BEYOND THE MEDICAL MODEL: A RATIONALE FOR INFANTICIDE LEGISLATION

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Introduction

> "These statutory provisions were enacted not to *recognize* legally the connection between childbirth and infanticide, but to *create* it . . . The terms of the infanticide laws are . . . their own justification."[1]

Infanticide legislation was first introduced in England and Wales in 1922. The Infanticide Act 1922 was later amended by the 1938 Infanticide Act.[2] The 1922 and 1938 Acts have provided the model for other infanticide measures which have been enacted in a number of jurisdictions, including the Republic of Ireland,[3] Canada,[4] Hong Kong,[5] Fiji,[6] New Zealand,[7] and a number of Australian jurisdictions such as New South Wales[8] and Victoria.[9] The general purpose of these legislative measures is to make lenient provision for mothers who kill their children, usually within one year of birth,[10] in tragic circumstances. The basis or rationale of infanticide

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[1] Osborne, "The Crime of Infanticide: Throwing Out the Baby with the Bath Water" (1987) 6 CanJFL 47, at 55, referring to Nigel Walker's description of the legislation as "an interesting example of myth making by legislation"; see Walker, *Crime and Insanity*, vol.1 (1968), p.136.

[2] S.1(1) provides for the offence of infanticide; see *infra* at n.78. S.1(2) provides for the defence of infanticide. The Infanticide Act 1922, was applied to Northern Ireland by the Uniformity of Laws Act (Northern Ireland) 1922. The infanticide measure was subsequently repealed and re-enacted with the relevant modifications introduced by the 1938 English measure; see Infanticide Act (Northern Ireland) 1939.

[3] Infanticide Act, 1949.

[4] *Criminal Code*, s.233 [R.S., c. C-34, s.216]. See also, s.662(3), which provides that on a charge of murdering an infant a jury may find a woman guilty of manslaughter or infanticide, if the evidence proves either of these offences, instead of murder.

[5] Cap 212, *Offences Against the Person Ordinance*, s.47C.

[6] *Penal Code* [Cap. 17], s.205.

[7] *Crimes Act* 1961, s.178

[8] *Crimes Act* 1900 (NSW), s.22A

[9] *Crimes Act* 1958 (Vic.), s.6, as amended by the *Crimes (Homicide) Act* 2005 (Vic.), s.5.

[10] The New Zealand measure covers the culpable killing of children under the age of 10 years. This measure is different from other infanticide measures in a number of other ways. S.178 of the *Crimes Act* 1961 provides that a woman will be guilty of infanticide, rather than murder or manslaughter, where she causes the death of *any child of hers* aged *under ten years* while the balance of her mind is disturbed, *to such an extent that she should not be held fully responsible*, by reason of her not having fully recovered from the effect of giving birth to that child *or any other child*, or by reason of the effect of lactation, or by reason of *any disorder consequent upon childbirth or lactation.* As in England and Wales, infanticide is

legislation is medical in nature in that the leniency it provides for is justified on the basis that at the time of the killing the balance of the mother's mind was disturbed due to the effects of childbirth or lactation. Infanticide generally operates as an alternative to a murder charge or conviction, and, in this way, it is both a substantive homicide offence and a partial defence to murder. In relation to its seriousness as a species of homicide, infanticide is similar to manslaughter; for example, the English measure provides that a woman who is charged with or convicted of infanticide is to be dealt with and punished as if she had been charged with or convicted of manslaughter.

Infanticide legislation has been criticised for a number of reasons. The accusations levelled against it are, *inter alia*, that it lowers the status of infant life,[11] and, because it is available for mothers only, is paternalistic and reinforces gender stereotypes.[12] This article will focus on one of the most significant criticisms of this legislation: the fact that its medical foundation may not be justified. I will challenge the perceived importance of the medical foundation of infanticide legislation and, in connection with this, the relevance of scientific discourse on this topic. I will argue that in order to provide a fuller understanding of the significance of the medical model of infanticide it is necessary to place these measures in the historical context in which they were enacted. I will contend that an exploration of the background to infanticide laws facilitates a more honest understanding of this legislation and its scientific basis; by firmly locating these laws in their broader historical context the true meaning of the medical rationale becomes evident. This permits us to look beyond a wholly scientific understanding of the rationale of infanticide laws, and, consequently, to place less reliance on the views of medical professionals and less emphasis on the validity of medical definitions in the debate about the future of this legislation.

First, however, I will begin with an overview of the widely recognised problems with the medical basis of infanticide legislation and the responses of various law reform bodies and legislatures to these. In brief, a number of law reform bodies have recommended that this offence/defence be abolished or amended to reflect contemporary medical thinking on postpartum mental disturbances. Notably, two jurisdictions, Victoria, Australia, and the Republic of Ireland, have opted for the latter course of action, recently

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both an offence and a defence. The Victorian measure was recently amended, see *infra* at n.29. Among the amendments made was an extension of this measure to cover the killing of infants aged under two years.

[11] Catherine Damme, "Infanticide: The Worth of an Infant Under Law" (1978) 22 *Medical History* 1, at 24, argues that "the lower status in which the infant was held by society . . . has been institutionalized in English laws on infanticide. . ."

[12] See generally, Wilczynski, "Mad or Bad? Child Killers, Gender and the Courts" (1997) 37 Brit. J. Criminol. 419; Morris & Wilczynski, "Rocking the Cradle: Mothers who Kill their Children" in Birch (ed.), *Moving Targets: Women, Murder and Representation* (1993), pp.198-217; Townsend and Baker, "Infanticide Law – Primitive and Uncivilised?" (1996) 160 J.P. Rep.655 at 656; New South Wales Law Reform Commission, *Partial Defences to Murder: Provocation and Infanticide*, Report No. 83 (1997), paras.3.31-33 (hereinafter referred to as NSWLRC, Report 83); Victoria Law Reform Commission, *Defences to Homicide: Options Paper* (2003), paras.6.15-17; Victoria Law Reform Commission, *Defences to Homicide: Final Report* (2004), para.6.12, (hereinafter referred to as VLRC, Options Paper; VLRC, Final Report).

amending their respective infanticide measures to take account of what is commonly considered to be the prevailing medical consensus on this issue. In addition, I will briefly examine the evidence in support of the medical rationale.

Problems with the Medical Model of Infanticide

> "Infanticide has been criticised because it is based on the problematic presumption that women who kill young children are necessarily mentally disturbed. This presumption does not take into account the complex factors which can lead to maternal child killings and does not reflect the range of circumstances in which children are killed by their mothers."[13]

There are three mental or mood disturbances associated with the period following childbirth: the postpartum/postnatal "blues"; postpartum/postnatal non-psychotic depression; and postpartum/postnatal psychosis. The "blues" is a mild and transitory mood disorder which affects about fifty to eighty per cent of all women in the days immediately following childbirth. It includes symptoms such as tearfulness, despondency, anxiety, confusion, tiredness, and hostility to the father. This disorder is generally considered to be caused by sudden and significant fluctuations in hormones after childbirth.[14] Postnatal depression is a less common but more severe mood disturbance which is thought to affect about ten per cent of all women after childbirth. Its symptoms include despondency, anxiety, unusual irritability, and feelings of inadequacy and an inability to cope with the baby.[15] Postnatal psychosis is a severe disorder which is thought to affect only one to two out of every thousand births. The condition generally involves marked disorientation, confusion, hallucinations and delusions and is characterised by a break with reality. Postnatal psychosis virtually always requires hospitalisation.[16] Non-

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[13] VLRC, Final Report, para.6.1.

[14] See literature cited *infra*, at n.16.

[15] See literature cited *infra*, at n.16.

[16] For a over-view of some of the medical literature on the subject of postpartum psychiatric disorders, including descriptions of these disorders, their prevalence, symptoms and features, see generally: Pitt, "Maternity Blues" (1973) 122 *British Journal of Psychiatry* 431; Pitt, "'Atypical' Depression Following Childbirth" (1968) 114 *British Journal of Psychiatry* 1325; Dean and Kendell, "The Symtomatology of Puerperal Illnesses" (1981) 139 *British Journal of Psychiatry* 128; Meltzer and Kumar, "Puerperal Mental Illness, Clinical Features and Classification: A Study of 142 Mother-and-Baby Admissions" (1985) 147 *British Journal of Psychiatry* 647; Kendell, Chalmers & Platz, "Epidemiology of Puerperal Psychoses" (1987) 150 *British Journal of Psychiatry* 662; Brockington and Cox-Roper, "The Nosology of Puerperal Mental Illness" in Kumar and Brockington (eds.), *Motherhood and Mental Illness 2: Causes and Consequences* (1988), pp.1-16; O' Hara and Zekoski, "Postpartum Depression: A Comprehensive Review" in Kumar and Brockington (eds.), *Motherhood and Mental Illness 2: Causes and Consequences* (1988), pp.17-63; Boyce and Stubbs, "The Importance of Postnatal Depression" (1994) 161 *The Medical Journal of Australia* 471; Cooper and Murray, "Postnatal Depression" (1998) 316 *British Medical Journal* 1884, (hereinafter referred to as Cooper and Murray, "Postnatal Depression"); Dalton, *Depression After Childbirth: How to Recognise, Treat and Prevent Postnatal Depression* (4th ed. 2001); Wisner, Gracious, Piontek, Peindl and Perel, "Postpartum Disorders: Phenomenology, Treatment Approaches and

psychotic postnatal depression is the disorder most commonly associated with infanticide; the "blues" do not last for a significant length of time after childbirth and are not sufficiently severe in nature to be involved in cases of maternal child killing; puerperal psychosis is an extremely rare condition which is very seldom involved in cases of child homicide.[17]

Infanticide legislation which is based on the English model of 1938 rests the offence/defence of infanticide on the fact that at the time of the killing the mother had been suffering from a disturbance in the balance of her mind which was caused by the effects of childbirth or lactation. However, the view that women may become mentally disturbed due to the direct biological effects of childbirth and lactation may be unsubstantiated by modern medical research. In fact, there appears to be considerable uncertainty about the exact relationship between childbirth/lactation and mental illnesses. For example, for some time it seemed to have been accepted that, while a connection between childbirth and mental disturbance could not be entirely discounted, the claimed link between breast-feeding and mental imbalance was untenable.[18] However, recent research suggests that the latter conclusion

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Relationship to Infanticide" in Spinelli, (ed.), *Infanticide: Psychosocial and Legal Perspectives on Mothers who Kill* (2003), pp.35-60; Spinelli, "Maternal Infanticide Associated with Mental Illness: Prevention and the Promise of Saved Lives" (2004) 161 *American Journal of Psychiatry* 1548 at 1550-1551, hereinafter referred to as Spinelli, "Maternal Infanticide Associated with Mental Illness: Prevention and the Promise of Saved Lives". See also McSherry, "The Return of the Raging Hormones Theory: Premenstrual Syndrome, Postpartum Disorders and Criminal Responsibility" (1993) 15 SLR 292 at 293-295; VLRC, Final Report, para.6.32; Wilczynski, *Child Homicide*, (1997), pp.155-156, hereinafter referred to as Wilczynski, *Child Homicide*.

[17] Wilczynski and Morris, "Parents who Kill their Children" [1993] Crim. L.R. 31 at 35, note that "puerperal psychosis is very rarely the cause of a woman killing her child". See also NSWLRC, Report 83, para.3.29. Mackay, in a recent study of infanticide convictions in England and Wales during the period 1990-2003, found, from an analysis of the psychiatric reports available in the Crown Prosecution Service (CPS) files for these cases, that puerperal psychosis was the primary diagnosis in 12.2% of the cases he analysed. The most frequent primary diagnosis in his sample was postnatal depression, which was diagnosed in 28.6% of cases; see Mackay, "Infanticide and Related Diminished Responsibility Manslaughters: An Empirical Study", in Law Commission, *Murder, Manslaughter and Infanticide* (Law Com No. 304, 2006), pp.192-243 at 201, (hereinafter referred to as Mackay, "Infanticide and Related Diminished Responsibility Manslaughters: An Empirical Study"). See also Appendix E of this Law Commission report which includes a table with the classification of the mental disorders associated with infanticide; Brockington, "Infanticide: Disorders and Classification" in Law Commission, *Murder, Manslaughter and Infanticide* (Law Com No. 304, 2006), p.244.

[18] See generally, the Committee on Mentally Abnormal Offenders, *Report of the Committee on Mentally Abnormal Offenders* (Cmnd 6244, 1975), para.19.23 (hereinafter referred to as the Butler Committee Report); Criminal Law Revision Committee, *Offences against the Person* (14th Report, Cmnd 7844, 1980), paras.103, 105, (hereinafter referred to as CLRC, 14th Report); Law Reform Commission of Canada, *Homicide*, (Working Paper 33, 1984), p.76, (hereinafter referred to as LRCC, *Homicide*); New South Wales Law Reform Commission, *Provocation, Diminished Responsibility and Infanticide*, Discussion Paper No.31 (1993), para.5.16 (hereinafter referred to as NSWLRC, Discussion Paper 31);

is not necessarily the case; there may indeed be some link between lactation and mental illness.[19]

It seems that medical experts cannot reach a definite conclusion on these matters. In an attempt to summarise the bulk of medical research into postpartum mental illnesses, one can assert that while some medical evidence supports a biological cause, the general consensus among medical experts appears to be that postnatal mental disturbances, particularly postnatal depression,[20] are not caused by the profound biological changes, such as chemical and hormonal imbalances, which accompany childbirth. As has been noted in relation to theories on a hormonal aetiology for these conditions, "[t]he results of endocrine research in puerperal mental illness are not encouraging. Despite a profound feeling that hormones 'have something to do with it', there are few positive data."[21]

It seems that the bulk of medical opinion supports an aetiology based on social and psychological factors, such as poor social support, particularly poor spousal support, the occurrence of adverse or stressful life events, including the pregnancy and the birth, and a personal or family history of mental disorder.[22] Thus, the association between the biological effects of

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NSWLRC, Report 83, paras.3.27-3.29; VLRC, Options Paper, paras.6.10-6.14; VLRC, Final Report, paras.6.11, 6.32-6.35.

[19] See Law Commission, *Murder, Manslaughter and Infanticide* (Law Com No. 304, 2006), para.8.26, (hereinafter referred to as Law Com No. 304), referring to research conducted by Dr. Maureen Marks; see Marks *et al*, "Neuroendocrine Studies in Women at Risk of Post Partum Psychiatric Illness", (forthcoming). The Law Commission notes that Marks and her colleagues found that "lactation may increase dopamine sensitivity in some women" which in turn "may trigger psychosis".

[20] It is thought that the postpartum "blues" are caused by biological changes after childbirth, and there is some research which suggests that postpartum psychosis does have a biological aetiology. In addition, while there is some research supporting a biological aetiology for non-psychotic postpartum depression, (*i.e.* postnatal depression), the general consensus appears to be that this disorder has a psychosocial aetiology; see the literature cited *supra*, at n.16, and *infra*, at n.22.

[21] George and Sandler, "Endocrine and Biochemical Studies in Puerperal Mental Disorders" in Kumar and Brockington (eds.), *Motherhood and Mental Illness 2: Causes and Consequences* (1988), pp.78-112 at 104.

[22] See generally, Cooper and Murray, "Postnatal Depression", p.1885. For some of the medical literature dealing with the aetiology of postpartum mental disorders see generally: Paykel, Emms, Fletcher and Rassaby, "Life Events and Social Support in Puerperal Depression" (1980) 136 *British Journal of Psychiatry* 339; Feggetter, Cooper and Gath, "Non-Psychotic Psychiatric Disorders in Women One Year after Childbirth" (1981) 25 *Journal of Psychosomatic Research* 369; Watson, Elliot, Rugg and Brough, "Psychiatric Disorder in Pregnancy and the First Postnatal Year" (1984) 144 *British Journal of Psychiatry* 453; Kumar and Robson, "Prospective Study of Emotional Disorders in Childbearing Women" (1984) 144 *British Journal of Psychiatry* 35; O'Hara, "Social Support, Life Events and Depression during Pregnancy and the Puerperium" (1986) 43 *Archives of General Psychiatry* 569; O' Hara and Zekoski, *op. cit.*, n.16, pp.36-48; Cooper and Murray, "Course and Recurrence of Postnatal Depression: Evidence for the Specificity of the Diagnostic Concept" (1995) 166 *British Journal of Psychiatry* 191; Lane, Keville, Morris, Kinsella, Turner and Barry, "Postnatal Depression and Elation amongst Mothers and their Partners: Prevalence and Predictors" (1997) 171 *British Journal of Psychiatry* 550; Steiner, "Postnatal Depression: A Few

childbirth and mental disturbance may be only or mainly temporal in nature. As McSherry notes:

> ". . . there is very little evidence to show that [postpartum] disorders stem primarily from hormonal or chemical imbalances. Most researchers would agree that . . . [they] are associated with multiple factors such as psychological variables including low motivation for pregnancy and low level of psychological health, demographic variables such as socioeconomic status, stress and previous psychiatric and genetic predispositions. Raging hormones alone cannot be blamed, but rather, it appears that a combination of external and perhaps internal stresses may give rise to such conditions."[23]

In addition to problems with identifying the precise aetiology of postpartum mental illnesses, there are also difficulties in determining the diagnostic status of these conditions. It appears that contemporary medical opinion doubts whether postnatal mental conditions can be distinguished from mental disorders which occur at other times in the life cycle. In fact, two major medical diagnostic systems do not provide for a specific diagnosis of puerperal mental illness. The American Psychiatric Association in the most recent edition of its *Diagnostic and Statistical Manual of Mental Disorders*, (DSM-IV), does not recognise postpartum psychiatric illnesses as separate disorders with a specific diagnostic status. However, it does provide that a limited number of diagnoses under this system can be designated as disorders

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Simple Questions" (2002) 19 *Family Practice* 469; Weisner *et al*, *op. cit.*, n.16, pp.45-47; Sichel, "Neurohormonal Aspects of Postpartum Depression and Psychosis" in Spinelli (ed.), *Infanticide: Psychosocial and Legal Perspectives on Mothers who Kill* (2003), pp.61-79; Spinelli, "Maternal Infanticide Associated with Mental Illness: Prevention and the Promise of Saved Lives", pp.1551-1552. Wilczynski, *Child Homicide*, p.56, notes some other factors of importance in the development of postnatal depression such as a "difficult infant temperament, . . . the reality of motherhood bearing little relation to the idealised societal view of it, the expectations made of women to be 'perfect' mothers, and the significant social and psychological changes frequently accompanying motherhood, such as a loss of paid employment and feelings of isolation and loss of identity".

[23] *Op. cit.*, n.16, p.295. Similarly, the NSWLRC noted: "[i]t is argued that the infanticide provisions more often apply to women suffering conditions which result from the psychological and social stresses of childbirth and child-raising, or from pre-existing mental conditions. *E.g.* for a number of women who suffer depression after giving birth, it may be arguable whether their depression is aggravated rather than caused by the birth, and may be induced by or equally attributable to other factors such as marital discord, lack of support or financial worries"; see NSWLRC, Report 83, para.3.29. The VLRC noted that it is "problematic for the law to treat infanticide as due to postnatal depression caused by the act of childbirth or lactation, when in fact the depression may have far more to do with the pressures of child rearing and be part of the process of adapting to parenthood"; see VLRC, Options Paper, para.6.13. For further discussion on the problems with the medical basis of infanticide legislation see generally, Wilczynski, *Child Homicide*, pp.154-159.

"with postpartum onset" if the illness had an onset within four weeks of childbirth.[24]

Similarly, the World Health Organisation's most recent edition of the *International Classification of Diseases*, (ICD-10), provides no specific diagnosis for postpartum mental illnesses. Such disorders are listed in Chapter Five (Mental and Behavioural Disorders) as "behavioural syndromes associated with physiological disturbances and physical factors". A psychiatric disorder can be designated as puerperal once two conditions are satisfied: the disorder must have commenced within six weeks of childbirth; and it must not meet the criteria for disorders mentioned elsewhere in that chapter.[25]

The dubious medical basis of infanticide legislation has been noted by numerous bodies interested in law reform. In some cases, notably in England, Canada and New South Wales, Australia, it has been suggested that infanticide be repealed. In those instances where abolition has been advocated, this has been on the supposition that the defence of diminished responsibility would be available to mentally disturbed mothers who are charged with murdering their infants. As yet, not one of these jurisdictions has abolished its infanticide provisions.[26] Other law reform bodies have responded to the well acknowledged problems with the medical rationale of infanticide laws by recommending amendments which would reflect what is perceived to be the general medical consensus on this issue.[27]

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[24] Wisner *et al*, *op. cit.*, n.16, p.38; Spinelli, Maternal Infanticide Associated with Mental Illness: Prevention and the Promise of Saved Lives", p.1551; VLRC, Final Report, para.6.33, referring to American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. 2000).

[25] S.F53 provides for mental and behavioural disorders associated with the puerperium, not elsewhere classified and this category "includes only mental disorders associated with the puerperium (commencing within six weeks of delivery) that do not meet the criteria for disorders classified elsewhere in this chapter, either because insufficient information is available, or because it is considered that special additional clinical features are present which make their classification elsewhere inappropriate". Postnatal and postpartum depressions are listed as mild mental and behavioural disorders associated with the puerperium, not elsewhere classified (F53.0). Puerperal psychosis is listed as a severe mental or behavioural disorder associated with the puerperium, not elsewhere classified (F53.1). F53.8 provides for "[o]ther mental and behavioural disorders associated with the puerperium, not elsewhere classified, and F53.9 provides for "[p]uerperal mental disorder, unspecified"; see, http://www.who.int/classifications/icd/en/ - accessed 21 April 2005.

[26] See generally, the Butler Committee Report, paras.19.22-26; LRCC, *Homicide*, p.76; NSWLRC, Report 83, paras.3.18-33.

[27] In the late 1970s the CLRC in England and Wales recommended, on the basis of advice received from the Royal College of Psychiatrists, that the reference to lactation be dropped from the 1938 Act, and that the definition of infanticide be widened to embrace the reality that environmental stresses also play a role in maternal infant killings. It considered that the phrase, "at the time of the act or omission the balance of the woman's mind was disturbed by reason of the effect of giving birth or *circumstances consequent upon that birth*", would serve to "more accurately reflect the existing practice of the courts"; see CLRC, 14th Report, para.105, (Italics added). See also CLRC, 14th Report, para.114, for a summary of their recommendations with respect to infanticide, including their

Two jurisdictions have responded to criticisms of infanticide by amending their respective measures. Victoria recently substituted its existing provisions on infanticide with a new measure (*Crimes (Homicide) Act* 2005, section 5) which, incorporating some of the recommendations made by the Victoria Law Reform Commission in its recent report, *Defences to Homicide*,[28] drops the reference to lactation and extends the definition of infanticide to cover disorders consequent upon childbirth. It also extends this offence/defence to cover children aged under two years.[29] In 2006, the Irish Legislature agreed to amendments to the Infanticide Act, 1949, which were proposed under the ambit of the Criminal Law (Insanity) Act, 2006. The amendments made are similar to those recommended by the CLRC and the VLRC, and those adopted by the Victorian parliament:[30] the reference to lactation has been dropped from the 1949 Act and replaced with a reference to a mental disorder as defined in section 1 of the Criminal Law (Insanity) Act, 2006.[31] The Irish infanticide measure now provides for leniency where a mother kills her infant while the balance of her mind is disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of a mental disorder consequent upon the birth of the child. The

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proposed definition of that offence. The Law Commission's *Draft Criminal Code for England and Wales* adopted this proposed amendment to the definition of infanticide. S.64 (1) of the *Draft Criminal Code* provides: "[a] woman who, but for this section, would be guilty of murder or manslaughter of her child is not guilty of murder or manslaughter, but is guilty of infanticide, if her act is done when the child is under the age of twelve months and when the balance of her mind is disturbed by reason of the effect of giving birth *or of circumstances consequent upon the birth*", (italics added); see The Law Commission, *A Criminal Code for England and Wales, Vol. 1: Report and Draft Criminal Code Bill* (Law Com No. 177, 1989), s.64. More recently, the VLRC, concluded that despite the problems with infanticide legislation it was "necessary" to retain a separate provision "in some form"; see VLRC, Final Report, para.6.22. It recommended that, in order to reflect the reality of maternal child murder and current medical thought on postpartum mental illnesses, the reference to lactation should be dropped from the Victorian measure and that infanticide be extended to embrace mental disorders consequent upon childbirth; see generally, VLRC, Final Report, paras.6.32-6.35, 6.37 & pp.316-317. Interestingly, the infanticide measure included in s.178(1) of the New Zealand *Crimes Act* 1961, already includes disorders consequent upon giving birth; see *supra* at n.10.

28 See *supra*, at n.12.

29 S.6(1) of the *Crimes Act* 1958, as amended by s.5 of the *Crimes (Homicide) Act* 2005, now provides: "If a woman carries out conduct that causes the death of her child in circumstances that would constitute murder and, at the time of carrying out the conduct, the balance of her mind was disturbed because of – (a) her not having fully recovered from the effect of giving birth to that child within the preceding 2 years; or (b) a disorder consequent on her giving birth to that child within the preceding two years – she is guilty of infanticide, and not of murder, and liable to level 6 imprisonment (5 years maximum)."

30 See *supra*, at nn.27, 29.

31 See Criminal Law (Insanity) Act, 2006, s.22(a). A mental disorder includes mental illness, mental disability, dementia or any disease of the mind, but does not include intoxication; Criminal Law (Insanity) Act, 2006, s.1. It is arguable that this may be too narrowly defined for the purposes of infanticide. This potential problem was highlighted by Deputy Costello in Dáil Éireann during the debates on the Insanity Bill; see *Dáil Éireann Parliamentary Debates*, vol. 616, cols. 2035, 2040.

Minister for Justice, Mr. Michael McDowell, explained that his reasons for this amendment were due to "academic and legal criticism of the perceived narrow, medical, psychiatric basis for infanticide as set out in the current law".[32] He asserted that he was trying to "remove what is an out of date and medically unsupportable proposition from the Infanticide Act and to modernise the language used in that Act to deal adequately with the phenomenon of mothers who shortly after birth ... injure their children...."[33]

More recently, the Law Commission in England and Wales consulted with a number of experts in the areas of law and medicine on the subject of infanticide as part of a wider investigation into the law on homicide in general. As a result of these consultations the Law Commission concluded that there "*is* sufficient medical evidence on which to justify the offence/defence of infanticide as it stands".[34] The Law Commission noted that while there may be no psychiatric disorders which are "specific to childbirth", there are still reasons to justify the connection between parturition and mental disturbances in the legislation.[35] It was noted that there is certainly a temporal connection between childbirth and mental disorder, the incidence of some disorders being higher in the postpartum period, and that this suggests that some women are more susceptible to mental disorder after they give birth.[36] With regard to lactation, the Law Commission pointed to recent research which suggests that the idea that some women may experience mental imbalances as a result of this biological process may not be entirely unfounded, as was previously thought.[37] The Law Commission concluded that infanticide should not be extended to include "circumstances consequent upon childbirth",[38] and, in light of recent research suggesting that the supposed link between lactation and mental disorder is not entirely fallacious, that the reference to lactation in the legislation should be retained.[39]

In summary, it is evident that there is little agreement about the causes and status of post-natal mental disturbances. It seems that mental disturbances experienced by women in the postpartum period may be attributable to any number of factors, and that while a biological or physiological explanation for these disorders cannot be completely discounted,[40] the vast majority of

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[32] *ibid.*, cols. 2034-2035.
[33] *ibid.*, col. 2035.
[34] Law Com. No. 304, at para.8.25, italics added.
[35] *ibid.*
[36] *ibid.*
[37] *ibid.*, at para.8.26, referring to research conducted by Dr. Maureen Marks. See *supra*, at n.19.
[38] *ibid.*, at para.8.31. See *supra*, at n.27.
[39] *ibid.*, at para.8.26.
[40] *E.g.* Watson, *et al, op. cit.*, n.22, pp.460-461, although finding that the majority of episodes of mental disorder among their group of fifteen women who experienced depression six weeks after childbirth were understood in terms of a previous psychiatric disorder and/or a reaction to life events, including the stress of the birth itself (at pp.460-461), two of these women gave no psychosocial explanation for their illness. A biological explanation was suggested for those two cases, (at p.461). Paykel *et al, op. cit.*, n.22, pp.344-345, suggested a similar aetiological foundation for a small subgroup of their sample of 120 women, 20% of whom were found to have mild clinical depression at six weeks postpartum. Depression

these instances of mental disturbance seem to arise as a result of external factors. The bulk of medical research appears to suggest that economic, social and psychological difficulties are more important than biological changes at childbirth, and that childbirth as a life event and the stresses and strains associated with child rearing are more important than the biological events of childbirth and lactation. The problem widely recognised with infanticide legislation is that it fails to reflect this reality.

Efforts have been made in a number of jurisdictions, notably in Victoria and the Republic of Ireland, to respond to this. However, the recent findings of the Law Commission suggest that any attempt to amend infanticide legislation to reflect the prevailing views of medical experts may prove to be unduly hasty. This is particularly pertinent when one considers the lactation issue. Until very recently it had seemed that there was little or no support for the theory that breast-feeding could cause mental disturbances, and, in light of this, it was generally accepted that the reference to lactation should be dropped from infanticide legislation. However, the findings of the Law Commission throw some doubt on the prudence of such a course if action. Certainly, it could be suggested that the decision to drop the reference to lactation from the Victorian and Irish measures cannot be welcomed without reservation. However, in defence of the Victorian and Irish legislatures, it seems that both were influenced by what was considered to be sound medical opinion. The problem with this is that it appears that medical experts are unable to reach a definite agreement on the matter of postnatal mental disturbance. It is suggested, therefore, that it may be unwise to place undue reliance on their conclusions.

I will argue that, in light of the above difficulties, it may be beneficial to look beyond the narrow parameters of the medical model to the historical context in which infanticide legislation was enacted in order to find a suitable means of rationalising these measures. First, however, it is necessary to briefly note some of the evidence in favour of the medical model of infanticide.

Support for the Medical Model

While criticisms of the medical basis of infanticide legislation are not without merit and may present compelling reasons for amending or even

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was strongly associated with life events, especially adverse life events. Social factors such as a poor marital relationship and poor social support were also noted as vulnerability factors, (at p.344). A previous psychiatric history was also found to be relevant. In addition, they found that the occurrence of postpartum "blues" in the early days following childbirth was associated with the presence of postnatal depression six weeks after the delivery. They noted that since the "blues" was a "common and time-distinctive phenomenon", it was likely it was "related to massive hormonal changes". This, in conjunction with the fact that the association between the "blues" and the later development of postnatal depression occurred only in the absence of undesirable life events, pointed towards the existence of a "small hormonal sub-group among the more persistent depressions", especially in the absence of life stress, (at p.345). Sichel, *op. cit.*, n.22, p.76, concluded, after a review of much of the recent literature and research on the subject of postpartum disorders: "[c]learly, the etiology of postpartum mood and psychotic disorders lies in the biological and physiological elements associated with pregnancy and childbirth."

abolishing these measures, the argument in favour of such a course of action is not necessarily straight-forward. It is important to acknowledge that the medical basis of the legislation is not entirely bereft of scientific merit. Thus, although there appears to be much uncertainty among experts about postpartum mental illnesses, particularly their aetiology and their exact relationship to childbirth, there seems to be little doubt that women can suffer from mental disturbances in the postpartum period. Psychiatrists may argue about the exact causes and suitable classification of postpartum mental conditions, and their relationship to childbirth, but the fact remains that these are real disturbances which cause immense mental and emotional upset for many women.[41]

In relation to this, studies indicate that although many women who have been able to avail of the infanticide legislation have not actually been suffering from distinct and recognisable disorders such as postpartum depression and postpartum psychosis, most were not mentally, psychologically and emotionally stable individuals.[42] This is illustrated, for example, in a study by d'Orban who examined the cases of eighty-nine mothers who had been admitted to Holloway Prison between 1970 and 1975 on a charge of killing or attempting to kill a natural child.[43] From these offenders, d'Orban identified six categories of maternal child killing: battering mothers (thirty-six cases); mentally ill mothers (twenty-four cases); neonaticides (eleven cases); retaliating mothers (nine cases); mothers who killed unwanted children (eight cases); and mercy killing (one case). From the eighty-nine cases examined a total of twenty-three women were convicted of infanticide. Although only two offenders fell into what d'Orban identified as the mentally ill group of mothers,[44] it seems that many, though not all, of the

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[41] See Lansdowne, "Infanticide: Psychiatrists and the Plea Bargaining Process" (1990) 16 MonLR 41 at 62. McSherry, *op. cit.*, n.16, p.293, notes that there "is now little doubt about the existence of postpartum depression and postpartum psychosis". See also, VLRC, Final Report, paras.6.32-6.34.

[42] *E.g.* see generally, D'Orban, "Women who Kill their Children" (1979) 134 *British Journal of* Psychiatry 560; Lansdowne, *ibid.*, Mackay, "Infanticide and Related Diminished Responsibility Manslaughters: An Empirical Study".

[43] See D'Orban, *op. cit.*, n.42. This study was not restricted to cases involving the killing of infants aged under one year.

[44] *ibid.* p.566, Table V. Of the twenty-three women who were convicted of infanticide, ten fell into the battering category; ten fell into the category of neonaticide; two fell into the mentally ill category; and one fell into the retaliating category. The group of mentally ill mothers included "all cases suffering from psychotic illness, cases of acute reactive depression associated with a suicidal attempt and cases of personality disorder with depressive symptoms of sufficient severity to require admission to psychiatric hospital and who did not meet the criteria of the other categories". Two-thirds of the victims in this category were aged over one year. In only half of the cases involving psychotic women did the illness occur in the puerperium. D'Orban concludes that "contrary to medico-legal tradition these filicides are not especially associated with the puerperium, when women are thought to be particularly liable to kill their children" (at pp.569-570). Marks and Kumar, in a re-analysis of d'Orban's data, found that the killing of older children was more associated with mental illness than the killing of young infants. Women who killed their children aged under six months were more likely to do so due to a loss of temper, *i.e.* in the context of fatal child abuse/battering. Mothers who killed older children were "most frequently categorized as mentally

other women convicted of infanticide were suffering from a mental, psychological or emotional disturbance, albeit of a less serious nature.[45]

Maier-Katkin and Ogle opine, after considering the medical evidence on puerperal mental disorders, including d'Orban's study, that "[o]n balance, it seems inappropriate to dismiss the link between childbirth and mental illness as a myth created by the authors of the Infanticide Act."[46] They note that while d'Orban classified only twenty-four of the eighty-nine cases he examined as being "mentally ill", the majority of women in his study did satisfy the requirement in the 1938 statute of a disturbance in the balance of the mind.[47] As Maier-Katkin and Ogle note, the 1938 Act does not expect a psychotic or severe mental illness to be shown; it only requires some disturbance in the balance of the mind.[48] They conclude that "even if most of the women who kill their own children do not suffer from psychoses or other extreme mental illnesses, many do; and the others probably suffer from the types of emotional distress contemplated by the statute."[49]

A more recent study by Mackay also indicates that women who have availed of infanticide in the past have not been mentally and/or emotionally stable individuals. Mackay examined a sample of forty-nine infanticide convictions in England and Wales from 1990 to 2003.[50] Using the information contained in the Crown Prosecution Services files,[51] in particular the psychiatric reports

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ill". They conclude: "[i]t would appear that while maternal mental illness has contributed to many of the younger infant homicides, more often infants had been killed, or nearly killed, because the mother had suddenly lost her temper with them"; see Marks, "Characteristics and Causes of Infanticide in Britain" (1996) 8 *International Review of Psychiatry* 99 at 104-105, referring to Marks and Kumar, "Parents who Kill their Infants" (1995) 3 *British Journal of Midwifery* 249.

45 Overall seventy-five (84%) of the eighty-nine women in the study were diagnosed with some kind of psychiatric abnormality. The diagnoses were as follows: personality disorder (43%); reactive depression (21%); psychotic illness (16%); subnormal (4%); no abnormality (16%); see *op. cit.*, n.42, p.562, Table II. Thirty-two of the thirty-six mothers who fell into the battering category were suffering from some psychiatric abnormality (at p.562). Fifteen of the cases in the battering group involved the killing of an infant aged under one year and ten of these cases resulted in an infanticide conviction, (at p.566). One woman from the retaliating group was convicted of infanticide, *ibid.*, p.566, Table V. All of the women in this category had been diagnosed with some abnormality, either a personality disorder (eight) or reactive depression (one) (at p.562) Table II. There was a lower incidence of diagnosed psychiatric abnormality among the group of neonaticidal women; eight of the eleven women who killed their infants within twenty-four hours of birth had no psychiatric abnormality, (at p.562). Two women were diagnosed with a personality disorder and one woman was diagnosed as being subnormal. In spite of this, ten of these mothers were convicted of infanticide. The infant of the one woman from this group who was not convicted of infanticide had survived, (at p.566).

46 "A Rationale for Infanticide Laws" [1993] Crim. L.R. 903 at 908.

47 *ibid.*, pp.908-909.

48 *ibid.*, p.909.

49 *ibid.*

50 See Mackay, "Infanticide and Related Diminished Responsibility Manslaughters: An Empirical Study".

51 In eleven cases these files could not be accessed and the psychiatric reports were, therefore, not available for consultation; see *ibid.*, p.201.

which were available,[52] Mackay distilled data on the type of diagnoses made in cases of infanticide during this period. In 22.4 per cent of cases (eleven in number), no information was available. In the remaining cases, the most frequent primary diagnosis[53] was postnatal depression (28.6 per cent, fourteen cases). In seven cases a diagnosis of depression was given (14.3 per cent of the total number of cases examined). The next most frequent diagnosis was puerperal psychosis, which was made in 12.2 per cent of the forty-nine cases analysed. In the remaining eleven cases for which Mackay had access to psychiatric reports, the diagnoses were as follows: dissociative disorder five cases (10.2 per cent); mental disturbance four cases (8.2 per cent); abnormality of mind one case (2 per cent); and personality disorder one case (2 per cent).[54] In addition, forty-three of the sixty-seven available reports (64.2 per cent) referred to the issue of infanticide and favoured this disposal.[55] This study indicates that, despite theoretical problems with the existence, causes and status of postnatal mental illnesses, and the connected dubious foundation of infanticide legislation, in practice, psychiatrists seem to have had little difficulty in ascribing some kind of abnormal mental condition to women who have availed of infanticide, and, in the majority of cases, have been willing to tie this in with the relevant legislative provisions. Therefore, it is arguable that the medical basis of infanticide legislation must have some merit, if not on a theoretical level, then at least on a practical one.

It is also important to emphasise that the medical foundation of the infanticide legislation should not be viewed restrictively. The background to the enactment of the 1922 and 1938 Acts and the language used in these measures suggest that a recognised disease or a disorder should not necessarily be required in order for infanticide to be established. It is evident from the circumstances in which this legislation was adopted in England and in Ireland that the legislature had no intention of restricting infanticide to situations where mothers killed their infants while labouring under severe and definable mental illnesses, such as depression or psychosis. It is more likely that the legislature was concerned with mental distresses or upsets caused by the exhausting and frightening experience of childbirth or the strains associated with the lactational period. The language chosen, "a disturbance in the balance of the mind", appears to reflect this; it can and evidently has been construed as requiring something much less than a mental disease, disorder or abnormality caused by the physical effects of childbirth

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[52] Each file contained between one and four psychiatric reports. In some cases it was evident that other reports had been available at the time but were not included in the CPS File. Mackay notes that the fact that these files did not include all relevant reports should be borne in mind when considering his analysis of the psychiatric evidence available in these cases; see *ibid.*

[53] This was based on the cumulative view of the reports available in each case; see *ibid.*, p.201 at n.8.

[54] See *ibid.*, pp.201-202.

[55] *ibid.*, p.203. In twenty-three reports no reference was made to infanticide. The author of the remaining report found that the woman's mental condition was a disturbance of mind within the 1938 Act, but left it to the court to decide whether this description was correct.

or lactation.[56] For example, D'Orban concluded from his study that the disturbance required by the Infanticide Act 1938:

> ". . . is clearly not interpreted by medical witnesses and by the courts as a severe abnormality amounting to psychiatric disorder; the degree of abnormality is much less than that required to substantiate 'abnormality of mind' amounting to substantially diminished responsibility under section 2 of the Homicide Act 1957."[57]

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[56] It seems evident from numerous studies that infanticide laws have not been applied in a restrictive manner, requiring the establishment of disorders such as psychosis and depression. In fact, in the right circumstances, that is those calling for an avoidance of a murder trial and a discretionary sentence, a mild and temporary mental disturbance caused by fear, panic, exhaustion, frustration and stress, all of which may be associated with childbirth and child rearing, have sufficed. *E.g.* see generally: Morris & Wilczynski, *op. cit.*, n.12; Lansdowne, *op. cit.*, n.41; Mackay, "The Consequences of Killing Very Young Children" [1993] Crim. L.R. 21, (hereinafter referred to as Mackay, "The Consequences of Killing Very Young Children"). For an examination of the operation of the Irish infanticide measure see Brennan, *Infanticide Past and Present: Law, History and* Culture (PhD Thesis, University College Dublin, 2006), chap.10.

[57] See *op. cit.*, n.42, p.570. If this is the case, it may cause difficulties with the new definition of infanticide in Ireland which includes a mental disorder consequent upon childbirth. As already noted, the term mental disorder is also used in the Criminal Law (Insanity) Act, 2006, in connection with the defences of insanity and diminished responsibility. D'Orban's finding is relevant in relation to the recommendations of the Butler Committee to abolish the Infanticide Act in England on the basis that it can be adequately dealt with by the defence of diminished responsibility; see the Butler Committee Report, paras.19.22-19.26. However, it is of interest to note that in Mackay's most recent study of infanticide, (*supra*, text at nn.50-55), 38.9% (twenty-six in number) of the psychiatric reports available on women who were dealt with under the 1938 Infanticide Act between 1990 and 2003 favoured diminished responsibility "rather than or as an alternative to" infanticide. In addition, only two (3%) of the sixty-seven available reports concluded that the woman's condition did not fall within the diminished responsibility provisions in s.2 of the Homicide Act 1957. Mackay notes that this is "of interest in view of earlier concerns expressed . . . that not all cases of infanticide would fall within section 2 as the requirements contained in the latter are stricter and more difficult to satisfy"; see "Infanticide and Related Diminished Responsibility Manslaughters: An Empirical Study", pp.205. These findings do cast some doubt on d'Orban's conclusion. However, it is worth noting, as Mackay does, that thirty-nine of the reports he examined (58.1%) did not mention the issue of diminished responsibility. It is not possible to know what the relevant author would have concluded had he/she addressed the issue in his/her report, but, as Mackay notes, one cannot be sure that, had he/she addressed the issue, he/she "might not have regarded D's condition as satisfying the section 2 criteria", (at p.206). In an earlier study of infanticide cases in England during the 1980s, Mackay concluded that "the criteria within the 1938 Act were being used primarily as a legal device for avoiding the mandatory penalty and thus ensure that leniency could be shown in appropriate cases"; see Mackay, "The Consequences of Killing Very Young Children", p.29. See also, Cheung, "Maternal Filicide in Hong Kong" (1986) 26 Med. Sci. Law 185. Cheung reached a similar conclusion to d'Orban's in his study of thirty-five maternal filicides in Hong Kong between 1971 and May 1985. Using the same classification system as d'Orban, Cheung found that only six of the thirteen women in his study who were convicted of

Thus, in summary, there are arguments in favour of the medical basis of infanticide legislation. First, in spite of the difficulties with classification and aetiology, postpartum mental disturbances are not necessarily fictitious illnesses; there is little doubt that many women do suffer from mental upsets in the period after childbirth. Second, it seems that infanticide legislation does work well in practice.

However, due to the problems which beset the medical basis of infanticide, more may be required to justify these measures in their current form. I suggest that the historical background to this legislation provides a broader perspective on the meaning of the medical model of infanticide and on the purpose of these measures; by placing infanticide legislation in its historical context, the actual significance of the medical basis of these measures should become evident and the real justification for the infanticide statutes will emerge. In the following section I will examine the background to the enactment of the English and Irish Infanticide Acts. In doing so, I will seek to provide a re-evaluation of the relevance of the medical basis of infanticide legislation and, consequently, the importance of medical discourse on this topic.

Locating Scientific Paternalism: The Background to Infanticide Legislation in These Islands

The English Experience

The Infanticide Acts 1922 and 1938 were introduced in England and Wales in response to the long recognised problems with the law of murder in the context of maternal infant killing. For many years it had been accepted that the law in this area was in need of alteration. The mandatory sentence of death in all cases of murder posed significant problems in cases where women were charged with murdering their infants. In England and Wales no woman had been executed for the murder of her child since 1849, and judges had long bemoaned the prevailing practice in cases where women were convicted of murdering their own infants whereby they were expected to don the black-cap and in all solemnity pass a sentence of death which everyone knew would be reprieved.

As far back as the mid-nineteenth century this particular difficulty with the law relating to maternal infant murder had been highlighted.[58] A number of

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infanticide (*Offences Against the Person Ordinance*, s.47C) could be classified as falling into the mentally ill group. The remaining seven women "did not suffer from any abnormality which could be described as mental disorder", (at p.191; p.189, Table VII). He similarly concluded that "the degree of abnormality in these cases was much less than that required to meet the definition of 'abnormality of mind' amounting to diminished responsibility" in Hong Kong, (s.3 of the *Homicide Ordinance* which was the equivalent to s.2 of the English Homicide Act 1957), (at p.191).

[58] This was not the only problem with the law relating to infant murder in the nineteenth century. In cases where persons where charged with the murder of newborn infants the prosecution had, due to the presumption of dead birth, the difficult task of proving that the murdered child had been fully born alive at the time of death. This meant that any child that had not been fully born alive at the time of death was afforded no protection under the criminal law. Thus, many

witnesses before the 1866 Royal Commission on Capital Punishment[59] referred to this problem which had been termed the "solemn mockery" or "black-cap farce". For example, the then Home Secretary, Sir Grey Bart, noted that between 1849 and the end of 1864 there had been thirty-nine convictions for maternal child murder, or infanticide as it was then commonly called.[60] He observed that since the last execution for infanticide in 1849, there had been five Secretaries of State, all of whom had commuted the death sentences imposed in these cases: "[t]he rule has now been adopted of commuting the [death] sentence, but I think that it is almost invariably done upon the recommendation of the judge, or in concurrence with him."[61] The Rev. Lord S. G. Osborne remarked that "[i]n nine cases out of ten, trying women for their lives for infanticide is a cruel farce" because "no one for one moment believes that the woman will be executed."[62]

The problem of the "solemn mockery" reflected the pity which was almost invariably felt for women who murdered their young infants. Infanticide was, during a period where women committed few offences, typically a female crime. Similar to the prostitute and female poisoner, the mother who murdered her infant was "a negation of the ideal of womanhood".[63] In spite of this, due to the social context in which she committed her crime, the infanticidal mother tended to attract a great deal of sympathy from jurors, judges and others who were involved in her murder trial. Throughout the eighteenth and nineteenth centuries, and indeed well into the twentieth century, infanticide and illegitimacy were commonly linked, the latter frequently providing a compelling motive for the former.[64] The typical

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persons who killed infants in the act of birth or before the child had been fully born alive escaped conviction for murder or manslaughter. Many mothers who killed their infants before they were fully born alive were convicted of the lesser offence of concealment of birth. In 1929, the Infant Life Preservation Act was enacted to close this loophole in the law; see generally Seaborne Davies, "Child killing in English Law" in Radzinowicz and Turner (eds.), *Modern Approach to Criminal Law* (1945), pp.301-343 at 303-310; Kenny, *Outlines of Criminal Law* (5th ed. 1911), pp.128-129; Williams, *The Sanctity of Life and the Criminal Law* (1958), pp.19-23; Atkinson, "Life, Birth and Live-Birth" (1904) 20 L.Q.R. 134-159. See also Casey, *Born Alive: The Legal Status of the Unborn Child in England and the U.S.A.* (2005), pp.12-19, who provides an historical account of the born alive rule.

59 B.P.P, 1866, xxi. The page numbers noted for the B.P.P.'s refer to the page number of the whole volume, rather than the page number of the individual paper, report, document etc.

60 *ibid.*, p.242. Thirty-four of these convictions were for the murder of illegitimate children.

61 *ibid.*, p.244.

62 *ibid.*, p.475.

63 Emsley, *Crime and Society in England 1750-1900* (2nd ed. 1996), p.156.

64 For an account of child murder during the nineteenth and early twentieth centuries, see generally, Rose, *Massacre of the Innocents: Infanticide in Britain 1800-1939* (1986). See also, Sauer, "Infanticide and Abortion in Nineteenth Century Britain" 32 *Population Studies* 81; Higginbotham, "'Sin of the Age': Infanticide and Illegitimacy in Victorian London" (1989) *Victorian Studies* 319. By the latter half of the nineteenth century infanticide seems to have provoked a certain amount of hysteria in the public domain and tended to be strongly associated with poverty and illegitimacy. One must be careful, however, not to assume that illegitimacy

infanticide offender was an unmarried mother, who, having much to lose by giving birth to an infant outside the bonds of wedlock, concealed the pregnancy and birth, killing her infant shortly thereafter.[65] The unmarried mother, or "fallen woman", by demonstrating disregard for the Victorian sexual code,[66] and, in particular, the revered ideal of female chastity could face social and economic ruin;[67] the consequences of illegitimacy were especially serious for domestic servants who relied on their respectability to gain and maintain employment, and infanticide was particularly associated with this occupational class.[68]

In addition, women were often left to deal with the results of their sexual encounters alone; the sexual double standards of the time ensured that men generally emerged unscathed from their pre-marital or extra-marital sexual encounters, something which was both demonstrated and reinforced by the

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automatically led to infanticide. Many women faced the daunting prospect of giving birth to a child outside of marriage, but only a few resorted to murder as a means of dealing with this. As Higginbotham notes, ". . .melodramatic claims about the extent of child murder overemphasised the actions of a few women and ignored the special circumstances surrounding most cases of infanticide", (at p.337). For a contemporary account of the problem of infanticide, see generally, Burke, *Infanticide: Its Law, Prevalence, Prevention and History* (1862).

65 Rose notes that upper-class women who became pregnant as a result of some sexual indiscretion had more options available due to the protection offered to them by their class and wealth; see Rose, *op. cit.*, n.64, p.20.

66 For accounts of nineteenth century Britain's social history, and particularly Victorian views on sexual morality, see generally: Seaman, *Victorian England: Aspects of English and Imperial History 1837-1901* (1973), pp.6-14; Rubinstein, *Britain's Century: A Political and Social History 1815-1905* (1998), pp.325-326, 331-332; L'Esperance, "Doctors and Women in Nineteenth Century Society: Sexuality and Role" in Woodward and Richards (eds.), *Health Care and Popular Medicine in Nineteenth Century England* (1977), pp.105-127 at 106.

67 See L'Esperance, *ibid.*, p.106; Seaman, *ibid.*, pp.13-14; Smout, "Aspects of Sexual Behavior in Nineteenth Century Scotland" in Laslett, Oosterveen & Smith (eds.), *Bastardy and its Comparative History: Studies in the History of Illegitimacy and Marital Nonconformity in Britain, France, Germany, Sweden, North America, Jamaica and Japan* (1980), pp.192-216 at 193-196. Incidentally, there were parts of rural Britain, particularly in Scotland and Wales, where illegitimacy posed no problem. Local customs, rather than frowning upon premarital sexual relations, actually encouraged them as part of a healthy courtship which would inevitably end in marriage. If a pregnancy resulted, stern community values ensured marriage in the vast majority of cases, while the occasional seduced and abandoned female generally avoided community censure and found it safe and acceptable to raise her child alone with family support; see generally, Smout, *ibid.*, pp.192-216, particularly pp.206-207; Ireland, "'Perhaps My Mother Murdered Me': Child Death and the Law of Victorian Carmarthenshire" in Brooks and Lobban, (eds.), *Communities and Courts in Britain 1150-1900* (1997), pp.229-244 at 242-243. Similarly, Rose, *op. cit.*, n.64, pp.20-21, notes that loss of virtue did not necessarily result in irreparable damage to a working-class woman's social standing; the economic consequences of illegitimacy were more significant to these women than any social stigma which might attach.

68 See Rose, *op. cit.*, n.64, pp.19-20, who notes the particular vulnerability of domestic servants. Smout, notes that if a domestic servant became pregnant she would almost certainly be dismissed without a reference, thus becoming unemployable, and this is why so many of Edinburgh's prostitutes had been domestic servants; Smout, *op. cit.*, n.67, p.196.

bastardy clauses in contemporary poor laws.[69] Perhaps, then, it is not surprising that mothers who murdered their infants were met with some compassion by the men whose duty it was to administer justice. Faced with a woman who committed what was perceived to be the most unnatural of crimes, but who portrayed the stereotypical image of abandonment, isolation, fear, poverty, ignorance and shame, the male juror or judge could hardly fail to respond with some pity, particularly if he, due to his sex and class, felt some form of collective responsibility for the situation in which the accused woman found herself. This is reflected in the words of the Rev. Lord Osborne in his evidence before the Commission on Capital Punishment, where he stated: "mankind generally are so far conscience stricken in this matter that they feel a very natural reluctance to visit on the woman the full penalty of a crime in which themselves have antecedently much to answer for."[70]

The abhorrence of the death penalty as a punishment in cases of maternal infant murder resulted in two problems. First, juries were extremely reluctant to convict mothers who killed their infants of the capital offence of murder. Although they were generally aware that this sentence would not be carried out, this being the established practice in cases of this kind since 1849, they were equally reluctant to put the "poor woman", who may not have been wise to this arrangement and who may have fully believed that the sentence would be carried into effect, through the torment of having this sentence declared in open court.[71] Essentially, the severity of the law prevented these offenders from being effectively brought to justice.[72]

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[69] See generally, Henriques, "Bastardy and the New Poor Law" 37 (1967) *Past and Present* 103; Rose, *op. cit.*, n.64, chap.4.

[70] B.P.P., 1866, vol. xxi, p.476. Mothers who murdered their infants may also have been treated more leniently than other intentional killers due to nineteenth century views on the value of infant life and, in connection with this, the seriousness of infant murder. Infant life seems to have been held cheap during this period, probably due to the high infant mortality rate from causes such as poverty, disease and a failure to educate mothers on infant health. Certainly, at least in the earlier part of this century, the common occurrence of infanticide may not have been regarded with any particular alarm, this crime being viewed as less heinous than murder; see generally, Rose, *op. cit.*, n.64, pp.35-36; Sauer, *op. cit.*, n.64, pp.82-83. The comments of some of the witnesses called before the Royal Commission on Capital Punishment, reflects this view of infanticide as a crime which was less serious than murder; see, B.P.P., 1866, xxi, pp.57 (Lord Cranworth), pp.109-110 (the Right Honorable S. H. Walpole, M. P.), p.343 (James Fitzjames Stephens). During the latter part of this century, however, there appears to have been a growing concern with infant welfare and protection, particularly among the medical profession, and with the problem of infanticide; see generally, Rose, *op. cit.*, n.64, chap.5; Sauer, *op. cit.*, n.64, p.85; Higginbotham, *op. cit.*, n.64, p.320.

[71] For a good description of this problem see the words of Lord Arnold, *loc. cit.* n.108, in the parliamentary debates surrounding the enactment of the 1938 Infanticide Act. Although he was referring to the problems with the 1922 legislation, his comments are relevant to the difficulties with the law pre-1922; the "black-cap farce" continued to be the main problem with the law post-1922 due to the narrow ambit of the first Infanticide Act which confined itself to the murder of "newly-born" infants.

[72] See generally, Seaborne Davies, *op. cit.*, n.58; Higginbotham, *op. cit.*, n.64; Rose, *op. cit.*, n.64, chap.8; Ireland, *op. cit.*, n.67. See also the evidence of those

Second, members of the judiciary appeared disgruntled about this arrangement whereby they would don the black cap and declare most solemnly that the convicted woman would be executed for her crime, knowing that it would very shortly be commuted by the Home Secretary, usually at their own request and that of the jury.[73] As Lord Coleridge noted in the debate surrounding a proposed infanticide clause in the Children's Act of 1908: "[w]hoever had passed through the experience of passing such a sentence knew well that he had discharged a very grave function indeed, and to deprive that function of its solemnity was to deprive it of its reality as well as of its efficacy as a warning."[74]

The solution to these problems, which was contained in the 1922 Infanticide Act, was to medicalise the crime of maternal infant murder by providing for lenient treatment on the basis that the balance of the mother's mind was disturbed at the time of the killing. The Infanticide Act 1922 created the offence/defence of infanticide, which would be akin to manslaughter for the purposes of trial and punishment. A woman could be charged with or convicted of infanticide if she "by any wilful act or omission cause[d] the death of her newly-born child" in circumstances amounting to murder while "the balance of her mind was ... disturbed" due to the fact that she had "not fully recovered from the effect of giving birth to such child".[75]

These provisions were subsequently extended by the Infanticide Act 1938 to cover the killings of infants up to the age of one year. This was a response to the construction which had been given to the term "newly-born" by the courts; this term had been interpreted narrowly to embrace infants aged up to three or four weeks only.[76] This had resulted in similar problems to those which had existed prior to the enactment of the 1922 legislation; judges were again solemnly declaring sentences of death on mothers who had been convicted of killing their infants in cases where everyone knew this sentence would inevitably be reprieved. In order to accommodate this extension of the infanticide provisions to mothers who killed their infants up to the age of twelve months, the 1938 Act incorporated a reference to a disturbance in the

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witnesses who appeared before the 1866 Royal Commission on Capital Punishment; B.P.P., 1866, xxi.

[73] See literature cited *supra,* at n.72. This has not been the only time in the history of criminal justice where the full rigor of the law was avoided in this way. *E.g.* during the latter half of the eighteenth century, despite the increase in capital property offences and convictions, the number of executions which were actually carried into effect remained fairly stable; the use of royal pardons ensured that many of those sentenced to death for property offences were not hanged, but were transported or imprisoned. Similar to the problem with infanticide in the nineteenth century, law reformers asserted that the "policy of terror" was ineffective and argued in favour of "more lenient but more certain punishments"; see generally, Hay, "Property, Authority and the Criminal Law" in Hay *et al* (eds.) *Albions's Fatal Tree: Crime and Society in Eighteen Century England* (1975), pp.17-64, especially pp.22-23. As Hay notes, "...rather than terrifying criminals, the death penalty terrified prosecutors and juries, who feared committing judicial murder on the capital statutes", (at p.23).

[74] *Parliamentary Debates* (H.L.), 1908, vol. 196, col. 490.

[75] See Infanticide Act 1922, s.1(1) & (2).

[76] See *R.* v *Donoghue* (1927) 20 Cr. App. R. 132; *R.* v *Hale, The Times,* 22nd July 1936, p.13.

balance of the mind caused by the effects of lactation. The English and Welsh infanticide legislation now provided for leniency where a mother killed her infant aged *under twelve months* while the balance of her mind was disturbed from the effects of childbirth *or lactation.*[77] The Infanticide Act 1938 has not since been amended. It has provided the model for infanticide legislation adopted in a number of jurisdictions, including the Republic of Ireland.[78]

The Irish Experience

Infanticide legislation was introduced in the Republic of Ireland in 1949. The background to this measure can be gleaned from the letters and memoranda contained in files of the Department of Justice, Department of the Taoiseach and the Attorney General's Office which are held in the National Archives in Dublin. The documents contained in these files provide a wealth of information on the origins of this measure, including the perceived reasons for the need to review the law on maternal child murder in that jurisdiction.[79] It is evident from these sources that, as in England and Wales, the main problem was that the law, which mandated a sentence of death in all murder cases, was considered to be too harsh where women killed their young infants in circumstances which demanded sympathy rather than severity.

As in England, the pervading view was that mothers who murdered their infants were generally "more sinned against than sinning". The vast majority of women who killed their infants were unmarried and they killed to avoid the shame, scandal, stigmatisation, isolation and economic hardship which illegitimacy attracted. Many girls and women who found that they were pregnant with a child conceived during an "illicit" sexual union concealed their pregnancies from their families and communities in order to avoid the dire social and economic consequences of this. Undoubtedly, many women who disguised their pregnancies and gave birth behind a veil of secrecy did not subsequently kill their infants. However, where death did occur, it was usually a result of or a continuation of this concealment: some infants died due to their mother's ignorance or neglect during the course of or in the aftermath of an unassisted birth; others were deliberately killed soon after

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[77] See Infanticide Act 1938, s.1(1) & (2).

[78] S.1(1) of the Infanticide Act 1938 defines the offence of infanticide as follows: "[w]here a woman by any wilful act or omission causes the death of her child being a child under the age of twelve months, but at the time of the act or omission the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent upon the birth of the child, then, notwithstanding that the circumstances were such that but for this Act the offence would have amounted to murder, she shall be guilty of felony, to wit of infanticide, and may for such offence be dealt with and punished as if she had been guilty of the offence of manslaughter of the child."

[79] See generally, National Archives Dublin: Department of Justice files (infanticide) 8/144/1; 8/144/A; H266/61; Department of Taoiseach files s14493 (infanticide), s.13311 (insanity) & s.7788(a) (capital punishment); Attorney General Office files (infanticide) 2000/10/2921 & 2922.

birth by their mothers who were desperate to conceal the fact that they had ever existed.[80]

It is also possible that an acceptance of reduced responsibility in cases of maternal infant murder was supported by common lay perceptions about the physical and mental effects of childbirth on women. It may have been assumed that many mothers who killed their infants around the time of parturition did so at a moment of great physical and mental weakness and, in some cases, mental disturbance. Such a popular belief in mental weakness and instability is illustrated in the trial judge's charge to the jury at the trial of a County Monaghan woman who had been charged with murdering her newborn infant by strangling it with a rope.[81] The accused in this case, a thirty-four year old married woman who became pregnant as a result of an extra-marital affair, claimed that after she had given birth alone in a barn in the middle of the night, she had fainted twice and could not remember much of the events thereafter. She emphasised that she was in great pain and that she did not know what she was doing. She did concede, however, that although she did not remember tying a rope around the neck of her newborn infant, she may have done so. Hanna J. told the jury at the Central Criminal Court that if they were of the opinion that the defendant had "lost complete control of herself" so as not to have committed her act "in a premeditated way but in a state of sudden feeling or emotion which diverted her sense of judgment" that they could bring in a verdict of manslaughter. In relation to the issue of childbirth and the possible effects of this experience on a woman, and on the accused in this particular case, he stated:

> "[n]ow everyone knows . . . that the bringing of a child into the world is accompanied very often – usually it is – with great pain and suffering to the woman. Some of them become demented by it – some of them are not so upset . . . . Well now, Gentlemen even if [the defendant] is exaggerating these pains she must have been in a rather distressed condition – I mean – one would infer naturally she would not be as vigorous in her mind and soul as if going about in the ordinary way. The crisis must have naturally affected her mentally and physically."[82]

This indicates that some judges were willing to utilise common conceptions about the travails of childbirth and the near madness this may entail to encourage verdicts of manslaughter.[83]

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[80] See generally, Brennan, *op. cit.*, n.56, pp.232-241 & Appendix 1.

[81] For the details of this case see the Court of Criminal Appeal file; National Archives Dublin: CCA 1934/31.

[82] See Judge's Charge to the Jury in the transcript for the trial; National Archives Dublin, CCA 1934/31.

[83] Mrs. C was acquitted of murder but convicted of manslaughter and sentenced to three years penal servitude. She successfully appealed this conviction and at a retrial was found "not guilty". See National Archives Dublin: CCA 1934/31. See also, National Archives Dublin: State Book at Central Criminal Court, November 1933 – April 1941, ID-11-92; *Attorney General* v *B.C.C.*, indictment no. 1, Central Criminal Court, Co. Monaghan, 11 June 1934 (trial); indictment no. 1, Central Criminal Court, Co. Monaghan, 19 November 1934 (retrial).

The response of those involved in the determination of justice in cases where mothers were suspected of murdering their infants was to persistently avoid the death penalty. A situation had evolved, similar to that in England, where for years no woman had been hanged for the murder of her infant child.[84] This was achieved in a variety of ways: pleas of guilty to lesser offences such as manslaughter and concealment of birth[85] were accepted in many cases, even where there was more than cogent evidence of murder; in cases where a murder charge was pursued at the Central Criminal Court, juries shied from convicting mothers of this offence, relying, instead, on acquittals or convictions for lesser offences, or, less frequently, verdicts of insanity; and, in cases where the jury did convict for murder, the mandatory sentence of death was commuted, usually on the recommendation of both the jury and trial judge.[86] Essentially, the abhorrence of the death penalty as a punishment for women who were convicted of murdering their infants had rendered the law on maternal infant murder both ridiculous and ineffective. The main problems with the law which were noted were the "tragic farce" involved in putting a woman through the "ordeal" of a murder trial and conviction, and the "grim spectacle" of a death sentence when everybody knew that this sentence would be reprieved, and, in connection with this, the "futility" of arraigning young girls for the murder of their infants when the killing took place shortly after birth.[87]

These problems were illustrated by figures presented in 1941 on the prosecution of child murderers in the Central Criminal Court. In 1937, eight persons were indicted for the murder of infant children: one of these was found insane; two pleaded guilty to concealment of birth; and five pleaded guilty to manslaughter. In 1938, there were seven such cases: one was found insane; one was convicted of murder; one was acquitted of murder; and four pleaded guilty to manslaughter. In 1939, there were four cases: one was tried for murder and acquitted; two pleaded guilty to manslaughter; and one

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[84] See National Archives Dublin: Department of Taoiseach files s14493 & s13311, Department of Justice memorandum dealing with the proposed legislation to amend the law on insanity and infanticide, dated 4th January 1944. See also, an updated version of this Department of Justice memorandum, dated 10th February, 1949; National Archives Dublin: Department of Taoiseach file s14493 & Department of Justice file 8/144/1.

[85] See Offences against the Person Act 1861, s.60.

[86] See two "Returns of Persons Sentenced to Death" in National Archives Dublin: Department of Taoiseach file s.7788(a). These Returns provide some information on cases where women where convicted of murdering their infants and subsequently sentenced to death between 1922 and 1937. The Returns, dated 1922-32 and 1932-37, include nine cases where women were convicted of the murder of their newly or recently born infants. In every case the jury recommended mercy and the trial judge agreed, sometimes adding his reasons for this. Every woman convicted had the mandatory sentence of death sentence that had been imposed on her commuted to penal servitude for life. In one case, the mother's younger sister, who was also convicted of murder, similarly had her death sentence reprieved on the recommendation of both the jury and trial judge. Many of these women were given early releases, with or without conditions, and, therefore, served only a couple of years of their life sentences.

[87] For a more detailed exploration of the problems with the law, see generally, sources noted *supra*, at n.79, in particular the memoranda noted *supra*, at n.84. See also, Brennan, *op. cit.*, n.56, pp.241-248.

pleaded guilty to concealment of birth. In 1940, six cases of child murder came before the Central Criminal Court: one defendant was acquitted of murder; the other five pleaded guilty to manslaughter. In the January/February sitting of the Central Criminal Court for 1941, two persons pleaded guilty to the manslaughter of infants. There were two cases of child murder pending in the next session. So, of the twenty-seven cases of child murder dealt with by the Central Criminal Court between 1937 and February of 1941, only one resulted in a conviction. The reluctance of juries to convict in these cases was emphasised in this document. It was noted that in almost all the cases mentioned the accused were young girls, and that all the trappings of a murder trial presented a "terrible ordeal" for these particular offenders.[88]

It was evident, then, that it was pointless to go through the entire rigmarole of a murder trial and the pronouncement of the death sentence in cases where mothers were suspected of murdering their young infants. It would have simplified matters considerably if these offenders could have been tried for some alternative offence where the seriousness of their actions could be recognised, but where consideration could also be given to the conditions under which they had committed their crimes. Concealment of birth and manslaughter, which were frequently used as a means of avoiding severity in these cases, were not always appropriate solutions. The former could not apply in situations of obvious and marked violence where the fact that the child had been killed could not be avoided. The latter could not apply to every case because it was sometimes difficult to avoid the conclusion that the woman had killed her infant with malice aforethought.

The response of the Irish legislature was to enact an infanticide measure which followed the English model. Although there had been suggestions to amend the law along this line as early as the late 1920s, the main impetus for reform of the law on child murder in Ireland came from the 1941 report of an informal committee of judges, which had been set up in 1939 at the request of the Minister for Justice, Mr. Ruttledge.[89] The task of this committee had

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[88] See National Archives Dublin: Attorney General Office file 2000/10/2921, letter dated 22 March 1941. The Chief State Solicitors Office sent a number of other similar memoranda to the Attorney General throughout the 1940s outlining figures in relation to child murder in the Central Criminal Court and urging reform. See National Archives Dublin: Attorney General Office files 2000/10/2921 & 2922, memos dated 1 August 1944; 29 May 1945; 13 May 1947; 21 November 1947; 19 January 1949.

[89] See National Archives Dublin: Department of Taoiseach file s.14493, letter dated 26 April 1939. It is interesting to note that as far back as 1928 there were suggestions that the English infanticide legislation, be adopted in Ireland. Department of Justice file H266/61 contains a copy of the 1922 Infanticide Act, along with the Infant Life Preservation Act 1929. Two notes are also contained in this file. The first is dated 31 July 1928 and is signed S.A.R, which presumably stands for S. A. Roche, the Secretary to the Department of Justice. He notes, in relation to the 1922 Act, that "we might profitably enact an identical measure", and he asked the Minister for Justice to examine the file. The second note, dated 13 December 1932, is also signed S.A.R. and is headed "RE our social legislation". It advises the Minister for Justice to consider both the English Infanticide Act 1922, and the Infant Life Preservation Act 1929, and proposes that they should be passed in Ireland, advising the Minister to see if his "informal

been to review the law on capital punishment with a view to its improvement on the understanding that a total abolition of the death penalty would not be contemplated. The "Committee appointed to Consider and Report on the Law and Practice relating to Capital Punishment" recommended, *inter alia*, that child murder should be dealt with by legislation in similar terms to the English Infanticide Act 1938.[90] In 1949, the Irish legislature followed this recommendation and the Infanticide Act was enacted.[91]

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committee" would help in getting them passed. There is no indication what this informal committee was. It may well have been the Committee of Judges on Capital Punishment, but since this group was not formed until 1939 it is unlikely that the reference is specifically to them, unless the idea to set up a committee along these lines was discussed as far back as 1932. It is interesting to note that the idea to introduce legislation similar to the Infanticide Act 1922 was being discussed over twenty years prior to the enactment of infanticide legislation in Ireland. However, because nothing seems to have been done in relation to drafting such legislation until the Judges' Committee on Capital Punishment presented their report in 1941, this report will be taken as the starting point for reform. There is no evidence in any of the files I examined that there were ever any discussions regarding the introduction of the Infant Life Preservation Act 1929, in the Republic of Ireland.

90 See National Archives Dublin: Department of Taoiseach files s14493 and s13311, "Report of the Committee appointed to Consider and Report on the Law and Practice Relating to Capital Punishment". The recommendations with regard to infanticide are provided in paragraph one of this report. The committee consisted of O'Sullivan C.J., and Maguire, O'Byrne and Hanna JJ.

91 This measure was almost identical to the Infanticide Act 1938. The same definition of infanticide was adopted. S.1(3), previous to being amended by the Criminal Law (Insanity) Act, 2006, provided: "A woman shall be guilty of felony, namely, infanticide if – (a) by any wilful act or omission she causes the death of her child, being a child under the age of twelve months, and (b) the circumstances are such that, but for this section, the act or omission would have amounted to murder, and (c) at the time of the act or omission the balance of her mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent upon the birth of the child and may for that offence be tried and punished as for manslaughter." The main difference between the newly enacted Irish Infanticide Act and the 1938 measure was procedural in nature. Like the 1938 statute, the Irish Act empowers the jury to return a verdict of infanticide at the trial of a woman charged with the murder of her infant aged under twelve months, once they are satisfied that she is guilty of infanticide (see s.1(2)). However, unlike the 1938 Act, the Irish measure does not seem to permit the authorities to initially charge a woman suspected of murdering her infant with the offence of infanticide. S. 1(1) of the Infanticide Act, 1949, provides: "[o]n the preliminary investigation by the District Court of a charge against a woman for the murder of her child, being a child under the age of twelve months, the Justice may, if he thinks proper, alter the charge to one of infanticide and sent her forward for trial on that charge." This section implies, though it does not expressly say as such, that the initial charge against a mother for the killing of her infant, in circumstances which point to murder, must be murder. When introducing the Irish infanticide measure to both the Dáil and Seanad, the Minister for Justice, General MacEoin, stressed that the initial charge against a woman suspected of murdering her infant would always be murder and that this charge could be reduced to infanticide by a district judge only after he had reviewed all the circumstances of the case, including the available medical evidence. It seems that this was done to emphasise the Irish legislature's continued respect for infant life; see *Dáil Éireann Parliamentary Debates*,

The Roots of the Medical Rationale

The idea contained in the twentieth century infanticide legislation, *viz.* that women could become mentally disturbed due to the effects of childbirth, was not a novel one. Indeed, as far back as 1866 assumptions about the effects of childbirth on women had also been put forward to explain the fact that some women were capable of killing the vulnerable babes in their arms. A number of witnesses before the 1866 Royal Commission on Capital Punishment drew a distinction between mothers who murdered their infants and other murderers which was based on the perceived mental or psychological condition of women subsequent to childbirth. Some witnesses mentioned the "hysterical" nature of mothers after birth;[92] the "state of weakness or great excitement" parturient women experience;[93] or the irresistible motives of shame which may operate on them.[94] For example, Lord Cranworth explained: "[t]he mother has influences operating on her which cannot affect any other person; she is hardly conscious of her acts, hardly a responsible agent."[95] James Fitzjames Stephen noted that

> ". . . women in that condition do get the strongest symptoms of what amounts almost to temporary madness, . . . they often hardly know what they are about, and will do things that they have no settled or deliberate intention whatever of doing."[96]

During the nineteenth century, the medical profession also sought to explain the act of maternal child murder "in a way that maintained the mythology of motherhood and the maternal instinct".[97] Psychiatric descriptions of puerperal insanity encompassed weaknesses in mind, body and self control.[98] However, as Showalter notes, the focus on puerperal mental illness failed to recognise the fact that infanticide did not occur "randomly" in all social classes and, essentially, ignored the social circumstances and causes of infant murder.[99] She asserts: "[r]ather than looking at the social meaning of infanticide and at its contexts, doctors, lawyers and judges categorized it as an isolated and biologically determined phenomenon. . .".[100]

This emergence of medical explanations for infanticide, particularly in relation to unmarried women, is also evident in nineteenth-century Ireland. Prior, in her study of the Criminal Lunatic Asylum in Dundrum, Dublin, provides an excerpt from the *Seventh Report of the Inspectors of Lunacy*,

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vol.cxv, cols.265-6, 282; *Seanad Éireann Parliamentary Debates*, vol.xxxvi, col.1472.

92 B.P.P., 1866, xxi, pp.342-343, (Fitzjames Stephen).

93 *ibid.*, p.249, (Grey Bart).

94 *ibid.*, p.112, (Walpole).

95 *ibid.*, p.58.

96 *ibid.*, p.343. The Rev. Lord S. G. Osborne, however, disagreed with this analysis. He indicated that he could not "admit the general truth of the view" that the woman, having been seduced and deserted by the father of her child, and being "driven to despair" from the shame of this and the burden of the child's support, acquires "a condition a little short of insanity"; see *ibid.*, p.475.

97 *The Female Malady: Women, Madness and English Culture 1830-1980* (1987), p.58.

98 *ibid.*, pp.58-59.

99 *ibid.*, p.59.

100 *ibid.*

1855-1856, which, after noting that the most common form of homicide among the female detainees at the asylum was infanticide, states:

> "[g]reat commiseration is, no doubt, due to many who come within this category [of inmate]; for we can fully imagine how shame and anguish must weigh on an unfortunate and betrayed female, with enfeebled system, what strong temptations induce her to evade the censure of the world in the destruction of the evidence of her guilt, by a crime that outrages her most powerful instinct, maternal love of offspring."[101]

However, in spite of the growth of medical theories to explain the "unnatural" crime of maternal child murder, it is evident, from an analysis of the background to the enactment of the English and Irish infanticide measures, that the necessity for law reform sprang from a desire to avoid the death penalty and the solemn pronouncement of this sentence in cases where mothers were convicted of killing their infants, rather than from a perception that murdering mothers were usually mentally disturbed. By abolishing this penalty for maternal child murder two purposes would be served. First, the judiciary would be relieved of the uncomfortable task of terrifying convicted women, whilst making a mockery of the death sentence. Second, juries would not revolt against convicting women of killing their young children if a more humane punishment were prescribed, and these offenders could be dealt with in a more effective and just way.

In relation to this, Seaborne Davies notes that references to the "solemn mockery" by the 1866 Commission on Capital Punishment "mark[ed] the starting point of . . . reform" on the law on maternal child murder in England and Wales.[102] This concern over the fact that sentences were being pronounced which were never carried into effect led to a "rare spectacle": it was the judiciary who encouraged continuous attempts at reform up until 1922.[103] Seaborne Davies claims: "[i]f any legislation could be described as above all others the creation of the judges, it is the Infanticide Act, 1922."[104] He asserts that "the decisive factor in the achievement of the reform was ... the judicial sentiment against the 'solemn mockery'. . ."[105] A review of the

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[101] See Prior, "Mad, not Bad: Crime, Mental Disorder and Gender in Nineteenth-Century Ireland" in O'Donnell and McAuley, (eds.), *Criminal Justice History: Themes and Controversies from Pre-Independence Ireland* (2003), pp.66-82 at 75, quoting the *Seventh Report of the Inspectors of Lunacy*, 1854-1855, p.19.

[102] See *op. cit.*, n.58, at p.319. The solemn mockery was not the only problem with the law on child murder which was noted by the 1866 Commission on Capital Punishment. Witnesses before the Commission also noted the difficultly in obtaining convictions in these cases. Tied in with this was the problems relating to the issue of live birth. For a very brief overview of the live birth issue, see *supra*, at n.58. In Ireland, the difficulty in obtaining convictions in child murder cases was also a significant issue; in the majority of cases where a mother was charged with murdering her infant she was either acquitted of murder or was disposed of by means of the offences of manslaughter or concealment of birth; see generally, *supra*, text at nn.84-88. The issue of live birth does not seem to have been considered to be a significant difficulty in Ireland; it did not receive any attention by the legislature.

[103] *ibid.*, pp.319-320.

[104] *ibid.*, p.319.

[105] *ibid.*, pp.339-340.

relevant parliamentary debates in 1908, 1909 and 1922 certainly indicates that this was the case.[106]

Thus, while the basis of the infanticide legislation is medical in nature, the desire to treat mothers who killed their infants more leniently than other intentional killers does not seem to have sprung from an established view that a significant proportion of these women were mentally disturbed. The pre-enactment history of the 1922, 1938 and 1949 Infanticide Acts illustrates that while concern with the mental state of infanticidal mothers was a factor in the reform process, it was not the determining factor. The real reasons for reform were the desire to avoid the "solemn mockery" of the death penalty and, in connection with this, the desire to treat with some leniency a group of offenders who, due to the pitiable social and economic circumstances in which they committed their offences, demanded sympathy rather than severity. These reasons were bolstered by popular perceptions about the connection between childbirth and mental disturbance: postpartum mental disturbance was not the reason for the reform, but the means by which reform was to be accomplished.

Indeed, it is difficult to avoid the conclusion that puerperal and lactational mental disturbances were used to justify the leniency extended to defendant mothers by infanticide legislation because the real reasons for maternal child murder were too contentious to be openly canvassed. This is evident from an unsuccessful attempt to broaden the basis of the 1938 Infanticide Bill.[107] Lord Arnold criticised the proposed measure on the basis that it would fail to put an end to the "black-cap farce". He stated:

> ". . . I believe I am correct in saying that some Judges in these cases in pronouncing the [death] sentence deliberately utter the words unintelligibly so that the wretched woman in the dock cannot understand what is being said. In one of these cases in the last few years the Judge told the woman not to take any notice of the words, and in another case a learned Judge said "[f]or God's sake tell her it will not be carried out". We shall all agree that happenings of that kind ought to be stopped if it is possible, but this Bill will not do it."[108]

He advocated that "mental disturbance due to distress and despair arising from solicitude for the child and extreme poverty, or either of these" should have been incorporated into the Bill.[109] However, Viscount Dawson, who introduced the Bill to the House of Lords, refused to extend his proposed measure in this manner; he feared that to do so would make the government more "nervous" than they already were.[110]

In Ireland, the medical merits of the Infanticide Act, 1949, were never seriously canvassed during the parliamentary debates which preceded its passage into law. Nor was the medical basis of the Infanticide Act investigated by those involved in drafting the measure. On the contrary,

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[106] *ibid.*, p.339.
[107] *Parliamentary Debates* (H.L.), 1937-38, vol.108, cols.303-304.
[108] *ibid.*, col.303.
[109] *ibid.*, col.304.
[110] *ibid.*, cols.308-309.

notwithstanding that it was recognised that the medical profession would probably find fault with the Bill on the ground that it encroached on the issue of mental illness and criminal responsibility, an issue which had always led to much disagreement between lawyers and doctors, it was positively decided that the latter should not be consulted on the matter.[111] In addition, the validity of the medical basis of the legislation was not questioned by anyone in either house of parliament. The only reference to the medical aspect of the measure was made by Senators Sweetman and Bigger, who, during the debate over the Infanticide Bill in the Seanad, questioned the necessity of including a specific reference to lactation. They did not, however, question or discuss the validity of the medical basis.[112] Indeed, the only concerns expressed about the proposed measure were that it would lessen the deterrent effect of the law and interfere with the sanctity of infant life.[113]

However, while it would be apt to conclude that, at least in the Irish case, the legislature did not investigate the medical rationale of the infanticide law in any meaningful sense, and that it certainly seemed unconcerned with the opinions of the medical profession, it would be unfair to infer from this that it consciously adopted a measure which it knew to be a contrivance. The failure to question the validity of the medical foundation of the Infanticide Act, 1949, may have been due to a belief that the existence of puerperal and lactational mental disturbances was indubitable. Indeed, there is some indication that contemporary medical opinion was to that effect. For example, one medical writer stated in 1927: "[c]hildbirth and lactation entail a severe stress on the female sex, and, under certain circumstances, are liable to cause insanity, during the course of which attempts at infanticide and suicide are common."[114] In addition, the 1938 Bill seems to have been drafted with the advice of medical professionals: Viscount Dawson of Penn, who was the president of the Royal College of Physicians, informed the House of Lords, when introducing the 1938 proposal, that this measure was the product of the "united wisdom" of a committee of medical experts to whom he had referred the question of infanticide.[115]

Beyond the Narrow "Medicine as Mercy" Paradigm

It is suggested that due to the problems with the medical basis of infanticide legislation, it may be beneficial to look beyond a narrow view of the medical

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[111] See National Archives Dublin: Department of Justice file 8/144/1, memorandum addressed "Minister", dated February, 1949. However, although they thought that the medical authorities would fault the Bill because it dealt with the contentious issue of mental illness in relation to criminal responsibility, they did not seem to believe that medical experts would criticise the Bill on the basis that childbirth and lactation did not cause mental disturbances.

[112] See *Seanad Éireann Parliamentary Debates*, vol. xxxvi, cols. 1475-77.

[113] See especially, comments of Major V. deValera; *Dáil Éireann Parliamentary Debates*, vol. cxv, cols.275-82

[114] Hopwood, "Child Murder and Insanity" (1927) 73 *Journal of Mental Science* 95 at 95. For some other contemporary views or accounts of this topic, see: Mc Ilroy, "The Influence of Parturition Upon Insanity and Crime" 22 (1927-28) *Transactions of the Medico-Legal Society* 53; Jones, "Puerperal Insanity" 1 (1902) *British Medical Journal* 579.

[115] *Parliamentary Debates* (H.L.), 1937-38, vol.108, col.308.

model by considering the Acts in their historical context. By doing this, a fuller understanding of the significance of the medical rationale may be reached. It is evident from this brief examination of the background to the enactment of the Infanticide Acts in England and in Ireland that the medical basis of these measures is not their *raison d'être*. The reason for introducing this legislation was to avoid the "black cap farce" and to provide for a more efficient means of dealing with a class of murderer who for well over half a century had been treated more compassionately than other intentional killers. Essentially, infanticide legislation was adopted in England and Wales and the Republic of Ireland as a means of extending leniency to mothers who killed their infants in extenuating circumstances of a social, rather than a psychiatric, nature. The medical basis of these measures was merely the means by which leniency could be extended to mothers who had murdered their infants in circumstances which attracted sympathy. It was not, however, the reason why this leniency was being extended; the medical foundation of these measures lent them an apparent legitimacy which the real reasons for their enactment could not have provided. As Osborne asserts,

> ". . . the medical rationale was never in vogue or scientifically established. It was simply more conventional, conservative and less contentious than the reasons for the courts' lenient treatment of murdering mothers."[116]

It also seems that originally the medical basis of the Act may have been based on popular perceptions about postpartum mental disturbance rather than actual valid medical principles. Although, medical experts seem to have had some input into the drafting of the Infanticide Act 1938, the parliamentary debates surrounding the enactment of both the 1922 and 1938 measures reveal little concern with the medical validity of what was being proposed. The drafters of the Irish Act certainly showed a complete lack of interest in the opinions of medical experts; they decided not to consult them on the proposed infanticide measure due to the potential disagreement which they thought would arise. Thus, while it is possible that medical research at the time the infanticide measures were enacted may have supported the psychiatric basis of this legislation,[117] this does not seem to have been a relevant concern; there appears to have been a lack of interest in the views of the medical community. It seems, then, that infanticide legislation was enacted either on the assumption that the experts would fully endorse what was being proposed, or in the belief that because they were unlikely to support the measure, they should not be consulted.

Essentially, the medical basis of the infanticide legislation is a legal invention, and, as with the insanity defence, agreement between lawyers and psychiatrists cannot be taken for granted. Thus, while medical opinion is helpful in the debate over the legitimacy of the medical foundation of infanticide legislation, it should not be determinative. This argument is lent additional support by the fact that medical experts may not be able to agree or reach any decisive conclusions on the issue of postpartum mental disturbance. In connection with this, even if this profession could arrive at some definite consensus, it cannot be assumed that psychiatric definitions

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[116] See *op. cit.*, n.1, p.58.
[117] See literature cited *supra*, at n.114.

will remain constant over time. It may, therefore, ultimately be damaging to place undue reliance on psychiatric descriptions. This is evident from recent support for the long out of favour lactation theory which casts some doubt over the wisdom of the Irish legislature's decision to remove the reference to lactation from the 1949 Act. Perhaps, therefore, the primary focus in the debate over the continuing validity of the rationale of the infanticide legislation should not be whether it can be justified on a theoretical level, but whether it is defensible for other reasons, such as, for example, by the fact that it appears to work well in practice.[118]

In conclusion, in any debate about the future of infanticide legislation it is important to recall the reason why these measures were enacted in the first place, and, in connection with this, that the history of maternal infant murder indicates that in many cases treating mothers who kill their infants as ordinary killers is an entirely futile exercise. Mothers who murder their infants have long been recognised as a special type of offender who, in most circumstances, should be viewed with more compassion than censure.[119] This is arguably still the case, particularly where mentally or emotionally distressed mothers kill their infants in tragic circumstances. Thus, while infanticide legislation certainly has its faults, its dubious medical rationale being only one of them, and while it may not be a suitable approach to take in every case of maternal infant murder, the offence/defence of infanticide does, by offering a more compassionate route, provide for a more expeditious means of dealing with troubled women who kill their infants in

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[118] A discussion of how infanticide legislation works in practice is beyond the scope of this article. However, research indicates that there are no problems with how the definition of infanticide works and that the offence/defence of infanticide is useful/beneficial in cases of maternal infant murder; see, *e.g.* studies cited *supra*, at n.42.

[119] This was not always the case. Severe legislation targeted the killing of illegitimate infants by their "lewd" mothers during the seventeenth and eighteenth centuries. The 1624 "Act to prevent the destroying and murthering of bastard children" (21 Jac. I, c. 27) reversed the common law presumption of dead birth and punished with death the concealment of the dead body of any illegitimate infant by its mother. This statute effectively reversed the presumption of innocence in these cases. See, Radzinowicz, *A History of the English Criminal Law and its Administration from* 1750, vol.1 (1948), p.431; Blackstone, *Commentaries on the Laws of England*, vol.4 (11th ed. 1791), p.198. The Irish Parliament adopted this measure verbatim in 1707 (6 Anne c. 4). For an account of infanticide in Ireland in the eighteenth century, see Kelly, "Infanticide in Eighteenth Century Ireland" (1992) 19 *Irish Economic and Social History* 5. By the latter part of the eighteenth century, the authorities and courts in England were effectively ignoring this 1624 Act due to its severity; see generally: Beattie, *Crime and the Courts in England 1600-1800* (1986), pp.118-124; Francus, "Monstrous Mothers, Monstrous Societies: Infanticide and the Rule of Law in Restoration and Eighteenth Century England" (1997) 20 *Eighteenth Century Life* 133 at 133-149; Hoffer and Hull, *Murdering Mothers: Infanticide in England and New England 1558-1803* (1981), pp.65-87; Malcolmson, "Infanticide in the Eighteenth Century" in Cockburn, (ed.), *Crime in England 1550-1800* (1977), pp.187-201 at 197-200; McLynn, *Crime and Punishment in Eighteenth Century England* (1989), pp.113-114. The legislation was repealed in 1803 by Ellenborough's Act, and the presumption of dead birth was restored for all cases involving the murder of an infant; 43 Geo. III, c. 58.

pitiable situations. Ultimately, the infanticide statutes appear to serve the criminal justice system quite well in their current form by allowing for special lenient treatment for deserving mothers.

Finally, it cannot be denied that criticisms of the medical foundation of infanticide measures are troubling, not only because they call into question the entire theoretical basis of infanticide, but also because they come from those who are expected to provide legitimate evidential support for the practical employment of this offence/defence at trial. The views of medical experts should not be ignored. However, these views should not be accorded undue significance such that they overwhelm the problems with medical analyses of postpartum mental disturbances and the importance of the practical origins of infanticide measures. In fact, it seems, particularly in light of the recent Law Commission report, that any effort to amend or abolish these measures on the basis of what medical experts argue may prove to be unduly hasty and problematic, and perhaps should be avoided.

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