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A Case of Infanticide

The murder of a child by an adult, especially a parent, is one of the most difficult crimes for the public or a physician to understand. Such murders are usually isolated events committed in the heat of passion or insanity. Rarely, however, one encounters an individual who deliberately and systematically murders children over a long period of time for no logical reason. Here is presented a case of an alleged habitual child murderer whose career apparently spanned 23 years.

Case Reports

Paul W

On 21 Sept. 196-, the Office of the Chief Medical Examiner of Maryland was notified by a Baltimore hospital of the death of a 7-month-old white male known as Paul W. The Medical Examiner's Office was contacted because of a number of unusual circumstances surrounding the illness and death of this child that strongly suggested child abuse.

Investigation of this case brought out the following account of the events leading up to the death. Paul W had been born the previous February to an unwed 13-year-old mother. Her pregnancy was uneventful, except for some hypertension with mild toxemia. The child was born breech and weighed 6 pounds, 9 ounces. From birth until placement for adoption his development was normal with no illnesses. In July, at 5 months of age, he was adopted by Mr. and Mrs. W. Mr. W was a member of the U.S. Army. On August 4 of that year, Paul was brought to an Army hospital emergency room with a history of a possible cyanotic episode occurring while playing with his adopted sister in his crib. This was to be the first of many hospital visits and admissions leading up to his death. On physical examination the child was alert, active, and in no distress. A chest X-ray performed to rule out aspiration of a small object was negative and the child was sent home. Later that same day he was brought back to the hospital with a complaint of two episodes of apnea. He was then admitted. On admission he was pale, cyanotic, and flaccid with a temperature of 98.6°F. He remained in the hospital under observation for three days. During this time the results of a chest X-ray, electrocardiogram, complete blood count, urinalysis, blood sugar, blood calcium, and a lumbar puncture were all within normal limits. He was asymptomatic for his period of hospitalization and was discharged with a final diagnosis of upper respiratory infection.

At 7:30 p.m. the following day, August 8, Paul was readmitted to the Army hospital with the chief complaint of having stopped breathing and having become cyanotic. On admission he was alert and active with a temperature of 98.6°F. Blood urea nitrogen,

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blood calcium, chest and skull X-rays, electrocardiogram, and a urinalysis were all within normal limits. The impressions on admission were "? seizure disorder; ? metabolic disease; hypocalcemia, hypoglycemia; ? breath holding spells; ? birth trauma." The hospital course was uneventful and Paul was discharged four days later on August 12, with the clinical impression of "breath holding."

At 2:00 p.m. the next day, August 13, Paul was admitted for the third time with generalized tonic convulsions. He was treated with paraldehyde and, after a postictal period of five hours, was alert and active with a negative neurological examination. The history given at this time was that he was at home when he suddenly became pale, limp, and stopped breathing. His temperature on admission was 97.8°F. A spinal tap was negative. The following day Paul was transferred to the regional Army hospital for further diagnostic work-up.

Paul was at this hospital for five days. During this time his hospital course was uneventful. A brain scan was negative. An electroencephalogram showed mostly movement artefact; what could be read, however, was normal. Chest and skull X-rays, electrolytes, a VDRL test, and various tests for defects in amino acid metabolism were all normal. The child was felt to have a convulsive disorder of undetermined etiology and was discharged on 10 mg of phenobarbital three times a day.

Less than 24 hours after discharge, Paul was again admitted to the original Army hospital in cardiac and respiratory arrest. He was resuscitated, given intracardiac adrenalin and intravenous nikethamide, and intubated. His respiratory and heart rates became regular but he was unresponsive to painful stimuli. The following day, August 21, he was transferred to a civilian Baltimore hospital. It is of interest that in a narrative summary provided by the Army hospital the following statement appeared: "Worthy of interest is the fact that the baby never presented any difficulty while in the hospital, but always at home and less than 24 hours after discharge."

On admission to the Baltimore hospital the child was comatose and unresponsive. He was noted to have myotic pupils, excessive oropharyngeal secretions, tachycardia, and hypertension. Electrolytes were normal. There was minimal response to pain. The parents denied trauma or any possible ingestion of toxic substance. At this time, however, they stated that "nerve gases" were being tested at the military base they were living on and that the bay adjacent to their home was closed because "all the fish were dying from some chemicals spilled into the bay." The admitting impression was "coma, etiology unknown, with history of repeated respiratory arrest." Blood and urine were obtained for toxicological study. On the second hospital day, the child's hematocrit suddenly decreased to 26 percent and massive melena was noted. The child was transfused multiple times with packed cells over the next 36 h before bleeding subsided. Following the multiple transfusions he developed hypocalcemia, which responded to treatment with calcium gluconate.

Initially, the diagnosis of poisoning by an organophosphate compound was pursued. On the second day of hospitalization the hospital received a report from a toxicological laboratory they used. (This particular laboratory had been found to be of questionable reliability by the Medical Examiner's Office in previous dealings and is no longer used by the Baltimore hospital.) The laboratory stated that there was "something abnormal on thin layer chromatography." On the third hospital day the toxicological laboratory informed the hospital by telephone that it could not conclusively identify the foreign substance in the urine or blood, but it did resemble patterns of diazinon, an organophosphate. In view of the clinical impression held at the time, the child was given atropine (a total of 25 mg) and three courses of pyridrine-2-aldoximine-methiodine (PAM) (60 g/kg) on the third, fourth, and fifth hospital days. A pharmacological response was obtained

with flushing, pupillary dilatation, decrease in secretions, and a marked increase in muscle tone. There was, however, no substantial improvement in the general clinical picture, nor in the patient's level of consciousness.

Because of the possibility of organophosphate poisoning, the hospital had contacted the military base where Paul had lived with his parents and found that the area had been sprayed with Malathion® and Dibrom® in the past. Blood samples were taken from Paul and sent for cholinesterase determinations. Unfortunately, the blood was obtained after the transfusions. Analysis of the posttransfusion blood revealed cholinesterase levels in the serum half the activity of a normal serum control, but red blood cell cholinesterase levels within a normal range. Separation of the red blood cells on the basis of age revealed no difference in the cholinesterase levels.

About the time that treatment with atropine and PAM was completed, the appearance of clonus and hyperreflexia was noted. The child gradually progressed from flaccid coma to spastic coma and finally to frank persistent decerebration. A tracheostomy had to be performed to assist respiration. Serial electroencephalograms were obtained and demonstrated progressive diffuse slowing. The child became febrile and died on September 21, approximately one month after admission.

An autopsy was performed the following day at the Office of the Chief Medical Examiner. The autopsy revealed confluent bronchopneumonia bilaterally with hyaline membranes. Examination of the brain revealed encephalomalacia in the resorptive phase involving both the globus pallida and inferior colliculi. There was sclerosis of the cerebellar cortex, the brain stem, the left Ammon's horn, and the thalamus. All the brain injuries were of the same age and dated back to the time of the cardiorespiratory arrest at the last admission.

Judy W

On September 9, twelve days prior to Paul's death, while he lay in a coma in the hospital, a second adopted child in the custody of Mr. and Mrs. W, named Judy, age 2½ years, was admitted to the Baltimore hospital after sustaining an anoxic episode and becoming cyanotic. This admission with symptoms similar to Paul's caused suspicion to be aroused in the hospital staff. The history obtained from Mrs. W was that Judy developed gasping respirations, appeared blue around the face, and collapsed. Breathing became normal after a minute and the color returned to her face. She remained limp, however, and stayed sleepy for about two hours. The child was taken to the Army hospital where Paul had been originally seen, was examined, and was found to be entirely normal. Judy was then taken to the Baltimore hospital, where she was admitted. On admission, blood was drawn for determination of cholinesterase levels by both an agency of the U.S. Army and the private source previously used by the hospital. On physical examination Judy was an apparently healthy child in no distress. Laboratory tests on blood and urine were uninformative. Toxicological tests performed by the Medical Examiner's laboratory on blood and urine were negative. Insecticides were specifically sought in these tests. Red cell cholinesterase concentrations, as determined by the physician who did these studies on Paul, showed a normal level for the red cell population as a whole and normal levels for the red cells when they had been separated into old and young populations. Blood samples sent to the Army Laboratory to determine cholinesterase levels were reported as normal for both serum and red blood cells.

Three days after Judy's illness began, a preventive medicine officer of the U.S. Army and an experienced epidemiologist visited the W home. No evidence of an organophosphate was found in the house, as well as there being no evidence of any leak

from furnace or gas line. The grounds outside the house were inspected, soil samples were taken, and dead insects searched for and collected. No organophosphate insecticides were detected.

Judy remained in the hospital until September 20. During her hospitalization she had no attacks of apnea or cyanosis and all tests were normal. On September 19, two days prior to Paul's death, due to the suspicious circumstances concerning Paul and Judy's illnesses, Judy was placed under the care of the juvenile court.

In view of Judy's admission with symptoms similar to Paul's and the negative findings during hospitalization, an extensive and thorough review of her background and her relationship to Mrs. W was conducted. While some of this information was available to the medical examiner's office at the time of Paul's death, much of it was collected by the Federal Bureau of Investigation for the U.S. Attorney's Office prior to the trial of Mrs. W.

Judy, like Paul, was an adopted child. At the time of Paul's death she was 2½ years old. She had been born in Denver, Colo., and placed with Mrs. W at three days of age. After adopting Judy, Mrs. W claimed that she began to receive repeated demands over the phone that she give Judy back to her true parents. Subsequent investigations by the adoption agency revealed that the true parents of Judy had moved to another state and were not involved. Mrs. W also claimed that a man and woman came to the door and asked for Judy. In one incident the man supposedly came to the back bedroom window and Mrs. W fired a gun at him but missed. Inflammable fluid was found at the side of the W's house in Colorado and Mrs. W alleged that someone was planning to burn down their house. She also reported a man in a car keeping watch and circling the house. These alleged episodes continued for a number of months. The Criminal Investigation Division (C.I.D.) of the Army investigated these events but could find no definite evidence to substantiate the statements of Mrs. W.

At the age of 5 months Judy was brought to the emergency room of an Army hospital in Colorado, after having allegedly passed out twice that morning. Loss of consciousness was preceded by crying and she appeared limp and blue after. Physical examination was negative and a tentative diagnosis of "severe upper respiratory infection or breath holding" was made. On admission to the hospital she was afebrile, alert, and active. Neurological examination was negative. Blood electrolytes, a blood urea nitrogen, and a white blood cell count were within normal limits. Chest and skull X-rays were negative. Judy was asymptomatic during the six days in the hospital and was discharged with a final diagnosis of "observation medical, ? seizure disorder, no disease found at present." Two days after discharge she had an electroencephalograph done at the Pediatric Clinic. This was reported as "normal sleep record for age."

At the age of 8 months Judy was brought back to the hospital by Mrs. W, who said that the child almost choked on mucus and turned blue. She responded to mouth-to-mouth resuscitation by Mrs. W. A chest X-ray was negative.

Judy was admitted a third time to the Army hospital six days after this episode because of an alleged history of apnea and cyanosis. On admission she had neither dyspnea nor cyanosis. She was kept in the hospital for five days, during which time her course was uneventful. A chest X-ray was negative. She was discharged with a diagnosis of "bronchitis." Because of the alleged threats Mr. and Mrs. W were receiving about Judy, they were given compassionate transfer from Colorado to Maryland. On arrival there, however, the alleged harrassments started again and a second transfer to another base in Maryland was made. Again, as in Colorado, investigation by the C.I.D. could not substantiate the alleged harrassment.

In February of the year Paul died, Judy was brought to the outpatient clinic at the Army hospital in Maryland where Mrs. W stated that Judy had passed out, vomited a lot of phlegm, and had had cyanosis around the mouth. A diagnosis of upper respiratory

infection was made by the clinicians at this time. In the 3½ years since Judy has been out of Mrs. W's care and in the custody of a foster parent, she has never had any episode of respiratory distress, cyanosis, or passing out.

The Other Children

As the investigation of Paul's death progressed, additional information concerning Mrs. W's relationship with the deaths of other children became available. By the time of the trial she was linked to six other deaths. The first child to die under her care was Charles S, her first natural child, born out of wedlock in 1946. Birth weight was 5 pounds, 8 ounces. At one month of age, he was admitted to an Ohio hospital with the chief complaint of having stopped breathing and turned blue while being held by Mrs. W. There was no preceding history of upper respiratory infection. On admission the child appeared well developed but poorly nourished, with a weight of 5 pounds, 3 ounces. The admitting diagnosis was "malnutrition." During the seven days in the hospital his course was uneventful with the child gaining 6 ounces. A physical examination was basically unremarkable. No cardiac murmurs were heard. A white cell count and urinalysis were negative. Two days after his discharge from the hospital the child died at home after an alleged episode of coughing, choking, and cyanosis. The child was not autopsied. The cause of death was listed on the death certificate as "enlarged thymus" and "status lymphaticus"—the former a normal finding in infants and the latter a nonexistent entity.

The second child was Mary H, Mrs. W's second natural child, born in 1950. The father, Mr. H, Mrs. W's first husband, was not the same as that of the first child. Because she was premature (birth weight 4 pounds, 11 ounces) she remained in the hospital for three weeks. At one month of age Mary was admitted to an Ohio hospital with the chief complaint of having stopped breathing and having turned blue. There was a questionable history of a convulsion. On physical examination the child was afebrile. There were no cardiac murmurs. Small white areas consisting of blebs of whitish, curdlike material were present in the mouth and on the tongue. The admitting impression was "thrush—possible aspiration." The two-day hospital course was uneventful. Final diagnosis was "dermatitis, stomatitis, monilial." Eight days later the child was admitted a second time for cyanosis. A history of a cyanotic episode with clonus four days prior to admission and an upper respiratory infection two days prior to admission was obtained. On the day of the second admission Mary H became apneic and cyanotic while alone with Mrs. W. The child allegedly responded to mouth-to-mouth resuscitation by Mrs. W. On admission to the hospital, the child had a mottled skin and a faint cry. Respiration was irregular; the heart rate was fast to slow. No murmurs were heard. The admitting diagnosis was "upper respiratory infection, rule out central nervous system and congenital diseases." During the three days of hospitalization the course was uneventful. A chest X-ray and subdural taps were negative, as were a white blood cell count, urinalysis, and lumbar puncture. The final diagnosis was "upper respiratory infection, acute; observation for convulsions." On August 21, Mary H suffered two cyanotic episodes. During the first attack she allegedly responded to mouth-to-mouth resuscitation given by Mrs. W. She was taken to the emergency room where she appeared well and was released. Her second attack occurred later that day while in Mrs. W's arms. At this time the child was dead on arrival at the emergency room. No autopsy was performed. The cause of death was listed as "asphyxia, due to a mucus plug" and "patent foramen ovale." The child was just short of two months of age at the time of her death.

Mrs. W's third child, Carol H, born in 1952, was three months and twenty-one days of

age at her death. On the day of her demise she allegedly had difficulty breathing, choked, and became cyanotic. Mrs. W allegedly attempted mouth-to-mouth resuscitation. The cause of death was listed as "epiglossitis" and "bronchopneumonia." When contacted in early 1972, the physician who signed the death certificate stated that his diagnoses were based merely on what Mrs. W told him regarding Carol's symptoms. He himself observed nothing which would have enabled him to make these diagnoses. No autopsy was performed.

The fourth child to die in association with Mrs. W was a nephew, John, age 3 years. John died in the defendant's bed. The possibility of natural disease must be considered in this case. Three other children were taken from the same house the day after his death with a diagnosis of diphtheria. None of these died, however. An autopsy was performed on the child, but the neck organs were not removed and were not examined. The death was certified as being due to diphtheria on the basis of the three other cases and not any specific diagnostic findings at autopsy.

The fifth child was Lilly S, a niece of Mrs. W, who died in 1958 at age 14 months. The parents of Lilly awakened in the night to find Mrs. W, the father's sister, holding the child. She stated that the child began choking and she administered mouth-to-mouth resuscitation. The child appeared cyanotic around the mouth. She was dead on arrival at a nearby hospital. No autopsy was performed. The cause of death registered on the death certificate was "acute fulminating pneumonitis."

The sixth child to suffer a cyanotic episode under Mrs. W's care was Eddie T., an 18-month-old child. Mrs. W told the mother that the child, while in his crib, developed breathing difficulties and became cyanotic. She administered mouth-to-mouth resuscitation on the way to the hospital. On arrival at the hospital the child appeared well and was released. Mrs. W subsequently told the mother that she had dislodged a mucus plug which had been causing the boy's breathing difficulties. She even offered to show the plug to the mother. However, when they arrived at the location where it was supposed to be she was unable to locate it and suggested that it had been eaten by dogs. After this incident the mother observed a bruise on the child's back that she had not noticed the night before when she bathed him.

The seventh child was Harlan R. Mrs. W was alone with the child on the three occasions he suffered cyanotic episodes. The first attack occurred in January 1964. While Mrs. W was babysitting, the child passed out and turned blue. She administered mouth-to-mouth resuscitation and brought the child to an Army hospital. The admitting complaint was cyanosis, apnea, and seizures. A physical examination revealed the child to be lethargic and afebrile. Blood electrolytes, blood glucose, blood urea nitrogen, urinalysis, a lumbar puncture, and skull X-rays were all within normal limits. The child was discharged on phenobarbital after five days in the hospital, during which time he was completely asymptomatic. Discharge diagnosis was "seizure epileptic." An electroencephalogram performed a month later was normal.

The second attack occurred in May 1964. Mrs. W claimed to have found the child lying on the ground, cyanotic and dyspneic. She administered mouth-to-mouth resuscitation and the child was admitted a second time to the hospital. On examination in the emergency room the child had convulsions and a temperature of 101.2°F. Admission diagnosis was "febrile convulsions." Immediately after admission, however, the child became afebrile. During the two days in the hospital he was afebrile with no convulsions. A lumbar puncture was negative and the child was discharged with a diagnosis of "acute pharyngitis and febrile seizure." The third and final cyanotic episode and final admission occurred later on the same day that he was discharged. Mrs. W was left alone with the child. She stated that the boy developed shallow breathing, became pale and cyanotic. She administered mouth-to-mouth resuscitation but he was dead on

arrival at the hospital. The child was 18 months of age at the time of his death. An autopsy was performed. The cause of death on the autopsy protocol was listed as "death, sudden, cause unknown." A toxicology analysis was negative except for therapeutic levels of phenobarbital which the child had received in the hospital.

Discussion

The Medical Aspect

Two and a half years after the death of Paul, Mrs. W was tried for his premeditated murder. After a trial lasting almost 5 months, Mrs. W. was found guilty of first degree homicide and sentenced to life imprisonment. The medical aspects of this case centered around two major problems. First was whether a murder had taken place and second, if it had, whether or not Mrs. W was legally sane at the time. (This paper is not concerned with the latter problem.) The main difficulty in analyzing Paul's death from the viewpoint of the forensic pathologist is the fact that the child had survived for a month in the hospital. Because of this time lapse any external evidence of acute trauma to the child had long since disappeared. What the autopsy mainly accomplished was to rule out any anatomical basis for his "illness." The autopsy revealed no evidence of cardiac, central nervous system, pulmonary, or other organic lesions capable of causing the symptoms presented. The anoxic injuries to the brain were all of the same age and dated back to the cardiorespiratory arrests at the time of the fourth admission. The determination of the cause and manner of the death had to be made on history, keeping in mind the negative autopsy findings. Initially the history presented was only of Paul's attacks with mention of the fact that a sister had a similar attack. Paul's clinical history, however, was more than enough to raise serious questions as to the cause and manner of death and to strongly suggest a possibility of a homicide.

On review of Paul's medical records one is immediately struck by the bizarre nature of the clinical presentations. He experienced multiple attacks of anoxia with cyanosis that responded immediately to mouth-to-mouth resuscitation. These attacks occurred only at home and never in a hospital under observation. Multiple laboratory tests combined with a complete work-up for seizure disorders all produced negative results. Finally, there was the observation that from time of birth until his adoption, Paul had never experienced such attacks.

The negative physical findings and laboratory tests during the hospital admissions, the absence of findings at autopsy, and the bizarre presentation of symptoms all strongly suggested that a homicide had been committed. Considering the age of the individual and the presenting symptoms of anoxia, it was concluded that the child was probably being smothered. This could have been performed by either one of two methods. The first would be by covering the nose and mouth with some object such as a pillow; the other method would be by pinching shut the nose while closing off the mouth. This latter method could be performed with one hand on a child of Paul's age. Since very little resistance could be put up by such a young child, it would not be unexpected that no evidence of violence was seen by the clinicians. When Judy's medical history is considered along with Paul's, any lingering doubts as to the cause and manner of Paul's death are dispelled. Here is another adopted child who has had multiple episodes of anoxia and cyanosis similar to Paul's. These episodes occurred both in Colorado and Maryland, and cannot be ascribed to a local geographical influence. A complete physical and toxicological examination of Judy provided no physical basis for these attacks. In addition, during the 2½ years after Paul's death, in the time prior to the trial, while she was in the care of a foster home, Judy never again experienced an episode of cyanosis or anoxia.

As evidence concerning the deaths and cyanotic attacks of the other children became available a very sinister pattern began to emerge. Paul's death and Judy's "illness" appear to be the end of a long chain of homicides and attempted homicides committed over a 20-year span.

Testimony at the trial brought out not only the facts concerning Paul's death but also the facts that from 1946 to 1969, nine infants and small children had suffered a minimum of 20 episodes of cyanosis while in contact with or under the care of Mrs. W. Seven of these children died. Of the dead children, three were her own by two different fathers, one was a nephew, one a niece, one a neighbor's child and the last, Paul, an adopted child.

With some slight variations a pattern to these deaths was apparent. The children were all very young—all but one under 2 years of age. They had breathing difficulties and became cyanotic. Mouth-to-mouth resuscitation was applied, usually by Mrs. W, and recovery would take place. (One discrepancy in Mrs. W's testimony not brought out at the trial was her claim of having given mouth-to-mouth resuscitation to two of her natural children. This form of resuscitation, however, had not been introduced at the time of their deaths.) On admission to a hospital their course would be uneventful with a negative physical examination and laboratory tests. No attacks of respiratory difficulty and cyanosis would occur while hospitalized. Episodes of cyanosis occurred only when the defendant was present or in the vicinity.

When Paul was admitted to the Baltimore hospital a differential diagnosis of insecticide poisoning was strongly considered. This was based on statements by the parents that large amounts of insecticide spraying occurred where they lived, as well as on a toxicological report from a private laboratory which suggested insecticide poisoning. When the director of the laboratory testified at the trial, however, he stated that the amount of insecticide detected in his analysis was within normal limits of modern drug exposure and was not toxic. Government expert witnesses testified that the amount and types of insecticide used near the home were within the prescribed safety levels. Red blood cell and serum cholinesterase levels performed on Judy, who would also have had to be exposed to the insecticide, indicated no exposure to organophosphate insecticides in the past few months. A lack of correlation between the sprayings and Paul's attacks was also demonstrated. In addition, the clinical picture of multiple attacks of anoxia that responded immediately to mouth-to-mouth resuscitation is not that of an inorganic phosphate poisoning. In such cases, there is a depletion of cholinesterase and emergency and transitory resuscitation will not reverse the symptoms. Only specific treatment with prolonged life support will bring about recovery.

The senior author, another forensic pathologist, and two clinicians also testified that in their opinion, based on the clinical presentation, the child was not suffering from insecticide poisoning. In addition to insecticide poisoning the defense alleged that Paul was suffering from one or more of the following conditions: epilepsy, crib death, breath holding, allergies, and birth trauma. All these diagnoses were rebutted by expert medical witnesses.

At the trial the senior author was asked his opinion as to the cause and manner of Paul's death. He stated that, based on the hospital records from the three hospitals where Paul was seen, the autopsy that he performed, and the testimony of the foster mother and physician regarding Paul's health prior to death, it was his opinion that the most probable cause of death was homicidal smothering. The author did state, however, that if only these facts were considered there was a small possibility that Paul died of a disease currently unknown to medical science. The author was expressly prohibited for legal reasons from considering the other deaths as well as Judy's symptoms when these

two opinions were given. Subsequently, as the trial progressed, and the deaths and "illnesses" of the other children were admitted in evidence, he was allowed to state that each additional death or "illness" was additional support for his opinion as to the cause and manner of Paul's death. Out of the presence of the jury, the author also stated that while considered individually each death could be natural, when all the deaths, including Paul's, were viewed together he felt beyond a reasonable doubt that Paul had been murdered. He further stated that Paul's symptoms could be produced in a few minutes by either smothering or closing the nose and mouth by pinching these orifices shut. These methods of homicide in young children who cannot defend themselves would generally leave no visible marks.

The Legal Aspect: The Insanity Problem and Admissibility of "Prior Acts" in Infanticide Cases

Mrs. W was tried in the United States District Court for the District of Maryland two and a half years after Paul's death. The trial lasted 5 months with over 9000 pages of transcript being taken. The resultant conviction was affirmed by the United States Court of Appeals for the Fourth Circuit, by a 2 to 1 decision. As of the time of this writing, the defendant has petitioned the United States Supreme Court for the writ of certiorari.

To obtain a conviction, the Government was faced with two massive legal problems. The first was the obvious appeal of the defendant's claim of insanity. At the present time, there is a striking deficiency in the Federal criminal process. Any defendant who successfully maintains a plea of insanity in any Federal court (with the exception of the District of Columbia) will most likely be released outright without any type of incarceration or hospitalization if the jury finds in their favor, that is, that they are, in fact, legally insane. In contrast to most state proceedings where an individual found not guilty by reason of insanity is sent to a mental hospital, a defendant successfully maintaining such a defense in a Federal criminal trial is released outright. In addition, the jury will never be informed that this will be the consequence of their action. The jury is merely instructed by the judge that they should decide the case upon the evidence before them and if they find that the defendant is legally insane, based upon that evidence, and as defined by the court, then they must return a verdict of not guilty by insanity.

A conscientious and compassionate jury could very well think that by returning such a verdict, they would be sending an individual to a mental hospital for treatment, while in reality, due to the lack of an adequate Federal remedy, they would be turning this person loose without any type of hospitalization. The natural initial reaction of almost any juror hearing this case would be that if the defendant had committed the wrongs alleged, she would certainly have to be suffering in some way from a pitiable emotional deficit. To establish this defense, the defense brought forth the testimony of two psychiatrists who testified that the defendant was suffering from psychomotor epilepsy, and that it was their opinion that if the defendant had committed these alleged acts, she must have done so while in the midst of psychomotor seizures. The government successfully rebutted this defense by producing two psychiatrists, two psychologists, two neurologists, and a physician to prove the defendant's legal sanity under the American Law Institute test, for criminal responsibility. Forty percent of the 9000-page transcript of this case deals with psychiatric testimony.

The second major problem faced by the government in this case involved the question of "prior acts." The basic rule of law, subject to several exceptions not here relevant, is

that evidence with regard to a defendant's prior bad behavior, or "prior acts," cannot be admitted into evidence against him. One of the basic reasons for this rule is that such evidence may be so overwhelmingly prejudicial to a defendant that he would never be able to receive a fair trial. Thus, if an individual is on trial for a bank robbery it would be legally improper for the prosecution to introduce into evidence facts showing that this individual had committed numerous other bank robberies at various times in the past. By such "prior act" tarring, a guilty verdict would inevitably be produced, even though the government might not have adequately proven its case with regard to the instant charge. Consequently, evidence of "prior acts" is rigorously excluded from the trial of a criminal defendant.

Normally, such a fair and laudable rule does not work undue hardship upon the prosecution, since it should be able to prove that the individual has committed the crime upon which he stands accused, without going back into his prior history; that is, the government should be able to produce evidence showing that this defendant robbed the bank in question, on the date in question, without resorting to showing that he had robbed other banks in the past.

With regard to the smothering of infant children, however, it is extremely difficult for the prosecution to prove that an individual has committed this crime. This crime is committed, almost invariably, when the defendant is alone with a child. The net result of this is that there are no witnesses to testify. If the child should somehow survive this attack, its inability to talk, based upon its youthfulness, will prevent verbal disclosures of the deed. Being virtually defenseless, little pressure need be applied to an infant to produce death by smothering. With the infant's ability to struggle limited, and the amount of pressure applied being slight, bruises or other telltale signs will generally not be apparent at autopsy. A pathologist faced with such an autopsy can usually rule out accident and natural disease. Nevertheless, while he may feel very strongly that such a child is a homicide victim, he will be very reluctant to so state, based upon the *one* case before him.

This was precisely the situation in this case. The Government's expert (the senior author), utilizing the autopsy that he had performed, and the prior medical history of the child, advanced the opinion that this child was the victim of a homicide. Without considering any of the defendant's alleged "prior acts," however, he could not be absolutely certain of this opinion, since he felt that it was theoretically possible that the child could have died from a disease currently unknown to medical science. Unfortunately, being partially certain is not sufficient to convict an individual of any criminal case. Such proof alone is inadequate to establish guilt, "beyond a reasonable doubt." Consequently, under the traditional rule of law, precluding "proper acts," as outlined above, the Government would have been unable to prove its case. Fortunately, at least from the Government's point of view, the trial court acceded to the Government's theory and allowed it to introduce into evidence the facts pertaining to the eight other children who had suffered similar cyanotic episodes while with the defendant. With this evidence admitted into the case, the jury returned a verdict of guilty. Upon appeal by the defendant, the Fourth Circuit Court of Appeals recognized the unique problem involved in this type of case. They stated that with regard to none of the children was there sufficient legal proof that the defendant had committed an illegal act. Only when all of the evidence concerning the nine other children and Paul was considered collectively, was the conclusion reached that the probability that some or all of the other deaths, cyanotic seizures, and respiratory deficiencies were accidental or attributable to natural causes was so remote that the truth must be that Paul and some or all of the other children died at the hands of the defendant. The Court of Appeals felt that when the crime is one of infanticide or child abuse, evidence of repeated incidents is especially relevant because it may be the only evidence to prove the crime. A child of

Paul's age is a helpless, defenseless human being. He is too young, if he survives, to allege the facts concerning the attempts on his life, and too young if he does not survive to have exerted enough resistance that the marks of his cause of death will survive him. What the Fourth Circuit Court of Appeals has established, in this precedent-making opinion, is that the prosecution faced with an infanticide case, may, under proper circumstances, support its case by introducing evidence of "prior acts" of the defendant, if they are similar to the case at issue. Armed with this tool, it is hoped that prosecutors and pathologists will be able to obtain convictions in cases that would otherwise result in acquittals under the more traditional rule of law.

Addendum

Since the time this paper was written, the Supreme Court has denied the defendant's writ of certiorari.

Summary

The death of a 7-month-old adopted child by smothering led to the discovery that his adopted mother was associated with the deaths of six other children over a period of 23 years. These seven children, as well as two children who survived, suffered a minimum of twenty cyanotic episodes while in contact with or under the care of the defendant. With some slight variation, a similar pattern to these deaths was apparent. The defendant was tried and convicted of murder in a Federal court in a trial in which the judge permitted the introduction of prior acts (the deaths of or attacks on the other children.) This trial and the subsequent affirmance of the U.S. Court of Appeals for the Fourth Circuit establish a legal precedent, allowing the introduction of evidence of prior acts with respect to cases of infanticide.

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