Erik K. Mitchell,[1] *M.D. and Joseph H. Davis,*[2] *M.D.*

Spontaneous Births into Toilets

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ABSTRACT: Since inception of the Dade County Medical Examiner Department in 1956 and the end of 1982 a total of 18 spontaneous births into toilets were investigated. A retrospective review of these cases revealed a high degree of maternal denial of pregnancy and refusal of responsibility for the fetus by primiparous mothers of term births, the instances of most questionable manner of death. A consideration in the examination of these natal deaths should be investigation of maternal postnatal behavior along with the circumstances of birth and autopsy findings.

KEYWORDS: pathology and biology, birth, death

Since the inception of the Dade County Medical Examiner system in 1956 there have been a total of at least 18 spontaneous deliveries into toilet bowls. These cases have included a variable degree of forensic science investigation but pose problems of particular interest to pathologists. These problems are of a type common since the advent of legal medicine.

Especially before the time of legalized abortion, but even in the modern day, unattended neonatal deaths have carried with them attendant suspicions of infanticide.

Always the first clear question is one of live birth. In many jurisdictions, the law requires, for a charge of infanticide, that a fetus attain independent existence prior to its destruction [*1*]. A number of tests have been devised to determine live birth, including as the most useful, airway pulmonary edema foam, aeration of lungs, and extrauterine materials in gastric content. Other related tests include middle ear aeration and evaluation of the umbilical stump for signs of postnatal vital reaction. Less reliable at autopsy is evaluation of intestinal gas patterns and lung to body weight ratios.

These examinations are made extremely difficult as the postnatal interval shortens. Postmortem signs of violence to which a vital reaction is found can give answers to the live versus stillbirth determination, but the death without savagery poses particular difficulties. Unique to the water closet birth is a short transition time between intrauterine and extrauterine aqueous environments which potentially may not allow for development of pulmonary aeration and associated air dependent signs. Despite the complexities accompanying definition of live birth, these difficulties are not the thrust of the current presentation. It is intended, instead, to examine more the circumstances of the births and the investigations that followed.

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[1] Medical examiner, Onondaga County, Syracuse, NY.

[2] Chief medical examiner, Dade County, Miami, FL.

Methods

Cases were selected by review of Dade County Medical Examiner's case files where there was report of stillbirth or newborn death during the first day of life. There were 74 such case files. These cases were, all but one, autopsied; the inspection only files no longer were immediately available. A total of 18 births into toilet bowls were found during the period 1959 through 1981, all instances of which were autopsied. Information from these files was tabulated in an effort to compare still and live births, on the basis of circumstances surrounding the birth in the immediate postnatal period as well as anatomic findings.

Results

There was a roughly equal distribution of black, white, male, and female fetuses (Fig. 1).

A 2000-g cutoff was chosen to separate term from preterm gestations for comparison of the mothers' behavior patterns between these two groups. There were nine deliveries of greater than 2000 g and eight of less than 2000 g. The parity of the cases was higher for term deliveries than for nonterm deliveries (Fig. 2). Note, one case only was multiparous in the preterm birth category. The average parity was 2.9 for term and 1.5 for preterm deliveries.

Live birth was determined by a combination of anatomic findings—primarily lung and gastric content—and witness statements when these latter documented postnatal activity. Term pregnancies had predominantly live births and preterm pregnancies (most of which were 1000 g or less) appeared predominantly as stillbirths. In each weight category, one case was uncertain as to live or still birth (Fig. 3). A concomitant finding was a natural manner of death ascribed to the preterm deliveries (Fig. 4). The original classification of the term pregnancies was one unclassified, two natural, five accidental, and two homicidal deaths, both of the latter from intentional neglect.

Two of the incidents originally listed as accidental came into question on review. One was probably a homicide rather than accident. The other remains a problematic question. The unclassified death, on review, appears a homicide with the discovery by others of a live, but dying infant in a trash chute.

Term mothers who bore into commodes had a strong tendency to deny knowledge of pregnancy or to engage in attempts at concealment of the conceptus (Fig. 5). In contrast, mothers of preterm commode deliveries, "toilet bowlers," if you will, despite the high instance of macerated fetuses and unequivocal stillbirths, did not appear to assign their offspring to trash baskets. Of course, there is no method with which to determine how many smaller fetuses, who could pass without blockage, were unceremoniously flushed into the plumbing.

An associated finding (Fig. 6) was that mothers of preterm stillbirths sought medical attention for themselves and the fetus, whereas most of the postterm deliveries resulted in little ac-

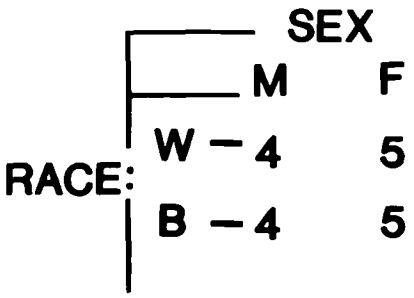

FIG. 1—*Sex and race of fetus born into toilet bowls.*

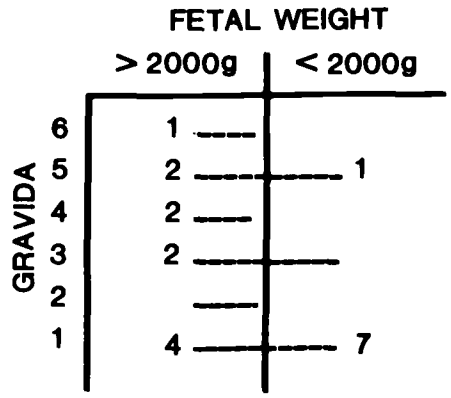

FIG. 2—*Mother's parity versus birth weight of the fetus.*

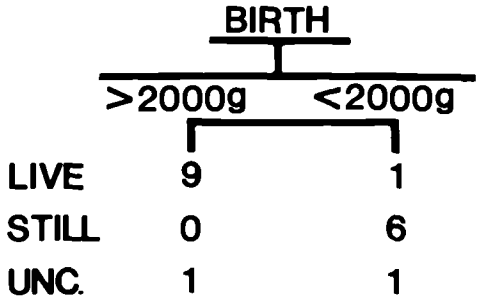

Fig. 3—*Term (>2000 g) and preterm (<2000 g) breakdown in live birth, stillbirth, and unclassifiable groups.*

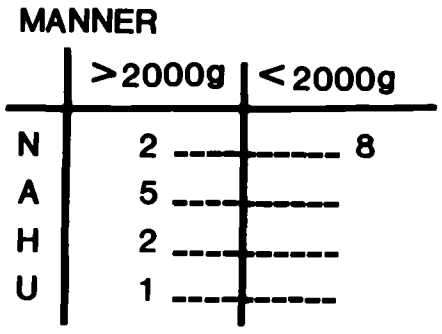

FIG. 4—*Breakdown, by birth of fetus, of manner of death originally certified.* N = *natural*, A = *accident*, H = *homicide, and* U = *unclassified.*

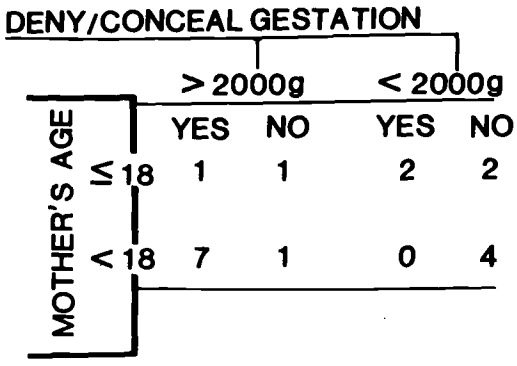

FIG. 5—*Breakdown by maternal age and fetal birth weight of denial or concealment of gestation.* Yes = *denied or hidden pregnancy.*

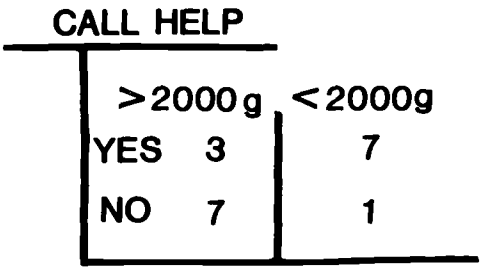

FIG. 6—*Breakdown, by birth weight of fetus, of mother's attempts to seek medical attention at time of delivery.*

tion. This differing interest in the decedent was carried one step further, for the term birth was rarely buried by the family (Fig. 7) but left to the offices of the Dade County Indigent Burial Service. In comparison, the stillbirth commode deliveries were, with the exception of one, buried privately.

Case Examples

Two cases are chosen here as examples. In Case 813525, a term infant was born to a gravida I, 27-year-old, white, unmarried female who six days previously had notified a Right to Life group of her intention to put her child up for adoption when born. At the time of delivery, this woman chose a toilet for her confinement calling on a friend to keep her company. After delivery, the infant was allowed to remain in the toilet for 1 h before medical assistance was requested, and this for the mother only. Autopsy demonstrated an apparently previously viable but dead fetus with a stomach full of bloody water from the toilet bowl. The evidence of swallowing was considered evidence of live birth. The mother later expressed happiness at this turn of events when she told a detective she was glad to be rid of the child.

Autopsy alone cannot reveal the manner of death. Ignorance and lack of concern for welfare of the fetus are not anatomically separable entities. The history, bolstered by the friend-cum-witness statements clearly demonstrate willful neglect in a situation of which the mother was aware.

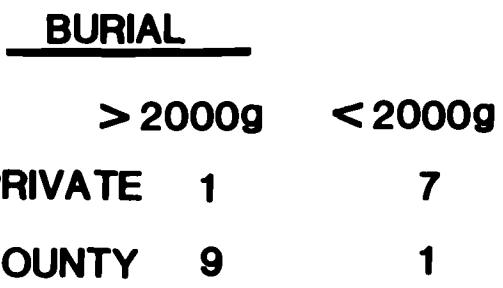

FIG. 7—*Breakdown, by birth weight of fetus, of manner of burial, private or county.*

A second case (801802) demonstrates the care that must be taken to adequately document cases. In this instance, a 19-year-old, unmarried, gravida I, white female gave birth in an airplane toilet shortly after takeoff. She explained away blood on her clothing as heavy menses, a story accepted by passengers and crew. After landing, a fetus was found in the aircraft holding tank.

The death was originally classified as a natural with precipitant delivery in a uniparous female, of itself an uncommon event.

The above conclusion was reached on the basis that the fetus has polycystic kidneys, therefore must have oligohydramnios and hence must have more easily been passed, even unnoticed. However, on review, the kidneys have a Type III polycystic disease and would be expected to have full function in utero [2]. Also, the cord apparently had been cut, a fact not described by the pathologist who gave no description of the cord. The cut was seen by an investigating officer as well as incidentally documented in a photograph. The combination of denial of pregnancy, denial of delivery, and cutting of the umbilical cord speak strongly for classification as homicide.

Discussion

Denial of pregnancy in the face of incontrovertible medical proof to the contrary would constitute evidence that a live born fetus might have died from willful lack of retrieval from a commode. The medical examiner should consider not only anatomy but facts of scene and postnatal maternal behavior in interpretation of agonal events. The latter factors may assist in suggesting the pathway a particular police investigation should follow.

In the balance are several factors, including obstetric history and the level of maternal ignorance, that must be carefully considered. Consideration must be given to each person's comprehension of events in order to prevent disproportionate emphasis on truly minor inherent inconsistencies of the case history or false inconsistencies based upon unskilled interrogation.

Too simple is a strict adherence to limited anatomic interpretation out of the clinical context, though such is certainly the course of least resistance in these cases. There appears, in these authors' review experience, to be a natural desire on the part of some medical examiners to avoid synthesis for the purpose of judgment of all available information in these potentially subtle infanticide cases.

What is here presented does not describe any new or unique finding applicable to deliveries into aqueous environments. There is, however, demonstration of the need to consider the mother's postnatal actions before classifying a neonatal death.

References

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[2] Potter, S. L. and Craig, J. M., *Pathology of the Fetus and the Infant*, 3rd ed., Yearbook Medicine, Chicago, 1975.

Address requests for reprints or additional information to
Erik K. Mitchell, M.D.
Medical Examiner of Onondaga County
330 W. Onondaga St.
Syracuse, NY 13202