Infanticide: Psychiatrists in the Plea Bargaining Process†

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The offence of infanticide has attracted critical attention in recent years, from law reform bodies concerned to rationalise the law of homicide and commentators on gender and the law alike.[1] It is a sex specific offence, that can only be committed by women, in fact only by mothers, which is additional to the general defences of disturbed mental state, insanity and, in New South Wales and England, diminished responsibility. Logically there should be no need for a specific offence dealing with just one sort of mental disturbance and, in any event, the medical premises of the offence are now considered of dubious validity. The mental disturbance required to make out the offence is presumed to be linked to reproduction. This could appear to legitimate the notion that women are inherently unstable because of their biology, which of course has implications for the integration of women into spheres outside the domestic. This feminist objection to the offence is similar to the feminist opposition to reliance on premenstrual tension in mitigation of criminal responsibility.[2]

These objections to the offence have lead some to call for its repeal.[3] When this was seriously proposed in England, however, a spirited defence of the law was mounted by an unlikely coalition of police, practising lawyers and women's organisations.[4] The offence was retained, being described as 'an example of common sense and common knowledge triumphing over tidy scientific classification.'[5]

In this paper I will examine the legislative history of the offence of infanticide, and its modern operation, based on a study of all cases where a woman or man was charged with the homicide of a child under the age of one year (the cut off point for the offence) over a five year period, 1976–1980, in New South Wales. It is my contention that an understanding of both is necessary to inform a decision about the abolition or retention of the offence in Australia.

Both the legislative history and the modern operation of the offence show

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1 The proposals made by the Butler Committee on Mentally Abnormal Offenders (*Report* Cmnd 6244 HMSO London 1975) and the Criminal Law Revision Committee ('CLRC') *Fourteenth Report*: *Offences Against the Person* Cmnd 7844 HMSO London 1980 have been discussed in numerous articles in English law and criminology journals. See also SSM Edwards, *Female Sexuality and the Law* Martin Robertson, Oxford 1981. Infanticide has most recently been evaluated by the Law Reform Commission of Victoria ('VLRC') in Discussion Paper No 14 *Mental Malfunction and Criminal Responsibility* August 1988.

2 See, for example, H Allen, 'At the Mercy of her Hormones Premenstrual Tension and the Law' *M/F* No 9, 1984, 20–43.

3 Butler Commitee, fn 1 supra, paras 19.17, 19.22 and others.

4 Recorded in CLRC, fn 1 supra, para 101.

5 Ibid. Also quoted in VLRC, note 1 supra, para 187.

an at times uneasy accommodation between intellectual rigour and the desire to achieve a lenient result. That tension has resulted in an offence which was, at its beginning, no more than an approximation of what legislators intended, and subsequently came to apply to quite a different sort of homicide.

The tension is seen today in the psychiatric assessments that form the basis of an infanticide conviction. The consultant psychiatrist is required to juggle the learning of his discipline and the artificial demands of the legislation in preparing a report which could effectively determine the outcome of the case.

The triumph of infanticide is that this juggling brings about a compassionate result in a class of case where most people would agree that leniency is appropriate. The question for those who would otherwise object to the offence is whether it is tolerable to retain an offence that is partial to women by affirming their inherent weakness to ensure this continued leniency.

THE OFFENCE OF INFANTICIDE

Infanticide is a specific homicide offence in three Australian states — New South Wales, Victoria and Tasmania. The offence is derived from England where it was introduced in 1922 and significantly amended in 1938. The 1938 form of words was adopted in Victoria in 1949 and New South Wales in 1955. The New South Wales provision is contained in section 22A of the *Crimes Act* 1900 (as amended) and is as follows:

> 22A. Infanticide. (1) Where 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 section the offence would have amounted to murder, she shall be guilty of infanticide, and may for such offence be dealt with and punished as if she had been guilty of the offence of manslaughter of such child.
>
> (2) Where upon the trial of a woman for the murder of her child, being a child under the age of twelve months, the jury are of opinion that she by any wilful act or omission caused its death, but that 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 such child or by reason of the effect of lactation consequent upon the birth of the child, then the jury may, notwithstanding that the circumstances were such that but for the provisions of this section they might have returned a verdict of murder, return in lieu thereof a verdict of infanticide, and the woman may be dealt with and punished as if she had been guilty of the offence of manslaughter of the said child.
>
> (3) Nothing in this section shall affect the power of the jury upon an indictment for the murder of a child to return a verdict of manslaughter or a verdict of not guilty on the ground of insanity, or a verdict of concealment of birth.

The Victorian provision, contained within section 6 of the *Crimes Act* 1958, is in indentical terms.

When first introduced in England in 1922 the offence referred to the death of a 'newly-born child' rather than a child under the age of twelve months and there was no reference to lactation. In *R* v *O'Donoghue*[6] the Court of Appeal affirmed a ruling by a trial judge that the offence could not be left to the jury in respect of a child thirty-five days old at its death. *O'Donoghue* was subsequently applied in *R* v *Hale*[7] where the child was three weeks old. As a result of these cases the *Infanticide Act* 1922 (Eng) was repealed and replaced by the *Infanticide Act* 1938 which set out the offence in its present form.

A similar process took place in Tasmania. The Tasmanian provision, section 165A of the *Criminal Code Act* 1924, was initially in similar terms to the 1922 English Act. Following a case where the offence was ruled inapplicable because the child was three months old,[8] the section was amended in 1973. The section now provides as follows:

> 165A — A woman who by any wilful act or omission, causes the death of her child (being a child under the age of 12 months), and who was at the time not fully recovered from the effect of giving birth to the child, and the balance of her mind being, by reason thereof, disturbed, is guilty of a crime, which is called infanticide, although, the offence would, but for this section, have amounted to murder.
>
> Charge: Infanticide.

The specific offence of infanticide was preceded by three centuries of legislative attempts to deal with the perceived problem of women killing their newborn illegitimate infants yet escaping their just legal punishment because of the difficulties of securing a conviction for murder. The first of these provisions was a 1624 statute entitled 'An Act to prevent the Destroying and Murthering of Bastard Children'.[9] This created a legislative presumption that a woman who concealed the death of her illegitimate child was guilty of that child's murder. The presumption was only rebuttable by proof from another person that the child had been born dead — even if the woman could prove that the child had been born alive and subsequently died of natural causes that was not enough to avoid the rigour of the statute.

Had the statute been applied strictly it is difficult to see how any woman who had given birth secretly to an illegitimate child, in an attempt to avoid disgrace, could avoid conviction for murder and the death penalty should the child die. By the mid eighteenth century, however, the statute had fallen into disuse and an ingenious case law had developed to avoid the harshness of conviction for murder in these cases.[10]

The statute was eventually repealed in 1803.[11] Henceforth the prosecution

[6] Cox's Reports of Cases in Criminal Law Vol 28 1925–29, 461
[7] *The Times*, 22 July 1936, 13.
[8] *R* v *Taylor* [1968] Tas S R 1
[9] 21 Jas I c 27.
[10] R W Malcolmson, 'Infanticide in the Eighteenth Century' in J S Cockburn, (ed), *Crime in England 1550–1880* (Methuen, London, 1977).
[11] By 43 Geo 3 c58 known as Lord Ellenborough's Act.

in a murder case would be required to prove both that the child had been born alive and that the mother had killed it, rather than relying on the fact of concealment as presumptive evidence of murder. In recognition of the difficulties this would place in the way of conviction for murder the statute created an alternative verdict of concealment of birth, an offence punishable by two years imprisonment. Concealment of birth was made a separate substantive offence, as well as an alternative verdict to murder, by the *Offences Against the Person Act* 1828 (Eng)[12] and further amended by the *Offences Against the Person Act* 1861 (Eng)[13] to bring it into its modern form. Every Australian state and territory adopted the offence into its criminal law.[14]

Concealment, which had formerly been presumptive evidence of murder, had become the more lenient alternative to conviction for murder. The alternative verdict was seen as meeting the dual ends of allowing for compassion and ensuring a conviction, albeit for a lesser offence. Conviction for murder was difficult to achieve in these cases because juries anxious to avoid the death penalty were very ready to accept the slightest suggestion that the prosecution had failed to prove that the baby was completely born when it died.[15] Evidence was routinely given by doctors that the child may have still been in the birth canal when it was strangled,[16] or even, in some cases, while its throat was cut.[17] Clearly this evidence was generated more by sympathy for the woman's desperate plight than by what was likely or even feasible.

Although the alternative verdict of concealment of birth allowed for some rough justice in cases of neonaticide (the killing of an infant immediately after birth) dissatisfaction continued to be expressed with the state of the law in this area. Some commentators argued that juries were being forced to find a wrong verdict to avoid the death sentence and so called for a lesser punishment for these homicides;[18] judges were concerned at the 'solemn mockery'[19] of imposing the death sentence in the rare case of conviction for murder when it

[12] Section XIV.
[13] Section 60.
[14] NSW: ss 85 and 22 *Crimes Act* 1900 (as amended)
Vict: ss 67 and 421(2) *Crimes Act* 1958 (as amended)
Qld: ss 314 and 577 *Criminal Code*
WA: ss 291 and 595 *Criminal Code*
Tas: ss 166, 333 and 334 *Criminal Code*
SA: s 83 *Criminal Law Consolidation Act* 1935
NT: s 171 *Criminal Code.*
[15] The prosecution must prove beyond reasonable doubt that the child was completely born, ie completely extruded from the body of the mother and alive when the violence done to it took place. Evidence that the child had breathed was often insufficient because the doctor would concede that the child may have breathed while still in the birth canal and died before complete extrusion. As to whether the umbilical cord must have been cut see *R* v *Hutty* [1953] VLR 338 and in NSW s 20 *Crimes Act* 1900 (NSW).
[16] *R* v *Poulton* (1832) 5 Car & P 329; 172 ER 997; *R* v *Ann Crutchley* (1837) 7 Car & P 814; 173 ER 355.
[17] *R* v *Hacking* (1846) discussed in T Stevenson, (ed) *Taylor's Principles and Practices of Medical Jurisprudence* (3rd ed London J & A Churchill, 1883) at 422. See also *R* v *Elizabeth Sellis* (1837) 7 Car & P 850; 173 ER 370.
[18] *The Law Times*, September 23, 1871, 371–2.
[19] The words of Keating J quoted in D Seaborne Davies, 'Child Killing in English Law' (1937) 1 MLR 203, 284–5.

had not been executed in such a case since 1849.[20] The *Report of the Commission into Capital Punishment* (1864–1866) called for changes in the law in relation to child murder[21] and there were numerous attempts to introduce changes from that time.[22] These were unsuccessful until the *Infanticide Act* 1922 (Eng) was passed. That Act sought to facilitate conviction for a homicide offence, rather than mere concealment, by introducing a specific offence, less than murder.

In its final form the *Infanticide Act* of 1922, which was the prccursor of the modern law of infanticide in New South Wales, required as an element of the offence that the balance of the woman's mind was disturbed by reason of the effects of giving birth. This would suggest that compassion for mental disturbance and an association between childbirth and mental disturbance were the prime motives leading to the reform. In fact, these were only some of the considerations that led commentators to call for a special class of homicide. First, the early attempts at reform spoke of a woman who was physically agitated from the birth, not mentally unstable. Secondly, the original promoters of reform were as much, if not more, concerned with social conditions such as poverty, abandonment by the father, and social disgrace as with the effect on the woman's state of mind of giving birth.[23] A stress on the woman's state of mind appears to have become a convenient catch-all for all the other concerns. For example, the evidence of Fitzjames Stephen QC to the 1866 Commission commented not only on the woman's state of health, but also on the associated social factors which excited sympathy in juries:

> The operation of the criminal law presupposes in the mind of the person who is acted upon a normal state of strength, reflective power, and so on, but a woman just after child-birth is so upset, and is in such a hysterical state altogether, that it seems to me you cannot deal with her in the same manner as if she was in a regular and proper state of health . . . Besides that, there is a strong sympathy, which it is never safe to neglect and which will always exist, with the miserable condition of the woman; and there is a sort of feeling (I do not say it is very reasonable, and I do not know exactly how to connect it with the fact) as a general rule against the father of the child, who goes unpunished, which makes its way with juries and with the public. It seems to me that that being so, and as you have to legislate for human nature as you find it, it would be a very desirable thing to pass a special statute . . . enacting that any woman who killed her new-born child with intent to conceal the birth should be liable to the severest secondary punishment in the discretion of the judge . . .[24]

Given this multiplicity of factors motivating the promoters of reform, it is interesting to speculate why the form of words finally adopted justified the

[20] Ibid. See also N Walker, *Crime and Insanity in England* Vol 1 : *The Historical Perspective* (Edinburgh University Press, 1968) 128.

[21] *British Parliamentary Papers*, 1866, Vol 21.

[22] These are discussed in detail by Seaborne Davies, fn 19 supra.

[23] Social conditions remained a major concern of reformers as is indicated by the Infanticide Bill of 1936 which referred to extreme poverty as a possible mitigating factor. Discussed in Walker, fn 20 supra, 132 and Davies, fn 19 supra, 286.

[24] *British Parliamentary Papers* 1866, Vol 21, 291–2 quoted in Davies, fn 19 supra, 269, note 13.

special offence by virtue of a mental disturbance. In my view there were a number of reasons. It was undoubtedly more consistent with fundamental notions of criminal responsibility to regard the mitigating factor to be mental disturbance rather than social or economic stress. A recognition of the role played by poverty in these cases could initiate a very unwelcome inquiry into the contribution made by class and power to crime generally. In any event, a temporary disturbance in the mother's balance of mind could be assumed to flow from the physical effects of the birth. Particularly if she was unattended, the woman might well be in considerable distress and shock at this time, although not mentally disturbed.

The choice of words, although expressly dealing with the homicide of newborn babies, may also have been influenced by the long forensic association between child murder and insanity.[25] Evidence that the mother was suffering from 'puerperal insanity' was frequently given to avoid conviction for murder in cases where the child was not newly born and so there was no issue about live birth.[26] Madness after childbirth was regarded as a frequent affliction,[27] a manifestation of the general susceptibility of women to the maleficent influence of their gynaecological organs.[28] In the thinking of Victorian specialists in mental diseases, insanity manifested itself in behaviour which broke the rigid rules of acceptable Victorian female and maternal behaviour. Doctors diagnosed rebelliousness, aggressiveness, rowdy behaviour, overt sexuality (and particularly masturbation) as indications of insanity.[29] It was entirely logical in this framework, that behaviour so far beyond the ideal of modest passivity as the violent killing of an infant should be seen as the act of a mind disordered by the recent event of parturition.[30]

From the late nineteenth century the character of infanticide began to change. The number of cases where the victim was a newborn illegitimate baby and the defendant had been motivated by panic and a desire to conceal the birth declined, and correspondingly the proportion of cases where the baby was older and the mother married increased.[31] These were the cases where insanity had traditionally been relied on by way of explanation.

This trend was reflected in a shift in the public debate, as evidenced by a

[25] This association is discussed by R Smith *Trial by Medicine: Insantiy and Responsibility in Victorian Trials*, (Edinburgh, Edinburgh University Press, 1981) 148.

[26] Ibid. See also Stevenson, fn 17 supra, 577.

[27] J Baker, 'Female Criminal Lunatics' [1902] *Journal of Mental Science* 13–28; J S Hopwood, 'Child Murder and Insanity' (1927) 73, *Journal of Mental Science* 95–108.

[28] B Ehrenreich, and D English, *For Her Own Good : 150 Years of the Experts' Advice to Women* (London, Pluto Press, 1979); S S M Edwards, *Female Sexuality and the Law* (Oxford, Martin Robertson, 1981), 76–80; E Showalter, 'Victorian Women and Insanity' *Victorian Studies* 23, 1980, 157–81.

[29] Edwards, id, 81 et seq; Showalter, id, 173.

[30] See also S S M Edwards *Women on Trial* (Manchester, University Press Manchester 1984) 82–5.

[31] For English figures see R Sauer, 'Infanticide and Abortion in Nineteenth Century Britain' (1978) 32 *Population Studies* 81–93 and Davies, fn 19 supra. The same pattern was evident in New South Wales and is discussed by Judith Allen in her PhD thesis *Women and Crime in New South Wales 1880–1940*, Dept of History, Macquarie University 1985.

discussion in legal journals about the *O'Donoghue* and *Hale* cases. Infanticide law was initially designed to meet the case of a desperate woman who, having concealed her illegitimate pregnancy for fear of social disgrace and consequent poverty, continued the concealment by killing the child shortly after its birth. Viewed in this way, it was entirely appropriate to limit the ameliorative provision to 'newly born' children. But by the 1920s at least, the distinctive characteristic of these homicides was considered to be the disordered condition of the mother's mind, rather than the temporal relationship to the child's birth and so intention to conceal the birth.[32] Infanticide became a crime more closely linked to insanity than to concealment of birth. The mother's state of mind, which was initially convenient shorthand for the whole range of distressing circumstances surrounding a concealed illegitimate pregnancy and birth, had become the raison d'être of the offence.

As a result of the *O'Donoghue* and *Hale* cases the law was extended in the *Infanticide Act* of 1938 to homicides of infants by mothers until the child was twelve months old. Twelve months was probably chosen as the end point because it had been the practice of the Home Office to commute death sentences for the murder by a mother of a child up to this age.[33] The extension was justified by a reference to the supposedly disturbing effects of lactation. This was consistent with the earlier reference to the effects of giving birth and reflected current medical views about lactational insanity.[34]

Although on its face the amended provision did no more than extend the protection already afforded by the 1922 Act in fact the extension to older babies substantially changed the ambit and content of the law. The offence now applied to two quite different types of homicide — neonaticides, where the mother is usually not mentally disturbed, although distressed by the immediate physical consequences of giving birth alone and unattended, and the homicide of older babies, where the mother is often seriously disturbed, and may attempt her own suicide and the homicide of older children as well.[35] Leniency and compassion were, and are, appropriate responses to both sorts of homicides, but for different reasons.[36]

[32] See the discussion of the *O'Donoghue* case in *Justice of the Peace and Local Government Review*, 10 December, 1927, 940; the discussion of the Infanticide Amendment Bill of 1937 in that journal of 5 February, 1938 at 85 and Davies, fn 19 supra, 283. The disordered condition of the mother's mind was also considered the central element when the introduction of the offence was debated in the New South Wales Parliament — *Hansard* House of Assembly 26, 27 September 1951; Legislative Council 10 October 1951.

[33] Walker, fn 20 supra.

[34] Baker and Hopwood, fn 27 supra.

[35] That these two types of infanticide are quite distinct was evident in my group of cases and has been verified in large samples by P T d'Orban, 'Women Who Kill Their Children' (1979) 134 *Brit J Psychiatry* 560–71; P J Resnick, 'Child Murder by Parents : A Psychiatric Review of Filicide' and 'Murder of the Newborn : A Psychiatric Review of Neonaticide' (1969–70) 126 *Am J Psychiatry* 325–34 and 1414–420; and A Wallace, *Homicide : The Social Reality*, NSW Bureau of Crime Statistics and Research, Attorney-General's Department, August 1986.

[36] The classic type of neonaticide still occurs despite advances in contraception, sex education and the lessening of the stigma of illegitimacy although few cases proceed to trial (only two of five such cases in my study). For a discussion of a recent case see Bartholomew and Milte, 'Child Murder : Some Problems' [1978] 2 *Crim L J* 2.

MODERN OPERATION OF INFANTICIDE

In *R* v *Hutty*,[37] the only reported Australian authority on the New South Wales and Victorian form of infanticide, the trial judge Barry J urged the Crown to henceforth charge infanticide rather than murder where the facts were made out.[38] The case concerned a young woman who had given birth alone in an outside toilet in the early hours of the morning and was subsequently charged with the murder of the newborn baby by causing injuries to the baby's head. This was of course the traditional type of infanticide. Notwithstanding these comments, infanticide is not usually charged as a substantive offence. In the years 1976–1980 inclusive, in New South Wales five women were convicted of infanticide, but none of these women were charged by the police or indicted with that offence. All were indicted on a charge of murder and pleaded guilty to infanticide in discharge of that indictment. In most of the cases the psychiatric evidence upon which the plea was proffered by the defence and accepted by the Crown was available by the time of the committal, and in all it was available to the Crown Prosecutor before the trial date. Yet none of these women was committed for trial on the lesser charge and none was indicted for it, although the charge was by that time something of a formality, the plea to the lesser offence having already been negotiated.

Infanticide is seemingly regarded, by both prosecution and defence counsel, as a defence to reduce what would otherwise be a murder charge, rather than a substantive offence. It is utilised in a very similar way to the partial defence of diminished responsibility, also available in New South Wales, which reduces murder to manslaughter by virtue of an 'abnormality of mind' which substantially reduced the defendant's 'mental responsibility' for the crime.[39]

There was one case where a woman was indicted for infanticide, although initially charged with the murder of her newborn baby. That indictment came about only as a result of an application to the Attorney-General for a 'no bill' ie for the matter not to proceed to trial. The application was partially successful in that the charge of murder was reduced to one of infanticide, in reliance on *R* v *Hutty*.[40] That woman pleaded not guilty to infanticide. After medical evidence of her distressed physical and emotional state after the birth was given by her local doctor, the prosecution did not oppose an application by the defence for discharge of the jury under the proviso to section 24 of the *Crimes Act* 1900 (NSW). That provides that where the judge is satisfied that a nominal punishment would be sufficient for manslaughter (infanticide being punished as for manslaughter) he may discharge the jury from giving a verdict, that discharge to operate as an acquittal.[41] The Crown's agreement to this

[37] [1953] VLR 338.
[38] Id 339–40.
[39] Section 23A *Crimes Act* 1900 (NSW) which was inserted in 1974.
[40] This recommendation of the Solicitor General was accepted by the Attorney General.
[41] Section 24 provides:

> Whosoever commits the crime of manslaughter shall be liable to penal servitude for life. Provided that, in any case, if the Judge is of opinion that, having regard to all the

course appears to have been in return for a plea of guilty to the lesser offence of concealment of birth.

That case throws light on the rationale for the practice followed in the majority of cases of using infanticide as a defence, rather than substantive offence. It is sometimes said that it would cast an impossible burden on the Crown to charge infanticide for it would then be required to prove the defendant's mental state, without being able to require the defendant to attend for examination.[42] In my view this difficulty is more theoretical than real. It was not a difficulty in the case just described where the Crown could subpoena contemporaneous medical evidence. This would also have been possible on the facts of the other cases. In any event, in all but one case the Crown consultant psychiatrist had also interviewed the defendant shortly after charge with her consent, or at least without her objection.[43]

In my view, the compelling reason for the prosecution to prefer infanticide to be used as a defence is that it allows the Crown to maintain a superior bargaining position. A charge of murder encourages the defendant to plead guilty to the lesser offence of infanticide rather than face trial (and, until recently, if convicted a life sentence) for murder. In the case just described where the worst that could happen was conviction for infanticide, the same inducement did not exist to plead to that offence. Having only charged infanticide, the area of negotiation for a plea necessarily related to still more minor offences.

PSYCHIATRISTS IN THE PLEA BARGAINING PROCESS

Psychiatric assessments in the seven cases where a woman went to trial charged with murder had enormous influence over the outcome of the cases. In every case the result was arrived at not by way of contested hearing but by way of negotiation on the basis of exchanged psychiatric reports. As discussed, in five cases the woman pleaded guilty to infanticide in discharge of the murder indictment; in two others a plea of guilty to manslaughter by way of diminished responsibility was proffered and accepted. Of the total seventeen women charged with the homicide of a child under the age of one year during this period, five other women went to trial charged with manslaughter only.[44] Infanticide or diminished responsibility was not available in their

circumstances, a nominal punishment would be sufficient, he may discharge the jury from giving any verdict, and such discharge shall operate as an acquittal.

[42] *R* v *Asamakan* [1964] P and NGLR 193; *R* v *Marchello* [1951] 4 DLR 751; *R* v *Jacobs* 105 Can Crim Cas 291; A A Bartholomew, and A Bonnici, 'Infanticide : A Statutory Offence' *Med J Aust*, Dec 18, 1965, 1018–21; J Arboleda-Florez, 'Infanticide : Some Medicolegal Considerations' (1975) 20 *Can Psychiatric Assoc J* 55–9.

[43] It was at this time in New South Wales the practice of the consultant psychiatrist retained by the Solicitor for Public Prosecutions to seek to interview all prisoners on remand for a homicide offence for the purpose of preparing a report for the prosecution on fitness to stand trial and possible mental defences.

[44] Four women initially charged with murder or manslaughter did not proceed to trial because of problems of proof in the prosecution case (three of these were young girls

cases and, apparently as a consequence, psychiatric evidence was not routinely sought. Thus it is not possible to tell whether these women as well could have been described as suffering from post natal depression.

The forensic psychiatrists retained by prosecution and defence to interview the woman charged and assess her state of mind at the time of the homicide did not confine their reports to clinical matters. With the exception of one pyschiatrist, who was consulted in two cases, they included an opinion as to the legal impact of their medical diagnosis, ie whether all the elements of infanticide or diminished responsibility were made out. Strictly this could be said to be an infringement of the common law rule that an expert witness may not be asked the question which the trier of fact itself has to decide (the 'ultimate issue' rule).[45] In practice this objection is never taken.[46] Indeed, as one case which is described in more detail below suggests, one suspects that plea negotiation depends on the willingness of consultant psychiatrists to make judgments about culpability as well as clinical diagnoses.

In fulfilling the role that has come to be expected of them, forensic psychiatrists have to accommodate the learning of their discipline to the often artificial requirements of the law. This comment applies to all defences of mental disturbance but it is well illustrated by these infanticide cases. The strict wording of the offence of infanticide requires proof that at the time of the act or omission causing death the balance of the woman's 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* (emphasis added). That is, the wording assumes that a causal relationship exists between certain sorts of mental disturbance and childbirth or lactation. In addition, the existence of a separate offence for homicides committed at a time of mental imbalance due to childbirth, as opposed to other causes, implies that there is something distinct about that sort of mental imbalance.

In the nineteenth century, as I have discussed, insanity (what would now be called psychosis) in women was regarded as arising from the various aspects of their reproductive functions. Thus psychiatrists even to the early years of this century spoke of the insanity of pregnancy, puerperal insanity, insanity of lactation and insanity of the climacteric.[47] These were thought to be specific entities distinct from other mental illnesses. By the 1920's, however, textbook writers were arguing that the category 'post partum' or 'puerperal' psychosis had no validity and should be abolished.[48] Ironically, the concept of lactational insanity was being abandoned by psychiatrists even before it was legislatively enshrined in the *Infanticide Act* 1938 (Eng).

In the following years the dominant view has become that puerperal

charged with the manslaughter of their newborn babies). The remaining woman was indicted for infanticide as earlier discussed.

[45] D M Byrne, and J D Heydon, *Cross on Evidence : Third Australian Edition* (Butterworths 1986) para 15.23.

[46] *DPP* v *A and B C Chewing Gum Limited* [1968] 1 Q B 159, 164 per Lord Parker CJ.

[47] Baker and Hopwood, fn 27 supra.

[48] J A Hamilton, 'The Identity of Post Partum Psychosis' in I F Brockington, and R Kumar, (eds), *Motherhood and Mental Illness* (London Academic Press, 1982) 2; J H Morton, 'Female Homicides' (1934) 80 *Journal of Mental Science* 64–74.

psychoses are no different to other mental illnesses. The current English and American registers of psychiatric disorders advise against the use of the term 'puerperal psychosis' because there is no demonstrated difference in symptoms and outcome to other psychoses.[49]

Although the clinical picture of puerperal psychosis is considered to be similar to other psychoses, there is evidence of a *temporal* association between serious mental illness and recent childbirth. Several studies have demonstrated that the rate of admission of women to psychiatric hospitals with depression or other psychosis is lower than average during pregnancy and rises to several times the expected rate for new episodes during the first three months after parturition (ie giving birth).[50]

There is also clear evidence that less severe, but still disabling, depression is more frequent after childbirth than at other times. The leading British study found an incidence of depression in the puerperal period at least six times more than the incidence one would expect on the basis of chance.[51] A recent Australian study found an even greater incidence of depression in the year after childbirth.[52]

Thus there is evidence that women are particularly likely to suffer depression or psychosis after childbirth, but little agreement as to whether there is something specific to birth or childcare that precipitates the illness. Some researchers[53] have speculated that the dramatic hormonal changes associated with parturition cause post natal depression but this is generally considered a minority view.[54] Other commentators have argued that psychological factors associated with the birth of a child may play a role. It has been suggested that conflict over the mothering role may be significant, due to hostility the woman feels towards her own mother coupled with identification with that mother due to the pregnancy and birth.[55] Another possible factor is the baby's extreme dependency which may arouse for the woman a wish to be cared for herself like a child. In this sense childbirth can be a significant maturational crisis.[56] Lack of feedback from the baby, lack of support from the husband and

[49] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (Third Edition — Revised), (Washington D C, American Psychiatric Association, 1987); United States National Center for Health Statistics, *International Classification of Diseases : 9th Revision : Clinical Modification* 1987 Vol 1, 1115; M Gelder, D Gath, and R Mayou, *Oxford Textbook of Psychiatry* (Oxford, Oxford Medical Publications, 1983) 390.

[50] R Pugh, et al, 'Rates of Mental Disease Related to Child Bearing', in (1963) 268 *New England Journal of Medicine* 1224–8 and R E Kendell, et al, 'The Influence of Childbirth on Psychiatric Morbidity' (1976) 6 *Psychological Medicine* 297–302.

[51] B Pitt, 'Atypical Depression Following Childbirth' (1968) 114 *Brit J Psych* 1325–35.

[52] B J Tonge, *Post Natal Mood States : Mother-Child Interaction and Child Developement*, M D Thesis, University of Melbourne 1984, 185.

[53] The most well known of whom to lay persons is Dr Katherina Dalton, who is also known for her work in premenstrual tension. See her book *Depression After Childbirth* (Oxford, Oxford University Press, 1980).

[54] Brockington and Kumar, fn 48 supra, 56, 112 and Gelder et al, fn 49 supra, 391.

[55] F T Melges, 'Post Partum Psychiatric Syndromes' in J M Bardwick, (ed), *Readings on the Psychology of Women* (New York, Harper and Row, 1972) 287.

[56] Id, 289 and R Kumar, 'Neurotic Disorders in Childbearing Women' in Brockington and Kumar, fn 48 supra, 82–3.

difficulty in coping with the tasks of mothering have also been identified as frequent problems.[57]

A feminist analysis of post natal depression by Oakley stresses the association between hospital birth, and a high degree of medical intervention in the birth, and depression. She argues that the resulting experience of loss of control over their own bodies leads women into depression, which can be exacerbated by the loss of identity and social isolation due to giving up work and lack of support from the spouse.[58]

These psychological factors specific to childbirth and childbearing are given some recognition in mainstream psychiatric texts as causal factors, together with the sheer loss of sleep and hard work invovled in caring for the baby.[59] They are considered to be of significance only in relation to mild or moderate depression, however. Psychotic depression, where the mother has lost touch with reality, is considered to have the same aetiology as other psychoses, and so to generally arise from problems with brain chemistry rather than as a reaction to the birth as a specific stressor.[60]

Against this background a psychiatrist retained to prepare a report in an infanticide case could comfortably assert a temporal connection between the birth and subsequent mental disturbance. This does little more than state the obvious, however, and the section clearly requires a causal connection. In theory this could be more problematic, particularly in cases of very serious illness ie psychosis. In addition there are difficulties with the precise wording of the English, Victorian and New South Wales sections. These require that for conviction for infanticide the disturbance of balance of mind must be caused by specific aspects only of childbearing, being lactation or insufficient recovery from parturition itself.

There is no support whatsoever for lactation as a cause of mental disorder.[61] The reference to lactation is intelligible only as a description of a period of time after childbirth, which is how it was sensibly regarded in these cases. The alternative requirement that the woman has not 'fully recovered' from the 'effect of giving birth' is arguably too narrowly focussed on the immediate physiological consequences of childbirth to encompass the full range of post natal mental disorder. An improved formulation was suggested by the English Criminal Law Revision Committee ('CLRC') in its Fourteenth Report.[62] The CLRC proposed that the reference to the effect of lactation be deleted[63] and, by majority, that the phrase 'by reason of (the mother) not having fully

[57] Melges fn 55 supra 289; Kumar, id, 87, 107–9.
[58] A Oakley, *Women Confined* (Oxford, Martin Robertson, 1980).
[59] Gelder, et al, note 49 supra, 392.
[60] In addition to the references cited in fn 49 see E Fuller Torrey, *Surviving Schizophrenia: A Family Manual* Revised Edition, (New York, Harper and Row, 1988) 105. Fuller Torrey notes that the onset of schizophrenia occurs most often during the same years that most childbearing takes place and so onset after childbearing may on occasion be coincidental.
[61] Evidence of the Working Party of the Royal College of Psychiatrists to the Criminal Law Revision Committee, note 1 supra, published in R Burglass, 'Infanticide' [1978] *Bulletin of the Royal College of Psychiatrists*, 139.
[62] fn 1 supra.
[63] Id, para 105.

recovered from the effect of giving birth' be replaced by the requirement that the disturbance arise 'by reason of the effect of giving birth or *circumstances consequent upon that birth*'.[64] (my emphasis)

Although this form of words would enable a closer match between psychiatric testimony and the strict legal requirements, the cases that I examined show that in practice in New South Wales rigorous adherence to the expressed elements of the offence is not required, perhaps in unspoken recognition of their outdated character. Nor is the mainstream view in psychiatric circles that psychosis after childbirth is no different to psychosis at other times, which makes it difficult to speak of the mental disorder being caused by the birth, a hindrance to the operation of the section. The forensic psychiatrists in these cases generally had little difficulty in ascribing the cause of the woman's mental disorder to the birth. Given the legal framework within which they work and the leniency afforded women where this connection can be drawn this is hardly surprising.

In making the connection between birth and illness the psychiatrists usually relied on no more than the mere temporal sequence: birth followed by illness.[65] They did not seek to specifically establish a causal relationship by any of the means adopted in the literature, such as a discussion of characteristic symptoms (other than time of onset), examination for hormonal imbalance or other physiological factors associated with childbearing, or a discussion of the psychological dynamics of the depression, for example an ambivalent identification by the woman with her own mother. Most of the psychiatrists made no attempt to relate the mental disturbance explicitly to the aspects of childbearing listed specifically in the section. Nor did the prosectuor or judge require that this precise connection be drawn provided the general description 'post natal' or 'puerperal' was applied to the mental disturbance.

Reliance on the temporal sequence alone was more convincing where there was no other apparent reason for the woman's disturbance. Of course the legal formulations of mitigation of culpability in diminished responsibility and infanticide positively discourage a search for environmental factors that may have led to the woman's depression or other mental illness. External or environmental stress is not specifically listed as a possible cause of abnormality of mind in the formulation of diminished responsibility, and acknowledging that it played any role in a depression after childbirth could undermine the relationship between the illness and the birth that is necessary for infanticide.

In several of the cases here the forensic psychiatrist described the illness as 'endogenous' ie arising from within, with no examination as to any external factors that may have contributed to the depression, even if there was material available suggesting that there had been some external stress. It is difficult to know whether it is the legislation that is forcing these forensic

[64] Ibid.

[65] The former consultant psychiatrist to Pentridge Gaol Dr Allen Bartholomew is critical of reliance on the temporal sequence alone in *Psychiatry, the Criminal Law and Corrections* (Bundalong, Victoria, Wileman Publications, 1986) 149–50.

psychiatrists to concentrate on intra psychic causes or whether legislation is reflecting the school of psychiatry to which these psychiatrists adhere.[66] In two cases where the forensic psychiatrists minimised or ignored environmental stress altogether the women's treating psychiatrists had placed greater weight on that environmental stress. In one case, for example, all three forensic psychiatrists said that the woman, Helen, had been suffereing from endogenous post natal depression.[67] They made no reference to possible problems with her marriage although these had been set out in the reports of the psychiatric hospital where she had been admitted prior to the homicide.[68]

In a number of cases there were references to whether the baby or birth had been particularly difficult. In one woman's case, whom I will call Pauline, where this was a very significant factor the forensic psychiatrist consulted by the defence set this material out in great detail in his report. Pauline was said to have been suffering from 'post puerperal blues' which the psychiatrist described as:

> a fluctuant type of depression, which affects many women following pregnancy in which for one to two days they can be downcast, tearful and agitated for no apparent reason, and then be happy and normal for a short spell.[69]

This description relates to 'maternity blues' which are identified in the literature as inconsequential and limited to the first ten days after birth. This was quite inadequate to describe the persistence and disabling nature of this woman's depression and anxiety. It would have been more accurate to describe her as suffering from mid range puerperal depression, disabling but not psychotic. Nevertheless, the case illustrates the range of disorders that can be encompassed by infanticide. At the other end of the spectrum where women had been hospitalised for depression before the homicide they were said to have suffered a puerperal psychosis.

The more difficult cases to relate to childbirth were those where the woman was either subject to considerable environmental and personal stress independently of the baby, or suffered from inadequacies of intelligence or personality that may have diminshed her culpability in any event. In these cases could it be said the woman's abnormal mental state arose from the birth?

The question of external stress arose most acutely in Margaret's case. Margaret killed her four month old daughter while on weekend leave from the psychiatric hospital where she was being treated for depression. Her treating psychiatrist at the hospital considered that her depression was reactive to conflict in her marriage, worry about financial problems caused by her husband's gambling and the recent loss of her father.[70] In his evidence at her committal he rejected the term 'post partum syndrome'. He said that depression could occur after birth just as is could occur at any time, birth being a

[66] Cf Bartholomew, id, 28–9.
[67] Dr O S, report dated 18 February 1981; Dr S G, report dated 22 August 1980 and Dr J S, report dated 2 February 1981.
[68] Discharge summaries dated 9 May 1980 and 8 August 1980.
[69] Dr P G, report dated 1 November 1977, 5.
[70] Dr G P, referred to in report of forensic psychiatrist Dr W L dated 26 June 1978.

stressful event like many others that could precipitate mental illness. In his view other factors as well as the birth itself were invariably present.[71] Under cross-examination by Margaret's lawyer he eventually conceded that the birth of the child she killed may have been a very significant factor in her depression in that it imposed considerable further responsibility on her at a time when she was already under stress.[72] The defence argued at the committal that Margaret should be committed for infanticide only. They relied on the evidence of this psychiatrist, together with evidence from her husband and neighbours to the effect that her personality had changed significantly since the birth of the child. In refusing this submission the magistrate referred specifically to the fact that the psychiatrist only reluctantly conceded the relationship between the birth and her depression.[72]

The causal connection was thus uppermost in the mind of the defence lawyers. They were probably somewhat alarmed then when the forensic psychiatrist retained by them adopted almost word for word the analysis (otherwise very careful and detailed) by the treating psychiatrist, whose reports he had read. In his first report, commissioned shortly before her committal, this psychiatrist accepted that Margaret had suffered a severe depressive illness, reactive to the stresses highlighted by the treating psychiatrist. In relation to the fact of recent childbirth he commented only:

> although there is no clear cut precipitant for the illness, depression not infrequently follows childbirth and I think that the death of her father may be important also. She had previously not worried to this degree or at least become depressed over her marital problems.[74]

He mentioned in passing that she suffered a pulmonary embolism after the birth but states: 'There were no sequelae to this incident as far as I am aware'.[75] He also comments briefly that she had trouble breast feeding both this child and her earlier child.

His conclusion in this first report is that diminished responsibility is available.[76] There is no mention of infanticide and the emphasis in the report is on factors other than those relating to the child. The depression was not described as 'puerperal'.

The psychiatrist wrote a second report a month later in relation to an application for bail but then a third report two weeks after that. There was no need for this third report—there were no further consultations to record. In format it is identical to the first, substantial report and most paragraphs are repeated word for word. The difference lies in a greater emphasis given to factors associated with the birth, factors which were barely mentioned in the earlier report, and the legal conclusion. In this third report, no doubt commissioned by the defence to be a rewrite of the first, in the place where earlier

[71] Transcript of committal, 26 June 1978.
[72] Ibid, cf evidence of the Royal College of Psychiatrists to the CLRC fn 1 supra, para 105.
[73] Committal, 26 June 1978.
[74] Dr W L, report dated 26 June 1978, 2.
[75] Ibid.
[76] Id, 3.

the psychiatrist had referred to diminished responsibility the conclusion is now infanticide.[77]

There was some suggestion, however that the psychiatrist did not feel entirely comfortable with the causal requirements and medical premises of infanticide. His conclusion was a guarded one:

> I think it is *not unreasonable* to attribute her illness to the birth of her child and subsequent difficulties. (my emphasis)[78]

He emphasised not the physiological sequelae of birth and lactation but the mere temporal association. Rather than referring to the 'effect of lactation' as the section requires, he noted that there were 'difficulties in the lactation period'.[79] Margaret had in fact stopped breast feeding well before the homicide. He did not delete any reference to the external stress she was under but qualified his remarks by referring to this temporal association:

> Her financial and marital worries were, of course, an important component of her depressive illness but it should be noted that they have existed for a long time and she has not become depressed like this before.[80]

The Crown psychiatrist apparently had less difficulty in describing Margaret's condition as a 'Puerperal Depression' which is 'not infrequently found in women following a confinement'.[81] Having made that diagnosis, however, he did not appear to draw any distinction between the two possible legal consequences of that mental state. In his report, he said that he supported 'the charge being changed to "Infanticide"' and then went on to describe her puerperal depression as a 'mental abnormality' which substantially impaired her mental responsibility for the alleged commission of the crime, these being the tests for diminished responsibility.[82]

The other situation in which this question arises is where the mother suffers intellectual or personal inadequacies that could have mitigated her responsibility whoever she killed. Is her abnormality of mind *by reason of* the birth of the child, her victim? It would be distrubing if a woman who has a low intellect is more likely to be considered by psychiatrists, and so the legal system, as having her responsibility diminished by reason of mental retardation or 'backwardness' then by reason of post-natal depression. There is clearly no reason why a woman of lower intelligence may not be depressed after the birth of a child and every reason why a woman of fewer personal resources such as this may in fact be more depressed than others. A comparison between the one case where diminished responsibility was relied on and another where the woman was convicted of infanticide, although the facts were very similar, illustrates this issue and shows the significance attached to the catch phrase 'post natal depression'. These were the cases of Alison and Julie. Both women were said to be of very low intellect who had found that they simply could not

[77] Dr W L, report dated 16 August 1978, 3.
[78] Ibid.
[79] Ibid.
[80] Ibid.
[81] Dr O S, report dated 27 October 1978, 2.
[82] Ibid.

cope with the care of this their first child. Both had sought medical help in the period before the homicide. Alison said that she had approached a local doctor when she felt she was having 'a nervous breakdown' and Julie had been hospitalised for depression when she admitted causing a fracture to her baby's arm.

In both cases the Crown Prosecutor when considering the appropriate charge (ie after committal and before indictment) noted that the woman appeared to have been suffering from a disturbance of mind and sought further psychiatric evidence. In Julie's case there was a report from her treating psychiatrist available at this time but this was not conclusive in the Crown Prosecutor's view in relation to infanticide because the emphasis in that report was on the accused's low intelligence rather than her depression. The Crown Prosecutor said that he would like 'more recent and further opinion specifically directed to the question of whether such disturbance (of mind) was "*by reason of*" her not having fully recovered from the effect of giving birth to her child.'[83] In Alison's case even though there was no psychiatric evidence then available the Crown Prosecutor could say on the basis of the other evidence that 'there is something very obviously wrong with the accused'.[84] He requested a report from the Crown psychiatrist and noted that both diminished responsibility and infanticide were possibilities.

Julie was fortunate in that the later psychiatrists who interviewed her, both the Crown psychiatrist and the psychiatrist approached by the defence, considered that she was not as dull as first reported. Julie had been deaf for a large part of her childhood and her consequent poor schooling may well have given her the impression of having lower intelligence than in fact she had. This was the opinion of the Crown psychiatrist who concluded that at the time of the homicide she was suffering from a 'puerperal depression' which '*might* have contributed largely to her behaviour'[85] (my emphasis). The Crown psychiatrist was positive that she had had a post-natal depression; his hesitancy lay in asserting whether the homicide arose from this depression or was part of 'the growing increase in the bashing of children in the community'.[86] On balance, however, he concluded that her plea to infanticide should be accepted. Of course, strictly speaking, it is not necessary under section 22A to establish a causal relationship between the mental disturbance and the homicide.[87]

The defence psychiatrist was of the opinion that 'her intelligence was a little below normal' and that she had suffered from 'a significant degree of depression shortly after the birth of a wanted baby'.[88] He asserted that the killing of the child was 'consequent' on the depression which in turn had 'followed'

[83] Endorsement by Mr V W, QC, Senior Crown Prosecutor dated 18 February 1977 on the instructions from his instructing solicitor.
[84] Endorsement by Mr R J, QC, Senior Crown Prosecutor dated 3 March 1977 on the instructions from his instructing solicitor.
[85] Dr O S, report dated 28 February 1977, 2.
[86] Ibid.
[87] The Law Reform Commission of Victoria has proposed that the law be amended to require a connection between the mental disturbance and the homicide: Discussion Paper No 14, fn 1 supra, 69.
[88] Dr W L, report dated 17 February 1977, 2.

the child's birth.[89] This was an assertion of a temporal relationship between the birth and the depression rather than a causal one but this report together with the Crown psychiatrist's report appear to have been sufficient for the Crown to accept a plea of guilty of infanticide. Like the other women convicted of infanticide, Julie received a bond to be of good behaviour.

In Alison's case, however, despite numerous indications that she had depression and anxiety when she felt she could not cope with the baby, the Crown psychiatrist did not feel able to positively assert that she had suffered a puerperal depression. In a report that focuses almost entirely on her intellectual deficiencies the psychiatrist concluded:

> It is my opinion that the accused is a borderline case of Intellectual Defectiveness. She *may* have had a Puerperal Depression following the birth of her baby, but this cannot be stated with any degree of certainty in the absence of any reliable information from her . . . it is further my opinion that the accused at the time of the alleged homicide suffered from an abnormality of mind (retarded and probably inherited cause) which would substantially have impaired her mental responsibility.[90] (emphasis added)

The psychiatrist's report suggests that, although Alison told him she had suffered 'a nervous breakdown' after the birth of the baby and had seen a doctor, because of her intellectual deficit she could not necessarily be believed. It may have been that she needed a sympathetic questioner to be able to explain how she had felt. The psychiatrist approached by the defence did not seem to have experienced quite the same degree of difficulty in eliciting information from Alison.[91] His report is more than twice the length of that of the Crown psychiatrist and sets out a detailed account of the anxiety, depression and confusion Alison experienced when she found she could not cope with the baby. Perhaps unfortunately, from Alison's point of view, this defence psychiatrist did not explicitly refer to infanticide but there is ample in his report on which a defence lawyer seeking a plea to infanticide could have a relied.

In the absence of an affirmative statement that Alison had been suffering from post-natal depression Alison pleaded guilty to manslaughter on the basis of diminished responsibility and was sentenced to seven years imprisonment. The judge's remarks on sentence are extremely short and there is no reference in them to the factors appearing in the evidence that suggested the homicide was at least as much related to the stress of caring for the baby as Alison's limited intelligence and hostile relationship to her mother. The remarks on sentence are quite different to the lengthy judgments in some of the infanticide cases where the woman's increasing inability to cope with the child is set out in considerable detail as justifying a lenient sentence. The only mitigating cirucumstances referred to in the remarks on sentence in Alison's case were her limited intelligence and the statement by her de facto (not by her!) that she

[89] Ibid.
[90] Dr O S, report dated 10 March 1977, 2.
[91] Dr P G, report dated 4 March 1977, 4 pages.

was prepared to be sterilized.[92] Whereas Julie's situation was described by the judge as 'a tragic case'[93] Alison's crime was described as 'horrifying'.[94] Not articulate enough, in the view of the Crown psychiatrist, to be believed when she said she had been depressed, she was treated as a dull brute to be sterilized for her and the community's good.

SENTENCING FOR INFANTICIDE

Alison and Julie's cases illustrate the considerable disparity in sentences that can flow from the characterisation of the case as one of infanticide, or on the other hand, diminished responsibility. The forensic psychiatrists used the terms interchangeably as the legal consequence of a puerperal disorder. It was for the defence lawyers to seek to rely on one rather than the other. In Margaret's case, discussed earlier, her lawyers were most anxious that she be convicted of infanticide, rather than manslaughter by reason of diminished responsibility. To this end it appears they requested that her psychiatric report be rewritten to stress infanticide and not the broader defence. The pattern of sentencing in the cases as a whole suggest that they were wise to do so.

The five infanticide cases were remarkably consistent in outcome. In every case sentence was deferred under section 558 of the *Crimes Act* 1900 (NSW). The woman was placed on a bond to be of good behaviour, for periods ranging from three to five years, and usually conditional on her continuing to accept psychiatric care for so long as her doctors considered it necessary. Seven other women were convicted of the homicide of their child under one year in this period, five of manslaughter (three by assault and two by neglect) and two of manslaughter by virtue of diminished responsibility.[95] These women were not all so fortunate. Only two were given bonds, and both women convicted of manslaughter by virtue of diminished responsibility were given custodial sentences. This suggests that the leniency in the infanticide cases cannot be entirely explained by reliance on evidence of mental disturbance. It is something about infanticide in particular that consistently attracts this compassionate response.

Although the numbers in the 1976–1980 study are small, subsequent cases support the proposition that while infanticide in New South Wales always results in a bond, diminished responsibility may not. Of five cases in the three years 1982–84 where a woman was charged with the murder of her child less than twelve months old, two women pleaded guilty to infanticide, and two to

[92] Remarks on sentence, 23 March 1977, Supreme Court of NSW.
[93] Remarks on sentence, 3 March 1977, Supreme Court of NSW, 1.
[94] Remarks on sentence, 23 March 1977, 1.
[95] All women who went to trial were found to have committed an offence in relation to the child's death. In addition to the manslaughter and infanticide convictions one woman was found to have concealed the child's birth but no conviction was recorded pursuant to s 556A of the NSW *Crimes Act* (1900). Interestingly all the verdicts were in the middle range—there were no convictions for murder, no acquittals and no acquittals on the ground of insanity.

manslaughter by virtue of diminished responsibility.[96] Both women convicted of infanticide received non custodial sentences, as did one of the women, an Aboriginal woman from outback New South Wales, who relied on diminished responsibility.[97] The other woman who relied on that general defence was sentenced to seven and a half years imprisonment with a non parole period of four years, reduced to two years on appeal.[98]

Conviction for infanticide in England is also usually followed by an non custodial sentence.[99] The view has been expressed in England that if infanticide was abolished and women who currently rely on it were convicted of manslaughter by virtue of diminished responsibility their sentences may well not be so lenient.[100]

I have suggested that the disparity in sentencing between infanticide and manslaughter by virtue of diminished responsibility is not necessarily explicable by different facts. The disparity is due not so much to particularly harsh sentencing in the diminished responsibility cases, as to consistently lenient sentencing for infanticide. This is a crime which for historical, political and emotional reasons has, at least since the eighteenth century, always been treated with leniency.

A CASE FOR RETENTION OF THE OFFENCE

In my view, the sentencing pattern for infanticide is a compelling reason for the retention of the offence. Although largely pragmatic, this reasoning does not sacrifice all principle for expendiency. In the first place, it seems to me that one can still mount a case for the special treatment of this particular class of homicide. Historically, special treatment was afforded women who killed their newborn illegitimate babies by the men who made up legislatures, the judiciary and juries because of the uncomfortable knowledge that where a woman was left pregnant, unmarried and without support the father of the child was very likely at least equally to blame. In addition to this awkward pity, there has always been a degree of mystery and fear surrounding female biology and childbirth.[101]

Admittedly, social circumstances have now changed. Illegitimacy is no longer such a stigma, better birth control is available, poverty is to some extent alleviated by state support and women are recognised as autonomous persons who can control their lives and are not necessarily confined to a

[96] The other woman was committed for trial on manslaughter only on the basis of lack of intent : *Sydney Morning Herald*, 13 July 1983.

[97] Personal communications from Mr Michael O'Donnell, solicitor for Diane Taylor (diminished responsibility) and Mr Robert Arden, solicitor for Lynne Craig (infanticide). Remarks on sentence in *R* v *Margaret Craig* (infanticide) Supreme Court of NSW, 11 September 1985 per Maxwell J.

[98] *R* v *Margaret Elliot*, unreported decision of NSW Court of Criminal Appeal, 14 July 1983.

[99] CLRC fn 1 supra, para 108.

[100] E Parker, 'Mentally Disordered Offenders and their Protection from Punitive Sanctions : The English Experience' (1980) 3 *Int J Law and Psych* 461, 462–3.

[101] Cf K O'Donovan, 'The Medicalisation of Infanticide' [1984] *Crim L R* 259, 264.

domestic sphere. Nevertheless, it remains the case that the care of infants is almost entirely the responsibility of their mothers. If mothers are to receive special treatment then perhaps this can be justified by the onerous and unalleviated nature of this responsibility.

Of course in most families the responsibility of the mother as prime carer does not cease when the child turns one. It is of interest then that children are far less likely to be killed by their mothers after one year of age.[102] This suggests that the cut off point of one year of age in the legislation is not as arbitrary as it may at first appear. As well as the greater physical vulnerability of the child when very young, the greater incidence of maternal filicide during this period may also reflect the greater likelihood of depression and distress for the mother in the first year of adjustment to mothering.

Children are also at risk from their fathers and stepfathers, but the rate of these homicides is far more constant over the first five years of the child's life.[103] The cases of paternal filicide in this study also suggest quite a different pattern for the killing of infants by their fathers, as opposed to mothers.

There were nine men charged with the homicide of a baby under one year in their care in the years 1976–1980, eight of whom went to trial.[104] Those who went to trial were all convicted of manslaughter, either on the basis of an assault on the child which was not accompanied by the intent to kill or cause grievous bodily harm, or on the basis of neglect. All but one received custodial sentences. While most of the men killed their first child, most of the women killed their second (or subsequent) child.[105] The parents in this study pursued a traditional division of household tasks so that child care was almost exclusively the responsibility of the mothers in each of the families concerned. No woman worked outside the home and almost every man did. Necessarily the women bore the brunt of care for the child killed and any other children while the man was at work, but even after working hours most of the men, and the women, continued to regard the baby as the woman's responsibility only. Women already under stress worried, for example, that the baby's crying would wake their husbands or felt a failure that they couldn't care for the child without calling for assistance.

The consequence for the men of this assignment of roles was that they had very limited opportunity to gain any confidence and experience in dealing with a baby. Men who killed babies did so by an impulsive assault in response to the child's crying after usually a very short period, sometimes minutes, alone with the child. On this view, the men killed infants because they had too little responsibility for them and too little exposure to and so tolerance of infant behaviour. The woman, on the other hand, killed their children because of the strains imposed by constant twenty-four hour a day responsibility for a dependent, irrational and often very demanding being together

[102] A Wallace, *Homicide: The Social Reality*, fn 35 supra, 126.
[103] Ibid.
[104] The other man was not committed for trial.
[105] Six out of eight men were indicted for the murder of their first child as opposed to only five women of thirteen indicted. All but one of the women convicted of infanticide had killed her second child.

with the care of an older child or children. The women were expected to carry out this mothering role even when they were plainly in the midst of mental confusion or despair. The traditional arrangement of family roles allowed them little space or time to resolve their difficulties without the demands of mothering.

Four of the five women subsequently convicted of infanticide had been receiving psychiatric care for depression after the birth of the child and prior to the homicide. The other woman had been in regular contract with her local doctor who was treating her for anxiety and stress. All five had been hospitalised for a period, three because of suicidal ideas or after attempting suicide. Two of these women subsequently attempted to kill themselves at the time of the homicide.[106] Despite their distress, in several cases the women felt compelled to return home from hospital earlier than their doctors wished, or delay an admission, because of the need to care for their children.

A specific homicide offence for mothers who kill young babies is still then a reasonably accurate reflection of the special character of these homicides. What remains to be seen in the future is whether the traditional sympathy for mothers who kill is eroded if more men assume child care responsibilities, or whether the compassion will be extended to all carers, whether male or female.

This is a case for a special offence in general terms. What of the requirement for a mental disturbance linked to childbirth? If one ignores for the moment the peculiarities of the wording, this too seems to me to be defensible. Post natal depression is a reality for many women, although one might argue about the cause, and it is undoubted that women who become deeply depressed may kill their child and attempt, or succeed, in their own suicide. The diagnosis of post natal depression in those women who did avail themselves of infanticide was not simply an ex post facto categorisation to make the offence available. As indicated, all had shown clear signs of mental disturbance or distress prior to the homicide, as indeed had most of the women who killed their children and were subsequently convicted of manslaughter. If infanticide were not available, women currently convicted of infanticide could only utilise the defence of insanity, or, in New South Wales, diminished responsibility to avoid conviction for murder. The leniency currently afforded these women could not then be guaranteed. In particular, acquittal on the grounds of insanity currently must result in indefinite detention at the Governor's pleasure.[107]

Ideally, the offence should be recast in accordance with the suggestions of the English Criminal Law Revision Committee and the recent proposals of the Victorian Law Reform Commission.[108] This would diminish the connec-

[106] Larger studies have also found that a high proportion of women who kill their children have recently been receiving psychiatric and medical care: Resnick and d'Orban, fn 35 supra.

[107] The Law Reform Commission of Victoria has recommended a range of sentencing options on a finding of 'not guilty by reason of mental impariment', Discussion Paper No 14, fn 1 supra, 34.

[108] Discussion Paper No 14, fn 1 supra, 70.

tion to gynaecology by deleting the reference to lactation and broadening the circumstances that may give rise to the mental illness to circumstances consequent upon the birth. But, even as it stands, in my view the violence that the wording does to female equality is slight compared to the benefits it affords those who can avail themselves of it.