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CRIME AND MISCONDUCT COMMISSION
QUEENSLAND

Vulnerable victims: child homicide by parents

Introduction

Vulnerable victims are those who are susceptible to becoming victims of violence because of their limited capacity to protect and remove themselves from danger.

Generally speaking, criminal investigations involving vulnerable victims are protracted, sensitive and labour-intensive. The investigations can be particularly complex and challenging to carry out using conventional law enforcement powers. For cases where conventional practices have not proved effective, the Queensland Police Service (QPS) may request access to the special investigative powers of the Crime and Misconduct Commission (CMC), if it is considered that the use of the coercive hearings power may benefit the investigation. Historically, these types of investigations were referred to the CMC on a case-by-case basis at the request of the Commissioner of Police.

On 30 January 2013, the CMC was granted a new general referral that streamlines the approval process (CMC 2013). A general referral applies to a category of major crime (as opposed to a particular incident of major crime). The referral allows the QPS to access the CMC's investigative powers in Queensland cases of suspected homicide, grievous bodily harm and torture,[1] where the victim is:

- unborn, or
- under the age of 16 years, or
- over the age of 70 years, or
- in a position of particular vulnerability because of a physical disability or mental impairment.[2]

The new referral also enables violent crime 'cold cases' to be investigated (those committed since 1 January 1970).

The CMC's vulnerable victims research program was established to help the CMC to conduct coercive hearings under the new referral. Papers in the vulnerable victims research program review published literature from a range of subject areas, including law enforcement, criminology, psychology and pathology.[3]

This Research and Issues Paper focuses on cases of suspected homicide of vulnerable victims under the age of 16, particularly homicide perpetrated by a parent. Although police investigators are the paper's primary audience, the paper is also a useful reference for professionals such as clinicians, ambulance officers or child protection workers who may encounter children at risk of being murdered by their parent.

1 Criminal Code ss. 300, 302, 303, 306, 307, 309, 313, 317, 320 and 320A.
2 Mental impairment means senility, intellectual disability or brain damage.
3 We did not scrutinise the methodological rigour of each study referred to in this paper.

Inside

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Scope of this Research and Issues Paper

Between July 1997 and June 2010, 338 children were victims of homicide in Australia. This accounts for about 9 per cent of all homicides over the same period (Chan & Payne 2013). When compared with adults, children are less likely to become victims of homicide. However, when death occurs in children, it is five times more likely to be due to homicide than is the case with a death in the adult population.

Despite public concerns about the risk of child homicide carried out by strangers, the majority of child homicides are committed by family members. For example, the most recently published Australian statistics indicate that the majority of child homicides (85%, *n* = 23) were committed by either a biological or a non-biological parent (Dearden & Jones 2008).[4] In light of these statistics — and the referrals that the CMC is likely to receive — this paper focuses on homicides committed by biological or non-biological parents.

This Research and Issues Paper explores:

Victim vulnerabilities: We examine vulnerabilities in relation to the child's relationship of dependence with the parent, the age of the child and the family composition.

Child homicide offences perpetrated by a parent: We examine offender characteristics, motives for the offence, the nature of the offence, investigative challenges and interviewing techniques in the context of investigations likely to be referred to the CMC under the new referral:

- neonaticide
- filicide in the context of mental illness (including filicide-suicide and familicide)
- filicide in the context of fatal child abuse
- filicide in the context of Munchausen syndrome by proxy (see the text box below for definitions).

4 The remaining homicides were committed by either a close friend or an acquaintance.

Prosecutorial challenges: In Queensland, child homicide offenders are charged with either murder or manslaughter. We discuss the difficulties associated with achieving the requisite criminal standard of proof. Evidentiary challenges often arise relating to circumstantial evidence in the form of propensity and similar fact evidence, as well as opinion evidence. Furthermore, a range of criminal defences may come into play, including automatism, insanity and diminished responsibility.

Crime prevention opportunities: We discuss opportunities for crime prevention as gleaned from the research literature. These crime prevention opportunities include the operation of safe haven laws (for neonaticide), the early treatment of mental illnesses and increased powers for child protection workers.

Victim vulnerabilities

Perpetrators of filicide often exploit a number of victim vulnerabilities associated with the parent–child relationship. Because of their level of dependence, younger children are most vulnerable. Stepchildren are also vulnerable; however, there is debate about the cause of this increased vulnerability.

Dependence

In cases of child homicide, the perpetrator is most likely to be the child's mother and/or father. The nature of the parent–child relationship allows for the exploitation of a number of victim vulnerabilities. The younger the child, the more dependent he/she is on the caregiver for everyday needs such as nutrients and shelter. It is not surprising, then, that the risk of filicide is greatest within the child's first 24 hours of life (Burton & Dalby 2012). The risk declines after the first day and again after the first week, but remains relatively high for the first four months of life (Koenen & Thompson 2008). After this, the risk of homicide by a mother or father declines steadily and levels off around the child's tenth birthday (Koenen & Thompson 2008).

Terminology

Throughout this Research and Issues Paper, the terminology shown here is used. These definitions are derived from the research literature and are not legal definitions. Furthermore, these definitions are not mutually exclusive. For example, a mother who kills her baby within the first 24 hours of life has committed child homicide, maternal filicide and neonaticide. For our purposes, this offence is categorised under neonaticide, as it is the most specific classification.

Child homicide: the killing of a child.

Neonaticide: the killing of a child within 24 hours of its birth.

Infanticide: the killing of an infant (1 day – 12 months old).

Filicide: the killing of a child by his/her mother (maternal filicide) or father (paternal filicide).

Filicide-suicide: the killing of a child by his/her parent, followed by the suicide of that parent.

Familicide: the killing of a child (and possibly another child) by his/her parent and the killing of the child's other parent, followed by suicide.

Age

Age of the victim is particularly relevant. The younger the child, the more vulnerable they are to homicide. However, older children remain vulnerable and this vulnerability is exacerbated if they are being raised in a stepfamily environment. These children are more likely to experience child abuse and are thus more likely to become victims of fatal child abuse. Although older children are at a decreased risk of filicide when compared with infants, they remain vulnerable because of their lack of physical and emotional maturity (Brown & Tyson 2012). For example, victims of fatal child abuse are often victims of ongoing abuse. This may be a consequence of children lacking:

- the physical strength to defend themselves
- the mental and emotional maturity to know that what their parent is doing to them is wrong, and
- the ability to communicate the victimisation to other adults.

Family composition

Another specific vulnerability identified in the literature relates to family composition. Filicides by stepparents are disproportionately common, with some studies indicating that stepchildren are nearly twice as likely to be killed in families as are birth children (Cavanagh, Dobash & Dobash 2007). It has previously been hypothesised that the increased risk of homicide is caused by the absence of a genetic relationship between the stepparent and the child. However, recent studies have disputed this explanation, instead finding that stepfamilies differ in their general disposition to use violence (Temrin et al. 2010).

Australian research has revealed that child abuse and maltreatment occur in blended and step families at more than twice the rate for non-step families (De Vaus 2004). Given this statistic, it is not surprising that filicides committed by stepparents tend to occur in the context of fatal child abuse (see pages 6–9 for further discussion). However, contrary to this pattern, research reveals that biological parents are more likely to be the perpetrators of child abuse in step or blended families.

Child homicide offences perpetrated by a parent

We do not suggest that all child homicides perpetrated by a parent fit neatly into the offence categories discussed in this section.

Neonaticide

Neonaticide offenders are those who kill a child within 24 hours of its birth. The perpetrator is most likely to be the biological mother, who is motivated to kill because of the undesirability of the newly born child. It is common for neonaticide offenders to attempt to conceal the victim's body, and this is often associated with the offender experiencing panic. Interviewers should aim to build rapport, familiarise themselves with every version of an offender's story, and be aware that offenders may portray themselves as victims.

Offender characteristics

In cases where homicide occurs in the first 24 hours of life, the mother is likely to be the perpetrator. Cases of paternal neonaticide are extremely rare and are usually linked to the father having a severe psychiatric disorder (Marks 2009). Consequently, most neonaticide research focuses on mothers as offenders.

The characteristics of mothers who commit neonaticide are very different from those of mothers who kill infants older than one day old (Marks 2009). Demographic characteristics associated with neonaticide offenders include being young, being unmarried and living at home with parents and/or other relatives (Shelton et al. 2011). Despite public perception that these women must be 'mad', research suggests that neonaticide offenders are rarely psychotic. Vellut, Cook and Tursz (2012) reviewed the psychiatric assessments of 16 mothers who committed neonaticide and determined all to be criminally responsible. Although mental illnesses were not diagnosed, additional psychological assessments revealed the presence of neurotic personalities and psychological stress. Neuroticism refers to a predisposition to experience negative emotions and has been associated with traits of anxiety, hostility, self-consciousness and jealousy. Furthermore, individuals with neurotic personalities tend to respond poorly to everyday environmental stress (Cimbolic-Gunthert, Cohen & Armeli 1999).

Motive for the offence

Undesirability of the child tends to be the main motivator for neonaticide offenders (Bourget, Grace & Whitehurst 2007). It has been suggested that this motivation manifests itself in seven stages:

- discovery of unplanned and undesirable pregnancy
- fear
- concealment of pregnancy
- emotional isolation
- denial
- dissociation, and
- panic.

These stages were identified by Riley (2005), who conducted in-depth interviews with nine women who had been incarcerated for neonaticide. A recent Australian neonaticide case highlighting the factors associated with neonaticide is *R v. Lane*[5] (see the text box on this page).

Nature of the offence

Asphyxiation is the most common cause of neonaticide deaths, often accomplished through suffocation, smothering or drowning (Shelton et al. 2011). Drowning commonly occurs as a result of the baby being born directly into the toilet.

Investigative challenges

The following investigative challenges are particularly relevant in cases of neonaticide:

- determining that a birth took place
- establishing that the neonate was viable
- locating the body of the deceased neonate.

Because the pregnancy is often concealed, many offenders do not seek medical care for the birth. In studying nearly 3000 homicides that occurred in infancy in the United States, Overpeck et al. (1998) found that 95 per cent of infants killed during the first day of life were not born in a hospital. In the absence of medical records and a neonate, it can be difficult to establish that a birth occurred.

Another common challenge involves establishing that the neonate was viable. Establishing that the child achieved a separate existence and lived outside the mother[6] involves looking for forensic signs that the child was born alive. Radiographic evidence of air in the lungs, middle ear and stomach, food in the stomach, and inflation of the lungs all support the existence of a liveborn rather than stillborn child (Griest 2009). When the child is born directly into the toilet, determining viability may be particularly challenging. The brief time between delivery and immersion into the toilet water may not allow for air to enter the lungs (Shelton et al. 2011).

Locating the body of the deceased neonate is another problem for investigators. Although the deceased body can often be found in close proximity to the delivery location, it is common for offenders to try to conceal their offence. Often, in a panic, offenders seek to conceal deceased newborns in sewers, rubbish skips and public toilets (Riley 2005). This can mean that remains are not discovered for a considerable amount of time, and sometimes never. Decomposition of remains makes it difficult to determine independent life and cause of death (Shelton et al. 2011).

R v. Lane [2011] NSWSC 289

In December 2010, Keli Lane (a former Australian representative water polo player) was convicted of the murder of her daughter Tegan. The Crown case (as accepted by the jury) was that Keli killed Tegan and disposed of her body. Although it was determined that Tegan was killed when she was two days old, evidence presented by a physiatrist at the trial suggested that the murder met the broad definition of neonaticide.

Patterns of Keli Lane's behaviour that can be associated with Riley's 2005 neonaticide profile include:

- concealment of pregnancy — none of her friends or family were aware of the pregnancy and subsequent birth of Tegan
- lack of evidence to suggest that Ms Lane suffered any disturbance to her mental processes so as to support a diagnosis of a mental illness or a mental disorder (although a psychiatrist at the trial suggested the existence of a personality disorder).

The sentencing judge, Whealy JA, in discussing the nature of the crime said [at 49]: 'It was committed in a situation of desperation arising from a sense of entrapment and isolation, and a perceived inability to communicate with the very people who would have eased her burden and helped her out of the desperate situation in which she found herself. Irrational though these feelings were, I accept that they were likely to have been experienced by the offender.'

Also of particular relevance to this paper were Justice Whealy's sentencing comments regarding aggravating factors (related to the victim's vulnerability) [at 40]: 'These are first, the age of the child, a baby of only 2 days old and secondly, the abuse by a woman of the position of trust as between a mother and her child. These are serious aggravating factors because the life that has been taken is that of a baby, a being who was completely defenceless, and who met her end at the hands of her mother, a person from whom she could ordinarily expect protection, sustenance and care.'

5 [2011] NSWSC 289. Keli Lane has since appealed her conviction and the New South Wales Court of Appeal is set to hear her case on 23 and 24 July 2013 (correct at time of publication).

6 In Queensland, viability is defined under s. 292 of the Criminal Code (see Appendix B).

Interviewing techniques

Little research literature deals with techniques that can be used when interviewing suspected neonaticide offenders. Recognising this deficit, Shelton et al. (2011) developed a set of empirical-based strategies for the investigation of neonaticide. These strategies were developed from a law enforcement perspective, with two of the four authors being Federal Bureau of Investigation agents assigned to the National Center for the Analysis of Violent Crime. While recognising the need for a tailored approach, Shelton et al. (2011) provided the following guidelines for interviewing neonaticide suspects:

Version of events: Before the interview, the investigator should become familiar with every version of events previously provided by the suspect. This will allow the interviewer to immediately identify any inconsistency in the suspect's account and challenge appropriately.

Interviewing manner: Interviewers should seek to maintain a calm and non-judgmental manner that builds rapport with the suspect in an effort to reduce the suspect's anxiety. This is important because during the interview the suspect may appear unresponsive, unemotional or overemotional. The authors found that an initial non-accusatory posture can prolong the interview, allowing the interview to later transition into an interrogation.

Pace of the interview: The interviewer should be aware that the suspect's emotions may affect the pace of the interview. The suspect's slow, disjointed or incomplete answers to questions may result in long periods of silence. The interviewer should allow the suspect to discuss her feelings, concerns and fears related to the pregnancy and birth. This is vital to obtaining the detail needed to progress the investigation.

Overcoming denial: The interviewer should understand that the suspect is likely to deny being aware that she was pregnant. However, the interviewer can often challenge this assertion by producing documents such as emails, diary entries or letters where the suspect confirms the existence of the pregnancy. If the suspect has previously been pregnant (as was the case for nearly half of the offenders in the study by Shelton et al. 2011), the interviewer should raise this in the interview, suggesting familiarity with the signs and symptoms of pregnancy.

Refuting claims of still-birth: When interviewers discuss details of the birth with a neonaticide suspect, it is common for offenders to describe something other than the delivery of a near-term or full-term infant. Once descriptions of miscarriage and pre-term are refuted (often through the presentation of autopsy results), many neonaticide offenders describe the infant appearing as stillborn. In attempting to establish that the infant was in fact born alive, the interviewer should approach the subject indirectly. The suspect may be more willing to give information regarding whether the infant urinated or defecated, opened or closed their eyes, or flinched.

Filicide in the context of mental illness

Filicide in the context of mental illness is largely perpetrated by mothers. The most common mental illnesses associated with filicide are mood disorders, schizophrenia and other psychotic disorders, and comorbidity often exists. Mentally ill mothers who kill their children tend to be older, be married, use more violent methods of killing and be less likely to attempt to conceal the offence. Although these offenders are likely to admit to their crime, their memories will often be hazy and the explanations provided may be consistent with psychotic delusions.

Offender characteristics

Australian research suggests that about 15 per cent of parents who commit filicide are mentally ill at the time of the offence (Mouzos & Rushforth 2003). The most common disorders associated with these offenders are mood disorders, schizophrenia and other psychotic disorders (such as schizophreniform disorder and brief psychotic disorder).[7] Although mental illness can be a factor in maternal and paternal filicide, these disorders are reported to be more prevalent in female perpetrators (Liem & Koenraadt 2008). As a result, research has focused on maternal filicide, and it is in this context that we discuss mentally ill filicide.

Mood disorders that have been associated with filicide offending include post-partum depression,[8] major depression, chronic depression and psychotic depression (Kauppi et al. 2008). In studying a sample of mothers with these disorders, Kauppi et al. (2008) found that in these cases the 'baby was wanted, healthy and not difficult to take care of, but the feeling of being responsible for the well-being of the baby, the present life situation, and depression increased the feeling of inability to cope with life and parenting' (p. 205).

Studies of mentally ill mothers who kill their child have commonly revealed diagnoses of schizophrenia, most commonly paranoid schizophrenia (Valenca et al. 2011). Comorbidity often exists between mood and psychotic disorders (see, for example, Stanton & Simpson 2006). When symptoms of both psychosis and a mood disorder are present, a diagnosis of schizo-affective disorder is likely.

7 See Appendix A for the diagnostic criteria of these disorders under the DSM-5.
8 Post-partum depression is a type of depression associated with the birth or miscarriage of a child.

In relation to personal characteristics, mentally ill mothers who kill their child are often older and more likely to be married than those who kill in the absence of a mental illness (Bourget, Grace & Whitehurst 2007). Although the presence of stressors is often a factor in all filicide subtypes, in this context psychological stressors precipitate the illness rather than the killing (Stanton, Simpson & Wouldes 2000).

Motive for the offence

Child homicides committed in the context of mental illness are often motivated by 'secondary altruistic motives'. Offenders with secondary altruistic motives believe they are ending their child's suffering. This is particularly seen in schizophrenic offenders who suffer from delusions. In D'Orban's 1979 study, one mother stated that she killed her two children 'to save them from a violent world', while another killed her child 'to prevent him from becoming a schizophrenic' (p. 565).

Nature of the offence

Filicides committed by mentally ill offenders have been associated with violent methods of killing, with older children as the victim/s and with more than one child being killed (Stanton, Simpson & Wouldes 2000).

Methods of killing associated with mentally ill mothers include drowning, gassing, suffocation with a pillow and poisoning (usually with antidepressants prescribed for the offender) (D'Orban 1979). In instances where mothers used violent methods of killing, psychotic women were eleven times more likely to kill their child with a weapon (such as a knife or gun) than were their non-psychotic counterparts (Lewis et al. 1998).

In the course of committing filicide, mentally ill offenders may also commit, or attempt to commit, suicide. Hatters Freidman et al. (2005) found that 16–29 per cent of mothers and 40–60 per cent of fathers who committed filicide also committed suicide.

Research suggests that around 80 per cent of filicide-suicide offenders have a history of psychiatric symptoms. Hatters Freidman et al. (2005) conducted a retrospective review of 30 filicide-suicide cases, with the results indicating a history of abuse in only one case (by the father), suggesting that filicide-suicides do not necessarily result from abusive parent–child relationships. The same research also revealed a common pattern of offending by males, with 13 of the 20 fathers attempting to kill their wives as well as themselves and their children.[9]

9 This is in contrast to the 10 cases of maternal filicide-suicide, where no attempt was made on the life of the husband or another family member.

Investigative challenges

Of the four offender categories discussed in this paper, filicides committed in the context of a mental illness are perhaps the least difficult to investigate. The 'intentional' nature of these killings means that mentally ill filicide offenders rarely attempt to conceal their crimes. Further, the often violent method of killing is likely to leave forensic evidence that aids the investigation.

Interviewing techniques

Interviewing filicide offenders who are suspected of being mentally ill can be challenging. In discussing their offences, the mentally ill filicide offenders in Stanton and Simpson's 2006 study described having only hazy memories of the offence. Furthermore, the women did not use the first person (for example, 'I killed') to describe the events. Although they disassociated themselves from the crime, an intensity of regret was often present. Mental health problems often intensify after the offences, as 'having to live with having killed one's own child is a considerable burden, particularly for someone already struggling with a major mental illness' (Stanton, Simpson & Wouldes 2000, p. 1458). The research literature does not offer techniques for overcoming problems associated with interviewing mentally ill offenders; however, this is commonly mitigated by the forensic evidence and the offender's lack of attempt to conceal the crime.

Filicide in the context of fatal child abuse

Filicides that occur in the context of fatal child abuse can result from an isolated event or cumulative child abuse or neglect. Often there is no intent to kill, although offenders — usually acting impulsively — intend to inflict harm on the child. Establishing a cause of death consistent with fatal child abuse is often difficult in cases of shaken baby syndrome (SBS) and homicide disguised as sudden infant death syndrome (SIDS).

Offender characteristics

Although fatal child abuse can be the result of an isolated event, studies have revealed that it is more likely to occur after recurrent child abuse. In instances of maternal filicide, Bourget, Grace and Whitehurst (2007) reveal that half of all fatally abused children have been victims of prior child abuse. A history of child abuse is even more prominent in instances of paternal filicide. In Cavanagh, Dobash and Dobash's 2007 study, 25 of the 26 children who fell victim to fatal child abuse had previously been physically assaulted by their father.

To understand fatal child abuse requires an understanding of child abuse in general (Stanton, Simpson & Wouldes 2000). These filicide offenders often report being raised in environments characterised by abuse and criminal activity

(Koenen & Thompson 2008). An intergenerational transmission of abuse may result in the projection of this abuse onto their children. In the context of paternal filicide, domestic abuse against the perpetrator's intimate partner is also commonly reported (Cavanagh, Dobash & Dobash 2007). Although there may be some psychiatric problems associated with these offenders (such as personality disorders), these are not the main indicators of filicide in the context of fatal child abuse (Bourget, Grace & Whitehurst 2007; D'Orban 1979).

The relationships between the offender and the child, and the offender and his intimate partner, are significant predictors of fatal child abuse. In the 2007 study by Cavanagh, Dobash and Dobash, nearly two-thirds of the 26 victims were stepchildren rather than birth children, and the great majority (81%) of offenders were fathers who were cohabiting with the birth mother rather than being married to her.

Motive for the offence

Death resulting from child abuse is usually the result of an impulsive act characterised by loss of temper (Stanton, Simpson & Wouldes 2000). Typically, the impulsive act stems from an intolerance of aspects of the child's behaviour, such as crying. In studying paternal filicide, Cavanagh, Dobash and Dobash (2007) suggested that, although fatal child abuse may not involve an intention to kill, there is usually an intention to harm the child. These fathers often use harsh and punitive disciplinary measures to punish child behaviour regarded as annoying or disobedient.

Nature of the offence

Though child abuse deaths may result from various forms of parental action or inaction, the most likely cause of death is head trauma (for example, from shaking, falling onto a hard surface or blunt force trauma) (Christian & Block 2009; Jenny & Issac 2006). The review of fatal child abuse by Showers et al. (1985) found that two-thirds of the autopsied children (n = 66) died as a result of severe head injuries.

Investigative challenges

Establishing a cause of death associated with fatal child abuse is often difficult. In the study by Showers et al. (1985), 33 of the 72 victims evidenced no external manifestation of abuse or neglect.[10] Although this study is over 25 years old and advances in forensic pathology have been made since that time, difficulties in determining the cause of death in cases of fatal child abuse remain a prominent obstacle.

In order for the cause of death to be attributed to assault or child maltreatment, the doctor or coroner must provide that as the underlying cause of death on the child's death certificate. If there is any uncertainty about the cause of death, then it is likely to be assigned to an 'accidental cause'.[11] It has been suggested that this process contributes to the underestimation of child maltreatment fatalities in Australia (Australian Institute of Family Studies 2012).

Shaken baby syndrome

The most common cause of death resulting from child abuse is shaken baby syndrome (SBS) (Blumenthal 2002). Generally speaking, SBS is diagnosed in infants 12 months or younger, with the peak age of victimisation being 10–16 weeks (Squier 2011). Traditionally, SBS is characterised by a triad of pathological findings: retinal haemorrhage, subdural haematomas and encephalopathy (Jacques & Harding 2008 — see the text box below for definitions of these terms). In practical terms, the triad implies that, although any one of these symptoms in isolation could be attributed to another cause, a combination of the three usually only results from SBS.

Forensic pathology definitions

Retinal haemorrhage: characterised by bleeding in the retina of the eye from a ruptured blood vessel.

Subdural haematomas: characterised by a collection of blood between the outermost membrane of the brain (the dura mater) and the middle layer (the arachnoid).

Encephalopathy: characterised by swelling of the brain.

However, recent studies have cast doubts on this triad, with findings suggesting that retinal haemorrhages and subdural haematomas are not always diagnostic of SBS (Gabaeff 2011). For example, a child may have pre-existing disorders that can cause subdural haematomas, including certain infections, clotting disorders and coagulopathy (a disease that affects the coagulation of blood) (Gena 2007). The recent Queensland Supreme Court of Appeal case *R v. Mark Albert Shoesmith* — see the text box on page 9 — discusses some of the challenges presented by SBS.

10 These deaths were reported for investigation solely because either the injuries were incompatible with the history given or the death was unexplained.

11 According to the requirements of the World Health Organisation's International Classification of Diseases — 10th Revision (ICD-10).

Sudden infant death syndrome

Establishing a cause of death that is consistent with homicide is further complicated in cases where the death may be attributable to sudden infant death sydrome (SIDS).[12] The current accepted definition of SIDS, as developed at the 2004 SIDS Redefinition Conference, is:

> The sudden and unexpected death of an infant under 1 year of age, with onset of the lethal episode apparently occurring during sleep, that remains unexplained after a thorough investigation including performance of a complete autopsy, and review of the circumstances of death and the clinical history. (SIDS and Kids, 2004)

The absence of autopsy findings relating to another cause of death raises the possibility of homicide disguised as SIDS (Levene & Bacon 2004). The most common problem lies in differentiating SIDS from suffocation. As the signs of suffocation and SIDS are usually nonexistent, in most cases it is impossible to make a distinction on purely pathological grounds (Saukko & Knight 2004). Thus a multidisciplinary approach is necessary in cases of suspected homicide where an absence of pathological findings would allow for the explanation of SIDS. Determining the cause of death is likely to depend on information gathered throughout the investigation by other means (such as interviews with the suspect, and surveillance footage).

Interviewing techniques

In cases of both SBS and homicide disguised as SIDS, a typical explanation given by the mother or father will be that the baby was 'fine' up until its death. In cases of SIDS — actual or asserted — an apparently healthy infant is put down for sleep, and some time later the baby is found dead (Giardino & Giardino 2009). In cases of SBS, the suspect may suggest that the healthy infant unexpectedly went into respiratory arrest or began having seizures (Parrish 2002). Another common claim of suspected SBS offenders is that the child fell off the couch, chair, changing table or bed, or down the stairs (Parrish 2002). In light of the previously mentioned pathological uncertainties, investigators may not be able to refute such claims based on forensic evidence. Consequently, investigators may have to rely on specialised interviewing techniques.

A number of publications[13] written by Craig Smith (a now-retired Canadian police officer) provide invaluable guidance for investigating SBS and child abuse. Smith (2010) offers many recommendations, some of which are listed below:

Encourage a free account: The interviewer should ask the suspect to tell them everything that happened. Often, the caregiver will provide an implausible explanation for the child's injuries. This explanation should not be disputed; rather, the interviewer should maintain an empathetic and non-accusatory manner, and work towards obtaining a detailed account of the suspect's version of events. This could be vital if this version of events is later to be discredited.

Establish 'exclusive opportunity': The interviewer should seek to establish whether or not the suspect was alone with the child at the time of the injury. If the suspect was alone with the child, this is known as 'exclusive opportunity' and may later prove to be vital circumstantial evidence.

Establish a timeline of events: Questioning should determine who first noticed that the child was injured, not breathing or dead, and who directed that the child be taken to a medical facility. It is quite common for child abusers to call friends or relatives before alerting the authorities.

Avoid 'tunnel vision': Although the initial evidence may point to a 'main suspect', it is important not to have 'tunnel vision'. The names of all people who had contact with the infant around the time of the death should be obtained and their involvement in the death should be assessed independently.

12 Sudden unexpected death in infancy (SUDI) is another commonly used term for SIDS.

13 *Guidelines for child abuse investigations* (1999), *Multidisciplinary guidelines on the identification, investigation and management of suspected shaken baby syndrome* (2004) and *Shaken baby syndrome: an investigator's manual* (2010).

R v. Mark Albert Shoesmith [2011] QCA 352

Mr Shoesmith was convicted of the manslaughter of Rose Marie Williams, the 14-week-old daughter of his girlfriend. The Crown case (as accepted by the jury) was that Rose's death was caused by shaking. Mr Shoesmith's version of events was that, two days before Rose's death, she fell off the bed and landed on concrete.

Dr Sive, a paediatrician, was of the opinion that the fall did not match the child's injuries. Dr Gole, a paediatric ophthalmologist, reviewed the retinal scans that had been taken of the baby's left eye. He said that the scans revealed retinal haemorrhages and a fold in the retina. Dr Gole said that there were a large number of causes of retinal haemorrhages 'but by far the commonest cause of extensive retinal haemorrhages which go from side to side inside the eye' is shaking [at 19].

The defence case centred on the contrary expert evidence provided by Professor Hilton. The absence of other injuries associated with that 'syndrome' persuaded Professor Hilton that the baby was not the subject of 'baby shake'. He also gave evidence that there were many theories about the cause of retinal haemorrhage. Extensive shaking of an infant can cause it, but the presence of any one of the 'triad' of retinal haemorrhage, bleeding over the surface of the brain, and a sudden collapse in brain function did not mean that the infant had been shaken. In Professor Hilton's opinion, retinal haemorrhage was not a sign necessarily of an abused child.

Dr Sive agreed that the exact science as to the cause of retinal haemorrhages had not been determined, and that there was now more reason to look for causes of retinal haemorrhages other than 'baby shake' than was the case 10 years ago.

Mr Shoesmith appealed his conviction on the grounds that the verdict was unreasonable (unsafe and unsatisfactory) having regards to all the evidence.[14] However, the appeal was dismissed on these grounds: 'Since there was acceptable evidence that the baby suffered the fatal injury whilst in the appellant's sole care, it was reasonably open to the jury to find that the Crown had proved beyond reasonable doubt that the appellant caused the baby's injuries by a conscious and willed act and that the baby's death was not the result of an accident' [at 43].

14 Section 668E (1) of the Criminal Code.

Filicide in the context of Munchausen syndrome by proxy

Munchausen syndrome by proxy (MSBP) and factitious disorder imposed on another are terms used to describe a behaviour pattern in which a caregiver deliberately exaggerates, fabricates and/or induces health problems of people in their care. These offenders are usually the child's primary caregiver and if death does occur it is likely to be a result of either poisoning or suffocation. The offender is likely to deny the offence, even in the face of overwhelming evidence, and engage in blame-shifting.

Offender characteristics

Munchausen syndrome by proxy (MSBP) is a term used to describe a behaviour pattern in which a caregiver deliberately exaggerates, fabricates and/or induces physical, psychological, behavioural and/or mental health problems in those who are in their care (Stirling 2007). MSBP is not recognised by the Diagnostic and Statistical Manual of Mental Disorders (DSM), which lists clinically diagnosable disorders. However, the synonymous term 'factitious disorder imposed on another' has been included in the DSM-5 (see Appendix A).[15]

The literature suggests that MSBP is best thought of not as a diagnosis but as a form of abuse. It is not something that someone has, but what someone does (Langer 2009). As it is a pattern of behaviour, MSBP is a determination to be made over time, rather than on the basis of a single occurrence (Chiczewski & Kelly 2003).

Caregivers who fabricate or induce illness in their children:

- are usually the child's primary caregiver (Fish, Bromfield & Higgins 2005); a recent review of the literature conducted by Lazenbatt (2013) revealed the mother to be the perpetrator in 93 per cent of cases
- often present initially as 'good carers' (Langer 2009)
- may have a history of self-induced symptoms and illness exaggeration or falsification; individuals may cross over from self-induced injury to the abuse of an unsuspecting child (Artingstall 1995)
- may have a background in the heath profession or an unusual degree of knowledge about health; for example, just over a quarter of the perpetrators in Rosenberg's 1987 study had some form of training in nursing
- may have a history of abuse in their background, although it is important to keep in mind that this information may also be fabricated by the caregiver (Langer 2009).

15 Throughout this paper, the term 'MSBP' is used as this is commonly referred to in the research literature.

The New South Wales Supreme Court case of *R v. Wilson* (see the text box below) highlights some of these common characteristics of MSBP.

R v. Wilson [2003] NSWSC 1257

On 28 October 2003, Linda Wilson was sentenced for the manslaughter of her foster son Jayden March, who was nearly two years old at the time of his death. On several occasions before Jayden's death, Ms Wilson took him to a doctor and presented him with a history of diarrhoea and vomiting. This was something of a puzzle to the doctors, who could not find anything wrong with him, other than on one occasion where he was dehydrated.

According to Ms Wilson, on the day of Jayden's death he was having trouble breathing. Concerned that she could not wake him, she rang her husband (after 30 minutes had passed) and he suggested that the child be taken to the doctor immediately. Ms Wilson then took Jayden to the local doctor, who determined that death had already occurred. A post-mortem examination revealed injuries related to the scalp, the brain and the eyes, as well as to the abdominal area and genital area.

One of the doctors who reviewed Jayden's case was of the view that the offender's condition was 'so extreme, that she subjected Jayden to repeated assaults, and that she presented him, on all those occasions to the doctors and to the hospital, as part of Munchausen's by proxy syndrome' [at 59].

Furthermore, characteristic of MSBP, the offender's psychiatrist revealed that Ms Wilson had described an exaggerated history of multiple rapes and sexual abuse during her childhood, and since, and of other abuse on the part of family members and other people. In determining the sentence to be imposed, the judge made the following comment on the victim's vulnerability: 'the deceased was extremely vulnerable, due to his age, size and lack of ability to communicate with other people who may have been in a position to assist him' [at 35].

Motive for the offence

Caregivers who fabricate or induce illness in children often seek attention through a gross distortion of their role as a 'good mother' (Langer 2009).

Nature of the offence

In extreme cases, MSBP may result in the death of a child. Rosenberg (1987), in reviewing 117 MSBP cases from the existing literature, found a 9 per cent mortality rate (n = 10). The most prevalent known methods of killing by MSBP offenders are suffocation and poisoning (Artingstall 1998; Bartsch et al. 2003). A range of substances are used to poison, including ipecac (used to induce vomiting), salt, insulin, alcohol, laxatives and various prescription medications (Criddle 2010).

Investigative challenges

The forensic challenges associated with suffocation have already been discussed in relation to neonaticide and fatal child abuse. However, if suffocation is inflicted by MSBP offenders, it will most often present as apnoea (temporary or permanent suspension of breathing). Offenders may have previously requested an apnoea monitor for their child (Artingstall 1998). In cases of suspected poisoning, detailed toxicological investigations in a specialised (forensic) laboratory are paramount (Vennemann et al. 2005).

Interviewing techniques

Historically, interviews of known or suspected MSBP offenders have failed to gain admissions of guilt (Artingstall 1998). These offenders continuously deny what they have done even in the face of overwhelming evidence against them. For example, offenders may continue to justify their actions despite being shown covert video surveillance of their crime (Southall et al. 1997). Despite decades of research on profiling MSBP offenders, it is still unclear whether denial is an assertion of innocence or an apparent symptom of the syndrome. Either way, these offenders are accomplished liars and manipulators, especially if there is a long-term pattern of behaviour (Fish, Bromfield & Higgins 2005).

Much of the research literature on the investigation of offences committed in the context of MSBP comes from Kathryn Artingstall, a police officer and certified MSBP court expert in Florida. Her publications, among others, provide the following suggestions for interviewing MSBP suspects:

Segregate other family members from the suspect: This is important because relatives may voice support and belief in the allegations if the suspect is present. In cases where there are obvious inconsistencies, family members may view facts differently when questioned separately from the suspect (Artingstall 1995).

Do not express disbelief in the suspect's account of events: Interviewers should convey to the suspect that they are keeping an open mind about the case (Artingstall 1995). This allows the interviewer to establish the relevant facts, even if these 'facts' later prove to be false.

Expect blame-shifting: The suspect is likely to deflect attention from their own behaviour by accusing those who are aware of their behaviour, such as medical professionals or family members (Langer 2009).

Expect to elicit intense emotional responses: During interviews, suspects will commonly cry or appear angry. The exhibition of these emotions, while appearing genuine, is often a calculated mechanism to escape lines of questioning that may expose the suspect to criminal charges (Artingstall 1998).

Be aware of the tendency to retreat: Often, just as the interviewer comes close to gaining an admission of guilt from the suspect, the suspect will retreat (for example, by refusing to answer any further questions). The interviewer should maintain their composure at this point and attempt to hide any frustration. In this situation, Artingstall (1998) suggests that the interviewer momentarily deviate from their line of questioning and later revisit the issue in another way.

Admission of guilt may shock the offender: In the event that the interviewer obtains an admission of guilt, it is important to realise that this admission may come as a shock to the offender themselves. After repeated denials, offenders may struggle to cope with the gravity of their crime and suicidal thoughts may emerge (Artingstall 1998).

Prosecutorial challenges

Once a decision to prosecute has been made, child homicide offenders are charged with either murder or manslaughter. Proving the guilt of the accused, beyond reasonable doubt, is often difficult because of a lack of direct evidence. As a result, the prosecution will often seek to rely on circumstantial evidence; in this case, however, strict admissibility rules must be overcome. Even if all elements of the offence are proven, defences of insanity, automatism and diminished responsibility may limit the offender's criminal responsibility.

Treatment of child homicide in law

'Child homicide' is not an offence under the Criminal Code. In order to gain a conviction, prosecutors must successfully establish the elements of murder or manslaughter.[16] Although this is the preferred method of conviction throughout Australia, criminal law legislation in some jurisdictions contains a specific criminal offence relating to child homicide, known as 'infanticide'. Generally speaking, a woman may be convicted of 'infanticide' when she kills her child while suffering from a mental disturbance, by reason of not having fully recovered from the effect of giving birth to the child. In most jurisdictions, the infanticide provision is restricted to child victims 12 months and under (New South Wales, Tasmania and the United Kingdom), but in New Zealand it extends to victims under the age of 10.[17] In all of these jurisdictions, the offender must be the victim's birth mother for the infanticide offence to apply.

Infanticide provisions were originally introduced in response to the resistance of police prosecutors to charge, and juries to convict, filicide and neonaticide offenders of murder. The introduction of the new provisions was in recognition of the particular experiences and difficulties women commonly face after childbirth and in child-raising (New South Wales Law Reform Commission 1997). However, there are fundamental flaws relating to both the operation and the underlying rationale of infanticide offences:

- There is a gender bias in the operation of these provisions as they only apply to mothers who kill their children. A father who kills his child cannot be charged with 'infanticide'. Instead he will be charged with murder, and must rely on establishing mitigating circumstances to reduce the charge to manslaughter, a process that is automatic for an offence of infanticide.
- The infanticide provisions limit themselves to mothers suffering from mental disturbances. As has already been revealed by the literature, mental illness is only one factor associated with maternal filicide offenders. Furthermore, if a mental illness is present, it cannot always be attributed to 'the effect of giving birth to the child'. As previously explained, offenders can suffer from a range of mental illnesses and these often cannot be attributed to a single cause (such as childbirth).
- The restriction of the offence to child victims younger than 12 months (other than in New Zealand) is not supported by the literature. As previously discussed in this paper, mothers with a mental illness are more likely to kill older children.

These criticisms led to the abolition of the infanticide provision in Western Australia and pressure for its removal in New South Wales. As discussed in the New South Wales Law Reform Commission's 1997 review of infanticide, the abolition of the infanticide provision would not disadvantage those offenders affected by a mental illness because of the current operation of the defences of insanity and diminished responsibility in Australia. This is the case in Queensland, and operation of the defences of automatism, insanity and diminished responsibility is discussed later (see page 13).

Fitness to stand trial

Before there can be any inquiry into criminal responsibility, an accused must be deemed mentally fit to stand trial. In Queensland, s. 613 of the Criminal Code provides for a separate trial to determine whether, for any reason, the accused is incapable of understanding the proceedings so as to be unable to make a proper defence. If the reason for a finding of incapacity is 'unsoundness of mind', there is a special verdict to this effect. The offender is dealt with under the relevant provisions of the *Mental Health Act 2000* (Qld).

16 Relevant provisions of the Criminal Code are extracted in Appendix B.
17 Section 22A *Crimes Act 1900* (NSW), s. 165A *Criminal Code Act 1924* (Tas), *Infanticide Act 1938* (UK), s. 178 *Crimes Act 1961* (NZ).

Evidentiary issues

At trial, the prosecution must prove the guilt of the accused, beyond reasonable doubt. Although each case of child homicide presents unique evidentiary issues, two prominent Australian criminal cases — *R v. Kathleen Megan Folbigg*[18] and *R v. LM*[19] (see the text boxes on pages 12 and 13) — highlight the general evidentiary challenges.

Circumstantial evidence — propensity evidence

For circumstantial evidence to be admissible, it must render a fact in issue more or less probable.[20] The category of circumstantial evidence that is most problematic in child homicide prosecutions is propensity evidence.

The prosecution will often seek to adduce propensity evidence to demonstrate that the accused was disposed to behaving in a certain way. Propensity evidence is generally not admissible as it is presumed to be highly prejudicial.[21] It undermines the presumption of innocence and has the potential to create undue suspicion and bias against the accused.[22] However, exceptions to the general rule do exist. Similar fact evidence is often regarded as one of these exceptions. Similar fact evidence is a form of propensity evidence which shows that, on another occasion, the accused acted in a particular way in a particular situation, which is tendered to prove that the accused acted a similar way on the occasion in question (Harris 1995). For example, in a case of multiple homicides, a prosecution may try to lead evidence of other prior deaths to rule out a defence that the subject death was caused by accident.[23]

The common law test for the admissibility of propensity evidence was established by the High Court of Australia in *Pfennig v. The Queen*.[24] Propensity evidence must be highly relevant and probative — it is only to be admitted if the trial judge is satisfied that there is no rational view of such evidence which is consistent with innocence. Some Australian jurisdictions have enacted specific legislative provisions relating to propensity evidence.[25] In those jurisdictions, the terms 'propensity evidence' and 'similar fact evidence' were abandoned in favour of the terms 'tendency evidence' and 'coincidence evidence'. Notwithstanding this, the courts in these jurisdictions have made it clear that the test established in *Pfennig* still applies.

While retaining the terms 'propensity evidence' and 'similar fact' evidence, Queensland has modified the common law in some respects. The relevant change for this discussion is section 132B of the *Evidence Act 1977* (Qld), which allows evidence of the history of the domestic relationship between the victim and the defendant to be admitted in certain prosecutions, including prosecutions for homicide. This could allow evidence of prior acts of violence against an infant to be admissible at a prosecution for the child's murder or manslaughter by another family member. The trial judge would be required to give the jury clear directions as to what inferences they are allowed to draw from the evidence, so that they did not engage in propensity reasoning such as 'They did it before, so they have done it this time'.

The case of *R v. Kathleen Megan Folbigg* (see the following text box) is an example of how the rules of evidence regarding propensity may be applied in a case of multiple child homicides.

R v. Kathleen Megan Folbigg [2003] NSWCCA 17

Kathleen Folbigg was charged with (and later convicted of) the murder of her four infant children (Caleb, Sarah, Lauren and Patrick). In this appeal, the defence argued that the primary judge had erred in allowing evidence relating to the death of each child to be heard together.

Caleb's and Sarah's deaths were originally attributed to SIDS, Patrick's was attributed to 'asphyxia due to epileptic fits' and Laura's cause of death could not be determined, but SIDS was specifically ruled out (mainly because of the age of the child, which was 19 months). The prosecution relied on the principle of coincidence evidence:[26] 'evidence that two or more related events occurred to prove that, because the improbability of events occurring coincidentally, a person did a particular act or had a particular state of mind' [at 10].

The Crown alleged that the coincidence evidence established:

- that each of the four children had died in a similar way
- that each of the four children had died from the same cause
- that the accused killed each of the four children by asphyxiating them
- that the four children did not die from SIDS or any other illness, disease or syndrome.

The material relied upon by the Crown as coincidence evidence related to similarities in the circumstances concerning the death of each child (set out in paragraph 62). The primary judge applied the *Pfennig* test in ruling that the evidence was admissible, with the Court of Appeal agreeing. Hodgson JA further commented that the 'probative value of the evidence is such that it does substantially outweigh any prejudicial effect' [at 33].

18 [2003] NSWCCA 17.
19 [2004] QCA 192.
20 *Wilson v. The Queen* (1970) 123 CLR 334.
21 *Makin v. Attorney-General* [1984] AC 57.
22 *Pfennig v. The Queen* (1995) 182 CLR 461.
23 *R v. Smith* (1915) 11 Cr App R 22.
24 (1995) 182 CLR 461.
25 The *Evidence Act 1995* (Cwlth and NSW), *2001* (Tas), *2008* (Vic) and *2011* (ACT), and the *Evidence (NUL) Act 2011* (NT).
26 A term used in New South Wales to describe 'similar fact evidence'.

Opinion evidence

The admissibility of expert evidence is a departure from the general rule that 'a witness is generally prevented from testifying as to opinion, only the facts' (Waight & Williams 2006, p. 539). In determining the admissibility of expert evidence, it is important to establish whether or not expert opinion is required.[27] For reasons outlined in *R v. LM* (see the text box below), expert psychiatric opinion evidence on MSBP is not admissible in Queensland.[28]

R v. LM [2004] QCA 192

The appellant, LM, was convicted of a number of charges relating to the torture and unlawful wounding of her four children.[29] One of the grounds for appeal in this case was that the trial judge erred in allowing the prosecution to adduce evidence of factitious disorder (Munchausen's syndrome) by proxy.

The Court of Appeal provided that the evidence was only admissible if it was relevant as expert psychiatric evidence. The Court of Appeal held [at 67]: 'A close examination of Dr Reddan's evidence as to the medical term, factitious disorder (Munchausen's syndrome) by proxy, used to describe people exhibiting behaviour like that alleged by the prosecution to have been exhibited by the appellant here, demonstrates that it does not relate to matters outside the sound judgment of a reasonable juror without any particular special knowledge or experience. Ordinary people are capable of understanding that some mothers may harm their children through deceitfully manipulating unnecessary medical treatment. As the term factitious disorder (Munchausen's syndrome) by proxy is merely descriptive of a behaviour, not a psychiatrically identifiable illness or condition, it does not relate to an organised or recognised reliable body of knowledge or experience.'

Possible criminal defences for child homicide

Criminal defences likely to be raised in the context of neonaticide and filicide are automatism, insanity and diminished responsibility.

Automatism

One of the fundamental principles of criminal law is that an accused is not criminally responsible for an act unless it is performed voluntarily.[30] Automatism 'is a term most often used to refer to involuntary conduct in the sense of it being conduct performed in a state of impaired consciousness' (Colvin, Linden & McKechnie 2005, p. 374). The defence's first option is likely to be automatism based on the following two principles (Carter 2013):

- the onus of proof rests with the prosecution to prove beyond reasonable doubt that an accused's conduct was voluntary, and
- if an accused is acquitted on the basis of 'sane' automatism, he or she is entitled to a complete acquittal.

Insanity

Once the accused's state of mind has been put at issue (for example, in the defence's argument for automatism), either party can raise the defence of insanity.[31] If the prosecution is in a position where they cannot prove beyond reasonable doubt that the accused's conduct was voluntary, they are likely to suggest that the accused was insane, under the meaning of section 27(1) of the Criminal Code. Evidence led by the defence to argue automatism may then be used by the prosecution, who will argue that the evidence suggests that the accused was suffering from a 'mental disease or natural mental infirmity'.

A finding of insanity results in an acquittal on the grounds of unsoundness of mind and the offender is dealt with pursuant to the *Mental Health Act 2000* (Qld). Although standard criminal sanctions do not apply, the offender can be detained indefinitely, subject to periodic review (Colvin, Linden & McKechnie 2005). This is a preferable outcome for the Crown, when contrasted with acquittal on the grounds of automatism.

Diminished responsibility

As set out in s. 304A of the Criminal Code, for the defence of diminished responsibility to be successful, the accused must have been suffering a 'state of abnormality of mind' that substantially deprived them of one of the following capacities:

- the capacity to understand what he or she was doing
- the capacity to control his or her actions, or
- the capacity to know that he or she ought not to do the act or make the omission.

These three capacities are also relevant to the law of insanity, but for the insanity defence to be successful there must be total deprivation (rather than substantial deprivation) of one of these capacities.

27 See Waight and Williams (2006) for an in-depth discussion of the admissibility of expert evidence.

28 It remains to be seen whether the inclusion of the term 'factitious disorder imposed on another' in the DSM-5 will impact on the admissibility of MSBP opinion evidence in Queensland (or other Australian jurisdictions).

29 This is not a case of child homicide, but it has relevant implications for the admissibility of expert evidence in relation to MSBP.

30 Section 23(1)(a) Criminal Code — see Appendix B.

31 *Bratty v. Attorney General for Northern Ireland* [1961] 3 All ER 523. This case has since been applied by the High Court of Australia in *R v. Falconer* (1990) 96 ALR 545.

Crime prevention opportunities

The prevention of the range of child homicides discussed in this paper is most likely to be achieved through the education of child protection and health care workers and early identification and treatment of mental illnesses. We also outline a number of general crime prevention interventions, such as safe haven laws and anonymous adoption laws, as suggested by the research literature.

Neonaticide

As previously discussed, neonaticide offenders are typically young women who fail to cope with the discovery of an unwanted pregnancy. In light of these offender characteristics, the following prevention opportunities have been offered in the literature on the subject.[32] It should be noted that the effectiveness of these interventions has not been established.

Access to sex education and contraception: Increased access to sex education and contraception for young women could help to decrease unwanted pregnancies and the subsequent act of neonaticide.

Legalisation of abortion: Resnick (1970, as cited in Pitt & Bale 1995) was one of the first researchers to theorise that increased access to abortion, while not an ideal solution, would offer women a more humane alternative than killing their newborn. The relationship between access to abortion and the rate of neonaticide is unclear because of mixed research findings.

Safe haven laws: First introduced in the United States in 1999, safe havens provide a means by which women can safely, anonymously and legally relinquish their newborn babies. Some evidence suggests that safe havens are associated with reductions in infant abandonment rates. Safe haven laws are now operational in nearly all American states (Hatters Freidman & Resnick 2004).

Anonymous adoption: Anonymous birth laws permit mothers to place their children while remaining anonymous. A recent study by Klier et al. (2013) reported a decrease in the number of police-reported neonaticides in Austria after the implementation of anonymous delivery.

Filicide in the context of mental illness

Early identification and treatment of mental illness, both before and after the birth of a child, are important for the prevention of filicides committed in the context of a mental illness (Hatters Freidman & Resnick 2004). Little is known about the prevention of paternal filicide committed in the context of a mental illness. Perhaps the greatest obstacle to prevention in relation to paternal filicide offenders is the absence of medical history pointing to the existence of a mental illness before the offence.

Filicide in the context of fatal child abuse or MSBP

In relation to fatal child abuse and MSBP offenders, the most important prevention opportunity lies in establishing the pattern of abuse. Where MSBP is suspected, a history of child hospitalisation or surgeries may act as a warning sign (Chiczewski & Kelly 2003). In cases of ongoing child abuse, prevention opportunities often rest with the ability of child protection agencies to remove these children from danger.

It is essential that professionals who come into contact with children understand MSBP and the appropriate response when MSBP is suspected. The Department for Children, Schools and Families' *Safeguarding children in whom illness is fabricated or induced* (2008) is a national framework setting out how United Kingdom government agencies and professionals can work together to safeguard children who have been victims of MSBP behaviour. Among other things, the framework sets out what is known about fabricated or induced illnesses, the ways in which it may affect a child's health and how to report suspected cases. A preliminary indication from the CMC crime hearings suggests that a similar framework is needed in Australia.

32 For an in-depth discussion of the neonaticide prevention opportunities identified internationally, see Hatters Friedman & Resnick (2004).

Conclusion

The CMC's new referral enables the CMC's special investigative powers to be used in cases of violent crimes against vulnerable victims who are unborn, younger than 16 years, older than 70 years or physically disabled or mentally impaired. This paper has examined child homicide of vulnerable victims under the age of 16, particularly homicide perpetrated by a parent.

The research literature suggests the following:

- Children are particularly vulnerable because of their dependence on their parents, especially if they live in a familial situation whereby non-biological parents (such as stepparents) are present.
- Neonaticide offenders tend to be the mother of the victim and are motivated to kill because they do not want the child.
- Mentally ill filicide offenders are inclined to be older, to be married and to use more violent methods of killing. In the research literature, mood disorders, schizophrenia and other psychotic disorders are the most commonly described mental illnesses associated with filicide.
- Offenders who kill children in the context of fatal child abuse (for example, cumulative abuse, neglect or Munchausen syndrome by proxy) often do not intend to kill the child; however, there is often intent to inflict harm.
- Offenders displaying behaviour patterns reflective of MSBP tend to be the mother of the victimised child, who seeks attention and induces, exaggerates or fabricates illness in the child over time.

This paper has also explored a number of investigative challenges commonly associated with neonaticide and filicide cases, including difficulties in determining cause of death, absence of pathological signs of trauma, and non-discovery of a child's body. Prosecutorial challenges include fitness to stand trial, evidentiary issues and a number of criminal defences (such as automatism, insanity and diminished responsibility).

Prevention of the range of child homicides discussed in this paper is most likely to be achieved through the education of child protection and health care workers and early identification and treatment of mental illnesses.

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Abbreviations

CMC	Crime and Misconduct Commission
DSM	Diagnostic and Statistical Manual of Mental Disorders
MSBP	Munchausen syndrome by proxy
Qld	Queensland
QPS	Queensland Police Service
SBS	shaken baby syndrome
SIDS	sudden infant death syndrome
SUDI	sudden unexpected death in infancy

Appendix A: Relevant definitions under the DSM-5

Disorder	DSM-5 criteria for diagnosis
Major Depressive Disorder	A. Five (or more) of the following symptoms must have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. 1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation). 3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. 4. Insomnia or hypersomnia nearly every day. 5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down). 6. Fatigue or loss of energy nearly every day. 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick). 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others). 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. C. The episode is not attributable to the physiological effects of a substance or to another medical condition. D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders. E. There has never been a manic episode or a hypomanic episode. A diagnosis based on a single episode is possible, although the disorder is a recurrent one in the majority of cases.
Schizophrenia	A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3): 1. Delusions. 2. Hallucinations. 3. Disorganized speech (e.g., frequent derailment or incoherence). 4. Grossly disorganized or catatonic behaviour. 5. Negative symptoms (i.e., diminished emotional expression or avolition). B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning). C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusually perceptual experiences).

Disorder	DSM-5 criteria for diagnosis
	D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness. E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition. F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated). Differential diagnoses for schizophrenia include (see the DSM-5 for diagnostic criteria): • Major depressive disorder or bipolar disorder with psychotic or catatonic features. • Schizoaffective disorder. • Schizophreniform disorder and brief psychotic disorder. • Delusional disorder. • Schizotypal personality disorder. • Obsessive-compulsive disorder and body dysmorphic disorder. • Posttraumatic stress disorder. • Autism spectrum disorder or communication disorders. • Other mental disorders associated with a psychotic episode.
Factitious Disorder Imposed on Another	A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception. B. The individual presents another individual (victim) to others as ill, impaired or injured. C. The deceptive behaviour is evident even in the absence of obvious external rewards. D. The behaviour is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

Source: American Psychiatric Association 2013, *Diagnostic and statistical manual of mental disorders*, 5th edn, Arlington, Virginia.

Appendix B: Extracts from the Criminal Code (Qld)

s. 292	**When a child becomes a human being** A child becomes a person capable of being killed when it has completely proceeded in a living state from the body of its mother, whether it has breathed or not, and whether it has independent circulation or not, and whether the navel string is severed or not.
s. 293	**Definition of killing** Except as hereinafter set forth, any person who causes the death of another, directly or indirectly, by any means whatever, is deemed to have killed that other person.
s. 294	**Death by acts done at childbirth** When a child dies in consequence of an act done or omitted to be done by any person before or during its birth, the person who did or omitted to do such act is deemed to have killed the child.
s. 300	**Unlawful homicide** Any person who unlawfully kills another is guilty of a crime, which is called murder or manslaughter, according to the circumstances of the case.
s. 302	**Definition of murder** (1) Except as hereinafter set forth, a person who unlawfully kills another under any of the following circumstances, that is to say — (a) if the offender intends to cause the death of the person killed or that of some other person or if the offender intends to do to the person killed or to some other person some grievous bodily harm; (b) if death is caused by means of an act done in the prosecution of an unlawful purpose, which act is of such a nature as to be likely to endanger human life; (c) if the offender intends to do grievous bodily harm to some person for the purpose of facilitating the commission of a crime which is such that the offender may be arrested without warrant, or for the purpose of facilitating the flight of an offender who has committed or attempted to commit any such crime; (d) if death is caused by administering any stupefying or overpowering thing for either of the purposes mentioned in paragraph (c); (e) if death is caused by wilfully stopping the breath of any person for either of such purposes; is guilty of ***murder***. (2) Under subsection (1) (a) it is immaterial that the offender did not intend to hurt the particular person who is killed. (3) Under subsection (1) (b) it is immaterial that the offender did not intend to hurt any person. (4) Under subsection (1) (c) to (e) it is immaterial that the offender did not intend to cause death or did not know that death was likely to result.
s. 303	**Definition of manslaughter** A person who unlawfully kills another under such circumstances as not to constitute murder is guilty of ***manslaughter***.
s. 314	**Concealing the birth of children** Any person who, when a woman is delivered of a child, endeavours, by any secret disposition of the dead body of the child, to conceal the birth, whether the child died before, at, or after, its birth, is guilty of a misdemeanour, and is liable to imprisonment for two years.

s. 27	**Insanity** (1) A person is not criminally responsible for an act or omission if at the time of doing the act or making the omission the person is in such a state of mental disease or natural mental infirmity as to deprive the person of capacity to understand what the person is doing, or of capacity to control the person's actions, or of capacity to know that the person ought not to do the act or make the omission. (2) A person whose mind, at the time of the person's doing or omitting to do an act, is affected by delusions on some specific matter or matters, but who is not otherwise entitled to the benefit of subsection (1), is criminally responsible for the act or omission to the same extent as if the real state of things had been such as the person was induced by the delusions to believe to exist.
s. 304A	**Diminished responsibility** (1) When a person who unlawfully kills another under circumstances which, but for the provisions of this section, would constitute murder, is at the time of doing the act or making the omission which causes death in such a state of abnormality of mind (whether arising from a condition of arrested or retarded development of mind or inherent causes or induced by disease or injury) as substantially to impair the person's capacity to understand what the person is doing, or the person's capacity to control the person's actions, or the person's capacity to know that the person ought not to do the act or make the omission, the person is guilty of manslaughter only. (2) On a charge of murder, it shall be for the defence to prove that the person charged is by virtue of this section liable to be convicted of manslaughter only. (3) When 2 or more persons unlawfully kill another, the fact that 1 of such persons is by virtue of this section guilty of manslaughter only shall not affect the question whether the unlawful killing amounted to murder in the case of any other such person or persons.

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