.<sup>1</sup> In some Aborigine communities in Australia it was not possible for women to bring up more than one baby, and it was the duty of the maternal grandmother to ensure that the weakest of twins did not survive. Today, if an Aborigine woman has twins and one is kept in hospital requiring resuscitation, local paediatricians inform me when it goes home it is likely, in some areas, to shortly present as a cot death. Currently in China, where the state is trying to limit families to one child, there has been an increase in the incidence of cot deaths in girls—girls are being suppressed.

It has been estimated that in western Europe one third of all infants were suppressed at the beginning of the last century.<sup>2</sup> It was no chance happening that Napoleon set up large orphanages in France at that time to save infants who would form the backbone of the future armies of France. In this country the act of 1933 recognised that a mother who kills her child before the age of 1 year will not be convicted of 'murder', but of 'infanticide'. Infanticide has now a legal meaning and is associated with death under 1 year of age at the hands of the mother, but also in general it means the killing of an infant by anyone. The term 'filicide' covers the topic we are discussing, which is child homicide by either parent. We need to think of filicide in relation to the current social attitude to killing babies. The killing of a baby in utero up to at least 20 weeks' gestation can be carried out for social reasons. The question of whether or not doctors may expedite death in a viable or live born child was not solved by the Leonard Arthur case, but it is noteworthy that no further paediatricians have been brought to trial on this front. Have doctors more responsibility to individual children than parents have? We are living in a period of moving social attitudes to procreation.

A quarter of all victims of legally proved homicide

in England and Wales are under the age of 16—81% of them being killed by their parents; and children in their first year are at a greater risk of being the victims of proved homicide than at any other age.<sup>3</sup> Most studies relating to filicide have been undertaken by psychiatrists working with people who have been convicted of killing their children. d'Orban,<sup>4</sup> reporting on 89 women charged with killing or attempting to kill their own children, put the causal groups in descending order of frequency as: (1) battering, (2) mental illness in the mother, (3) neonaticide, that is the killing of a baby within 24 hours of birth, (4) retaliating mothers, (5) unwanted children, (6) mercy killing.

Cases of filicide fall into two groups—newborn and later. The first present with a younger aged group of parents. These deaths are frequently registered under the heading of 'inattention at birth'—women who claim not to have known they were pregnant, and classically the baby born into the lavatory pan. Unless there has been gross violence to the child or the child has been suffocated by a cloth being thrust into its mouth, these deaths are rarely the subject of further proceedings by the police. It is in the death of the older baby that the relation to cot death becomes important.

### **Pathology of filicide**

There are four main groups of causes of death: (1) accidents; (2) poisonings, which may or may not be accidents; (3) non-accidental injury; and (4) 'gentle battering'—a term which is self evident, as victims do not show the evidence of violence characteristic of group (3). It is this last group that merits discussion in relation to cot death. In detective fiction the forensic pathologist is able to say with certainty whether or not a person has died from asphyxia—in fact this is by no means the case. The classically accepted stigmata petechiae are known to have very complicated patterns of causology. We have all seen children who have been accidentally suffocated by plastic bags over their faces and who have shown none of the classic stigmata of suffocation or asphyxia. Furthermore, the presence of infection or a minor disease does not help in eliminating filicide. If parents are at the end of their tether psychologically, a mild illness in the child

makes him more irritable and therefore more likely to produce a final, emotional, parental crisis.

Evidence relating to filicide has to come from much more than conventional histopathology, it requires a polyfactoral approach to the death. Perhaps the most important factor at necropsy is an assessment of the biochemical state of the child such as was carried out in the recent multicentre study for the Department of Health and Social Security (DHSS),<sup>5</sup> together with a psychosocial study of the family and its background. The latter is not easy. Once a child has been given the label of 'cot death' or 'sudden infant death syndrome' (SIDS), and most pathologists are prepared to do this on naked eye necropsy, the parents are given the literature on SIDS and immediately told that their child has died from natural causes for which they were not to blame. This affects the parameters of any subsequent discussion of the death.

If a mother or father says that they killed the child it in no way proves that they did so (I have had far more mothers tell me that they have killed their child than I believe have actually done so), people make confessions because they feel guilty, not because of what they did. Furthermore, if a confession of smothering is obtained by the police it is easy for a defending lawyer to claim that the confession was obtained under duress—and is not a bereaved parent always under duress?—and so is inadmissible as court evidence. Thus the confessional statement has limited value. This was brought home to me very clearly several years ago when my forensic pathologist colleague and I believed that a certain young mother had smothered two of her children: she had also confessed to this to the police. When brought to trial, however, the confession was withdrawn as not admissible in evidence and we were forced to agree that the features we described at necropsy existed in the published reports as findings in cot deaths. The case was dismissed. Such is the current dilemma.

### Diagnosis of SIDS

If we consider the situation of children found unexpectedly dead in their cots and presenting as cot deaths 40 or more years ago, there were many who believed that most of these were instances of filicide. Many parents were submitted to intense interrogation and investigation by the police. As knowledge of paediatric pathology increased it was realised by many that a considerable number of these deaths were due to natural causes, and that many parents were being harassed quite unnecessarily when babies presented in this way. Through social and humanitarian motives a group in Seattle came forward with the concept of there being a sudden

infant death syndrome, which is an unexplained natural cause of death. The introduction of the diagnosis SIDS did not alter the steady rise in the diagnosed infanticide rate in the United States.<sup>6</sup>

The diagnosis of SIDS greatly helped many parents, but it has had an unfortunate effect upon the research into the causology of these babies' deaths. It is too easy to find nothing at necropsy, and a situation has been created whereby people who have very little knowledge of paediatric pathology are justified in propounding theories of causology and carrying out very extensive investigations along these lines. Being a condition of unknown aetiology, nobody is to blame or need do anything active about it except to comfort the parents—and many are active here. Against this background the suggestion that some of these babies' deaths are due to filicide becomes unacceptable.

### How common is filicide among cot deaths?

While some centres examine some aspects of necropsy in greater detail (for example virology in Melbourne), the general depth of investigation into cot deaths in Sheffield is not exceeded anywhere in the world, and the Sheffield necropsy findings have largely been substantiated by the DHSS multicentre study. Since that study the local investigation of cot deaths has been extended to include a psychosocial study of the family, and it is this further information in collaboration with that of the necropsy pathology that led us to believe that in Sheffield, filicide is the probable mechanism in death in approximately one in 10 of the unexplained, unexpected deaths.<sup>7</sup> It is important here to use the term *filicide* rather than *infanticide* because, in our opinion, all these deaths are not due to actions on the part of the mother alone. How do our findings fit in with earlier findings and those of other people elsewhere? We are not aware of any other community group of deaths, including the DHSS multicentre study, that has been studied in this way. I have recently studied a group of cot deaths in another country with a very experienced paediatric pathologist. In a random series of 50 deaths there were five in which the question of unnatural death was raised. In a more superficial assessment of a further 120 deaths presenting as cot deaths in other centres the suspicion occurred in only two. Thus where one is looking at the cases in great detail the rate could be as high as one in 10, and where looked at on a more superficial level it seems to be around one in 50. These are not court proved cases, simply deaths that required further study. The pattern of causes of death in children presenting as cot deaths is not the same in all communities, it even changes in time in

one community. It would be unreasonable to expect any one major factor in cot deaths to be constant throughout the world or from state to state. Thus, as a working hypothesis, I would suggest that the figures for filicide as a major factor in unexplained cot deaths are between one in 10, and one in 50.

#### Does this alter our attitude to cot deaths?

The importance of these observations has been misinterpreted. The development of the concept of SIDS as a natural disease was not based upon any firm evidence, and thus the possibility of most of these deaths being due to filicide remained. But we can now say with much greater certainty than ever before that more than nine of 10 cot deaths are *not* due to filicide, and this needs to be said much more clearly. I have great sympathy with pathologist friends who feel that until such times as they can stand up in court and sustain a case, they are not justified in raising suspicion, especially where the family has already been counselled as SIDS and we have a basis from which to help the parents with the next child.

#### What can we do about cases of suspected filicide?

In families where filicide is suspected the mother usually becomes pregnant in a very short time. When we have been able to help during this next pregnancy with support for the parents, the subsequent child has not died. In one family which we could not support there was another cot death. In instances where police investigations have taken place relating to these cases we have found it impossible to get close enough to the parents to give them adequate help during their next pregnancies, or with the later child. These people need help. As the situation stands the legal system is paralysed. The person who can help the most is he or she who can most gain the confidence of the parents. All parents of cot deaths need support with their next child, and those where there is suspicion of filicide need even greater support. In recent cases we in Sheffield have attempted to organise this support by means of a case conference involving the family doctor, the community paediatrician, the health visitor, and the social worker.

#### Towards prevention

First we need to accept the existence of filicide among cot deaths. I well remember many years ago, before the 'battered baby syndrome' had been accepted, talking to a colleague when we were

dealing with a subdural haematoma which had recurred. I suggested that trauma might have been a factor. His comment I still remember, 'But his parents are such nice people and so concerned with the child'. I heard exactly the same words recently when the question of filicide was raised in the case of a child who had been admitted to hospital twice with bizarre symptoms, in whom nothing was found, and who later presented as a cot death.

While a vast amount is being done on bereavement counselling, there is very little work done on the mental state of parents before a child's death. Is it pure chance that the period at which cot deaths are most common largely coincides with the period when mothers are most likely to be depressed? Zilboorg<sup>8</sup> makes the point that in depressive reactions related to parenthood, hostility towards the child is the nodal point of a mother's depressive reaction. Psychiatrists tell us<sup>9</sup> that obsessive and infanticidal thoughts in mothers are usually manifest by excessive concern over the baby's health and care. This fits our own experience in helping these families with their next child. Perhaps we could prevent some cot deaths by spending a little more time in this field of study. If indeed one in 10 cot deaths are associated with filicide, this becomes an important aspect of prevention. Taking note of and giving assistance in parental postnatal depression may be more important than doing breathing or cardiac monitoring of the infant.

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