CASE REPORT

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A Killing of Baby Doe*

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ABSTRACT: An anencephalic infant died in the Neonatal Intensive Care unit six hours after birth. Eighteen months later, in a discussion of intrusive federal "Baby Doe" regulations with co-workers at the hospital, a registered nurse mentioned that he had found a way to avoid these provisions, and that he had in fact done so on one occasion by killing this particular infant. A co-worker related his story to police, and the "wheels of justice" were set into motion. I describe the chronology of events and the pathologic findings in this case of infanticide, purportedly committed "with mercy-aforethought."

KEYWORDS: forensic science, infanticide, neonaticide, Baby Doe, euthanasia

The sequence of events in this report begins with a birth in one state in 1982 and culminates with a criminal court conviction in another three years later.

In April 1982 in Indiana, a baby was born with Down syndrome and congenital atresia of the esophagus (1). On the advice of their obstetrician, the parents agreed that no reconstructive surgery would be attempted, and that the infant would be allowed to die without fluids or feeding gastrostomy. The infant died on the sixth day of life, but not without legal notice. A nurse at the hospital reported the case to local prosecuting attorneys and to the Indiana Supreme Court. No major legal action was taken at that time (2–4) or later (5).

However, the death of this baby, who came to be known as "Baby Doe" in the national press, became the stimulus for a major federal response. Following the concerted actions of the US Department of Justice, the Office of the Surgeon General of the US, and the newly remodeled US Department of Health and Human Services, the news through the remainder of 1982 and through all of 1983 was filled with articles about proposed new federal regulations and/or interventions to prevent the recurrence of such cases (6–9). Several "trial balloons" were floated for public review, including suggestions for a toll-free telephone reporting system in which "snitches" would inform federal investigators of apparent negligence or malfeasance in the neonatal nursery (10). This was the climate in mid-1983 in the neonatal unit of a tertiary hospital in eastern North Carolina when the death of another "Baby Doe" took place.

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Case Report

In July 1983, a female infant was born after a full-term, uncomplicated pregnancy. The infant was anencephalic. She was transferred to the Neonatal Intensive Care unit before midnight, and death was recorded at 5:30 a.m., aged 6 hours. Records indicated that the infant's body was received by the designated funeral director at 7:30 a.m., and that embalming was complete at 8:30 a.m. Burial took place two days later.

In December 1984, during a coffee-break, a group of hospital employees was discussing the current national news involving yet another "Baby Jane Doe," an infant born in New York State in October with hydrocephalus and spina bifida with meningomyelocele, and at that time the subject of state and federal investigations and a court proceeding. One of the employees present, a newly licensed male nurse, declared that he had "found a way to solve the problems" posed by such severely ill newborn babies. He then described how, on an occasion in 1983 while he was in training, he had ended the life of an anencephalic new-born merely by pressing on its chest with his fingers.

One of the nurses who heard this revelation was quite distressed and soon presented herself to the local district attorney to relay the tale. An investigation began.

Exhumation took place in March 1985 and autopsy followed immediately. The embalmed body measured 43.5 cm and weighed 2.5 kg. The postmortem growth of fungus was notable only over the skin surfaces of the lower trunk. The usual embalmer's button and incisions were identified.

The head was typically anencephalic, with no evidence of bone growth above eyebrow level. There was no external evidence of injury on the face or neck. There was evidence of injury over the chest, however: an 8-mm dull gray contusion immediately above the areola of the left breast.

With sharp dissection, the contusion of the left chest was seen to extend into the pectoralis muscle and the underlying intercostal muscles. Sections of the contusion at deeper levels were dark red and sharply defined with a greatest transverse dimension of 14 mm. Dissection of the heart disclosed a single focus of dark red subepicardial hemorrhage on the anterior interventricular septal wall near the cardiac base, 6 by 8 mm in greatest axes. Seen best externally, it was barely visible on section. In that portion of the right lobe of the thymus which extended downward and was adherent to the anterior pericardium, there was a discrete zone of

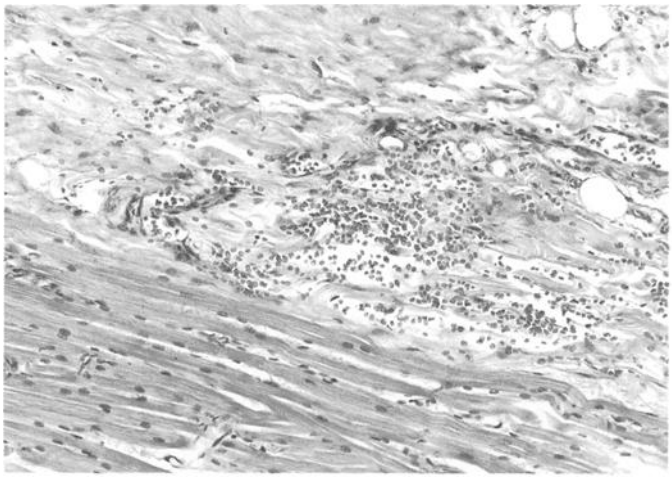

FIG. 1—*Skeletal muscle of anterior left chest wall. Recent interstitial hemorrhage.*

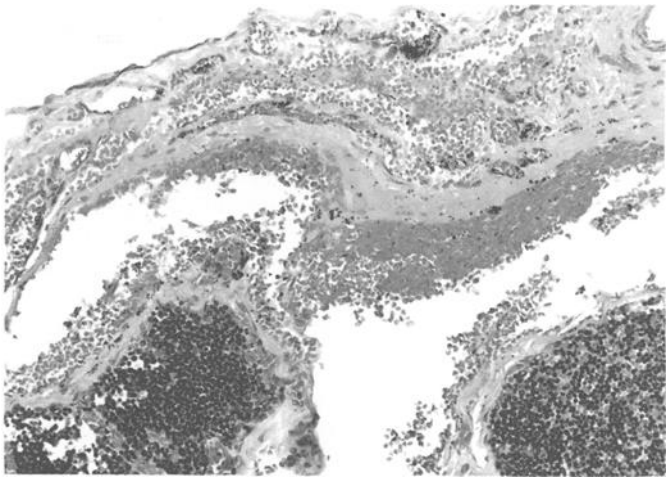

FIG. 3—*Thymus, anterior right lobe overlying the pericardium. Recent hemorrhage and mechanical disruption of thymic architecture.*

subcapsular contusion measuring 4 by 8 mm. In its normal position in life, this lingular portion lay directly beneath the sternum and over the anterior cardiac base.

The embalmer's trochar (diameter = 5 mm) had produced the usual visceral perforations, but none involved the anterior pulmonary segments or the contents of the anterior mediastinum. Thus it was of interest to note that both anterior lower pulmonary lobes displayed atelectasis, with dry, lusterless surfaces. Finally, dissection of the liver revealed a recent contusion beneath the capsule of the anterior-superior right lobe underlying the costal margin.

Microscopic sections confirmed the initial impressions of recent contusions in left thoracic skeletal muscle (Fig. 1), heart (Fig. 2), thymus (Fig. 3), and liver (Fig. 4). In the section of the anterior interventricular septum, it was noted that the interstitial hemorrhage was greatest just beneath the trunk of the left anterior descending coronary ramus (Fig. 2); if the concentration of blood at that site represents the center of pressure against the sternum, it follows that the arterial lumen must have been compromised by that pressure during the period of time over which it was applied. (Cardiac ischemia might thus have been produced, but my microscopic sections failed to disclose evidence of ischemia in apical ventricular myocardium—not unexpectedly if one assumes that death had ensued rapidly after the event.)

Encouraged by the autopsy findings, detectives interviewed the man named by the informant in her deposition to the district attorney. In these interviews, the suspect implicated a second man, also a male nurse, stating that they had acted together in the killing. When the second man was subsequently interviewed, essentially the same story emerged. Both suspects agreed that they had discussed the "emotional and financial impact on the parents" of this anencephalic baby. Both men stated that they had agreed that "if it was alive at 7:00 a.m., when those damned right-to-life doctors came on duty, they'd keep it alive for another week." (Personal communication to the author by Agent Lewis Young of the North Carolina State Bureau of Criminal Investigation, in August 1985.)

Both suspects gave the same account of the killing episode with minor variations, as follows: while the first man applied manual (thumb and finger) compression of the chest wall, the second "pinched the nose and chin between (his) fingers" for a period of at least 2 min (11).

The time of death was best reconstructed to have taken place between 4:30 and 5:00 a.m., when a third person, a "circulating nurse," reported finding the infant lifeless in its crib. It should be noted that no effort to resuscitate was made at any time.

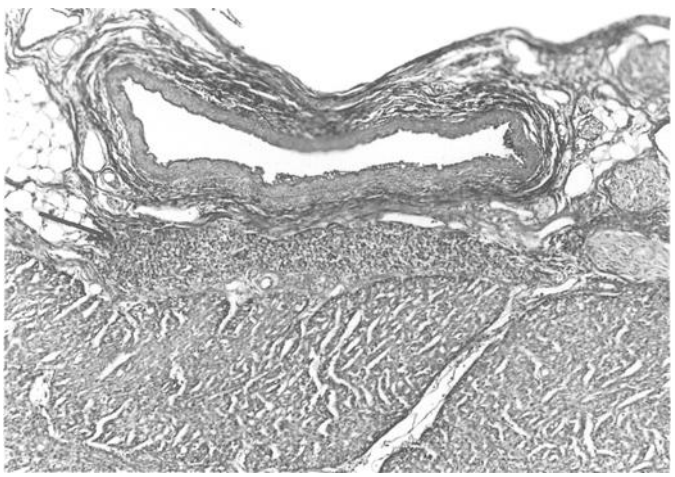

FIG. 2—*Heart, anterior interventricular septal base. Recent epicardial hemorrhage (arrow) beneath the left anterior descending ramus (phosphotungstic acid-hematoxylin).*

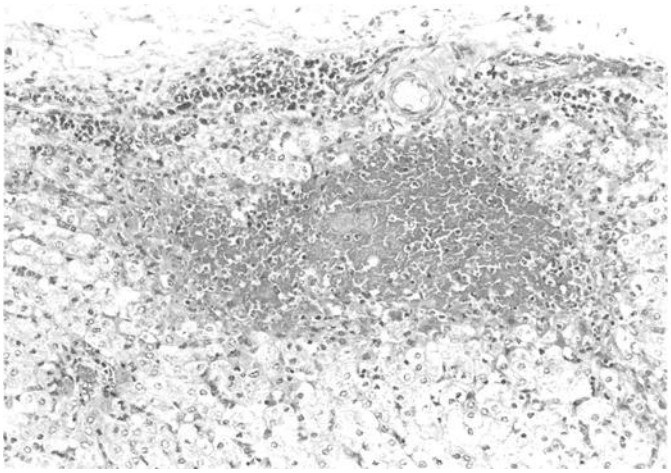

FIG. 4—*Liver, right lobe beneath costal margin. Recent contusion.*

Both suspects were arraigned on charges of first-degree murder, and trial dates were set. The first suspect negotiated a plea-bargain, pleading guilty to a charge of voluntary manslaughter. Sentencing was set to follow his testimony in the jury trial of the second suspect a trial which took place in August 1985 (12). In that trial, the judge gave instructions to the jury that they consider only the charges of first-degree murder or attempted first-degree murder. The jury reached a verdict of "not guilty" (13). A few days later, the man who had pleaded guilty to manslaughter received a sentence of four years in prison (14).

Discussion

I have chosen to entitle this paper "A Killing of Baby Doe" to call attention to a major point: this is clearly not the only killing of a deformed newborn infant in the past few decades. In 1973, two physicians from the Yale-New Haven Hospital reported details of the deaths of 43 "congenitally handicapped" newborn infants over a 30 month period (15). All these deaths were reported to have been "related to withholding treatment," that is, "passive" rather than "active" killing, and may be argued not to be comparable to the case reported here. There are some ethicists and legal writers, however, who consider such "deaths by neglect" to be the moral or legal equivalents of murder (6,16,17). Moreover, in the years since this infant's death, at least three instances of active killing of "physically disadvantaged newborns" have been reported (19,20).

My contention is further supported by rather astounding testimony from one of the defense witnesses in the jury trial of the second defendant. Another male nurse, in 1985 an administrator at another hospital, testified that at an earlier time he had been present at the birth of a defective infant who was not expected to live, and that he had "closed the baby's mouth with his hand, hoping it would be his last breath." He further testified that he was "trying to help the baby complete the dying process" (21).

In this case, the accused defendants stated that their motives for terminating this life were to reduce the "financial and emotional burden on the parents." In essence, their defense was that they were "doing the parents a favor." In terms of reducing the period of hospitalization and thereby reducing the hospital bill, they may well have done so. A newborn with complete anencephaly and no treatment can be expected to survive for up to seven days before sepsis or adrenal exhaustion take their toll (22). At nearly $1000.00 dollars per day in hospital fees alone in mid-1983, a substantial monetary saving was indeed probably effected by their actions. (Financial information was provided to the author by Mr. B Sitterson, a vice-president of the referent hospital, in December 1985.)

But this has been a tale of three tragedies. The first was the conception, birth and death of an anencephalic infant. The second evolved from the criminal act of one of the defendants, leading to his conviction and the destruction of his professional future. Finally, in spite of the defendants' assertions that they meant only to "reduce the parents' burden," the third tradegy was the necessity for the parents to re-live the first tradegy, two years after the death of their baby girl.

Perhaps the most challenging words printed in the news accounts of this case were attributed to the paternal grandmother of the deceased infant, herself a former obstetric and delivery room nurse. At the conclusion of the jury trial and the acquittal of that defendant, she was quoted: "I think we ought to give (him) a great big apology for what the state has put him through. This trial should never have happened" (13).

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