Detecting the Undetectable: An Examination of the Intersection Between Sudden Infant Death Syndrome and Munchausen by Proxy Syndrome

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I. INTRODUCTION: A HYPOTHETICAL CASE

On January 1, 2005 Emma Curry was arrested and charged with killing her two children, Alex and Oliver. Emma, a twenty-eight-year-old stay-at-home mother, lived in Avon, Connecticut with her husband, Peter, an accountant in nearby Hartford, Connecticut. Emma and Peter had married in 2000, and in February 2002, Alex was born. Soon after his birth, Alex began to experience apnea-like symptoms. Emma took him to the hospital several times requesting tests and treatment to determine what was wrong with him. The doctors complied but were never able to find any specific problems with Alex. In July of 2002, Emma rushed Alex to the hospital, claiming that when she tried to wake him up that morning, he was not breathing. Unfortunately, it was too late, and doctors pronounced Alex dead soon after he arrived at the hospital. Doctors determined that the cause of death was Sudden Infant Death Syndrome (SIDS), a mysterious ailment that causes infants to suddenly stop breathing.

Two years later, in 2004, Emma gave birth to the couple's second child, Oliver. Initially, Oliver was a relatively healthy baby, showing no signs of his brother's medical problems. However, when Oliver turned seven months old, all that changed. Oliver, like Alex, began showing apnea-like symptoms, and on many occasions, Emma rushed him to the emergency room. Once again, doctors found nothing wrong with the child. In November of 2004, when Oliver was just eleven months old, he died.

The medical examiner performed a full autopsy on Oliver, and although he found nothing out of the ordinary, he was suspicious because both of Emma's sons had died without explanation. The police became involved and immediately suspected foul play when the medical examiner explained to them that it is often difficult, if not impossible, to distinguish between a SIDS death and a death by gentle suffocation. The police then interviewed the physicians who had cared for Alex and Oliver prior to their deaths. Dr. Eric Johanson, Alex's attending physician, noticed nothing out of the ordinary in Alex's case, stating simply that Alex was a

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sickly infant who had been rushed to the emergency room several times before he died. But Oliver's attending physician, Dr. Michael Roberts, stated that he had immediately become suspicious of Emma, partly because of Alex's death and partly because of her behavior while Oliver was hospitalized. Dr. Roberts revealed to the police that he believed that Emma had Munchausen by Proxy Syndrome (MBPS), an extreme form of factitious disorder in which a mother creates symptoms in her child and claims that her child is sick in order to gain attention and sympathy for herself. Based on Dr. Roberts's statements, the police obtained a warrant for Emma's arrest. They executed the warrant on January 1, 2005 and the prosecutor ultimately charged Emma with killing her two sons.

The state must determine whether to introduce Dr. Roberts's statements at trial. If introduced, the state may opt to claim that Emma Curry has MBPS and her strong desire to portray herself as a good mother led her to suffocate both of her infant sons. MBPS is not recognized as a defense in most jurisdictions, but it can mitigate murder to a lesser homicide charge because the mother's intent is not to kill. Alternatively, MBPS could bolster the state's claim because Emma's actions prior to her sons' deaths did fit the profile of the typical Munchausen by Proxy mother. However, if the state decides, and is allowed by the court, to introduce evidence of MBPS, its burden may become excessively high if the defense claims that Emma Curry did not have MBPS and further that MBPS does not warrant court recognition as a genuine disorder. The state is likely uninterested in Emma Curry's trial turning on whether MBPS evidence should be admitted rather than on Emma Curry's guilt or innocence.

Emma denies having MBPS and claims that she has never done anything to harm either of her sons. She suspects that both her sons died of SIDS but acknowledges that another rare disorder may also have been the cause of death since the definition of SIDS is technically one of exclusion. Jack Tyler, Emma's defense attorney, has suggested to Emma that she admit to having MBPS in hopes that it would support a defense of diminished capacity, thus mitigating the crime. Emma is understandably uncomfortable with this idea because it means that she essentially admits to killing her sons as well as to having a serious mental disorder. Attorney Tyler has never handled a defense case of this severity before and is unsure whether a defense of complete denial or diminished capacity would better help his client.

Both the state and the defense agreed that the bodies of Alex and Oliver Curry should be exhumed for further testing to determine the true causes of death. However, once exhumed, the medical examiner was unable to definitively state whether Alex and Oliver had been killed or had died of natural causes.

II. SUDDEN INFANT DEATH SYNDROME: A DIAGNOSIS OF EXCLUSION

Sudden Infant Death Syndrome, more commonly referred to as SIDS, has puzzled the medical world for centuries. The earliest suspected case of SIDS is documented in the *Bible*.[1] Before the twentieth century, doctors believed that SIDS was caused by the mother or the wet nurse accidentally suffocating the child because co-sleeping was common with infants.[2] Even now, with the tremendous progress that has occurred within the medical field, the exact cause of SIDS remains unknown and a diagnosis of SIDS is merely a diagnosis of exclusion.[3] This means that when a medical examiner or doctor concludes that an infant has died from SIDS, what he or she is truly saying is that he or she is unable to find any reason for the infant's death. Because a diagnosis of SIDS leaves the exact cause of death unknown, it is entirely possible that a certain percentage of SIDS cases are actually homicides.[4]

The term "Sudden Infant Death Syndrome" was coined at the Second International Conference on SIDS in 1969.[5] At that same conference, Dr. J. Bruce Beckwith also proposed the definition of SIDS that has been widely accepted for nearly four decades: "[T]he sudden and unexpected death of an apparently healthy infant, typically occurring between the ages of three weeks and five months, and not explained by careful postmortem studies."[6] Experts agree that approximately five thousand babies die each year from SIDS, but additionally, many other deaths with cause listed as "unknown" may also be SIDS since so little is known about what contributes to a SIDS death.[7] Of those five thousand deaths, ninety percent occur before the infant is six months old.[8] Certain infants appear to be at a higher risk of dying of SIDS, such as African-American infants, infants born prematurely or at a low birth weight, and infants whose mothers are particularly young or who smoked during pregnancy.[9] Additionally, epidemiological studies suggest that SIDS deaths are more frequent during the winter, at night, during the first three months of life, in poor or

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[1] 1 *Kings* 3:19–20 ("During the night this woman's child died because she overlaid it . . . .").

[2] *See* WARREN G. GUNTHEROTH, M.D., CRIB DEATH: THE SUDDEN INFANT DEATH SYNDROME 4–7 (3d ed. 1995).

[3] Catherine L. Goldenberg, Comment, *Sudden Infant Death Syndrome as a Mask for Murder: Investigating and Prosecuting Infanticide*, 28 SW. U. L. REV. 599, 602 (1999).

[4] *See infra* Part IV.A.

[5] GUNTHEROTH, *supra* note 2, at 1.

[6] Goldenberg, *supra* note 3, at 601.

[7] R.B. MAWHINEY, D.C., D.I.S.R.C., S.I.D.S.: NEW RESEARCH INTO SUDDEN INFANT DEATH SYNDROME CAUSE AND EFFECT 13 (2002).

[8] Committee on Child Abuse and Neglect, *Distinguishing Sudden Infant Death Syndrome from Child Abuse Fatalities*, 107 PEDIATRICS 437, 437 (2001) [hereinafter Committee].

[9] Robert M. Reece, M.D., *Fatal Child Abuse and Sudden Infant Death Syndrome: A Critical Diagnostic Decision*, 91 PEDIATRICS 423, 424 (1993).

illegitimate infants, and in males.[10]

Because no exact cause of SIDS is known, doctors cannot meaningfully counsel parents on preventive measures; however, the American Academy of Pediatrics suggests several strategies that appear to reduce the chances of an infant dying of SIDS. Most of these measures are now widely know and utilized throughout the United States. Those suggestions include ensuring that the child sleeps on its back,[11] keeping the baby warm during sleep, using a firm sleeping surface, feeding the child breast milk, taking the child to the doctor's office frequently, and providing an alarm or monitor system for the baby's room.[12] It is important to remember, however, that none of these suggestions is a fail-safe means of preventing SIDS since the true cause remains unknown.

Many scientists and doctors have attempted to pinpoint the exact cause of SIDS, but so far none has been successful in their studies. Brouardel proposed the first modern day explanation for SIDS in 1895 when he noted that all the infants that he had studied had a specific respiratory ailment.[13] Several years prior, Paltauf had made the same observation, but had determined that the inflammation of the bronchioles that he had discovered was too minor to have been the cause of death.[14] Another study in 1923 suggested that sleep apnea may lead to SIDS. Dr. Still observed "arrested respiration" in the five infants that he studied, ranging in age from a few hours to a few weeks old. In his subsequent report, he "described a silent onset, with abrupt cessation of breathing during sleep, followed by a cyanosis and continued heart beat. Between episodes, the infants were remarkably normal to observation. However, only one of his patients survived . . . ."[15] More recent studies have reported findings of abnormalities in the arcuate nucleus of the brainstems of some SIDS victims. This suggests that SIDS may "reflect delayed development of arousal, cardiorespiratory control, or cardiovascular control."[16] Further, autopsy findings of SIDS victims report increased extramedullary hematopoeisis,[17] periadrenal brown fat retention,[18] and astroglial gliosis.[19]

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[10] GUNTHEROTH, *supra* note 2, at 11.

[11] *Cf.* State v. Padua, 273 Conn. 138, 195, n.2 (2005) (Katz, J., dissenting and concurring) (recalling that in a prior case, the court ruled that expert testimony was necessary to demonstrate to the jury the importance of placing a sleeping infant in a supine or side position, rather than prone, which was important because information on the dangers of prone sleeping has not been widely disseminated, and until only recently, prone sleeping was favored and thought to be the safest position).

[12] MAWHINEY, *supra* note 7, at 14.

[13] GUNTHEROTH, *supra* note 2, at 9.

[14] *Id*.

[15] *Id*.

[16] Committee, *supra* note 8, at 437.

[17] Haemopoiesis (the formation of the cellular components of blood) typically occurs in the bone marrow. When it occurs outside of the bone marrow, it is dubbed "extramedullary". *See* BLACK'S MEDICAL DICTIONARY 270, 387 (40th ed. Gordon Macpherson ed., Scarecrow Press, Inc. 2004); MERRIAM-WEBSTER'S MEDICAL DICTIONARY (2005), *available at* http://www.nlm.nih.gov/medlineplu

Unfortunately, none of these findings is completely uniform and represent just a few, of many, autopsy findings.[20]

After practicing medicine for nearly five decades, Dr. Ralph Mawhiney has his own ideas about what causes SIDS, although no scientific study or analysis has yet to be conducted on his theories. Dr. Mawhiney suggests that SIDS results from an injury to the phrenic nerve[21] during childbirth.[22] The phrenic nerve controls the functioning of the diaphragm, which in turn controls the infant's breathing. Pressure placed on this nerve disturbs its transmission which limits the functioning of the diaphragm.[23] This pressure, Dr. Mawhiney suggests, is actually caused by the obstetrician who, during birth, often holds the infant's head in his or her hands, then turns the infant's body so that it is facing upwards.[24] This twisting of the infant's body causes a subluxation, or displacement, of a vertebral segment, which ultimately affects the infant's diaphragm and the baby's ability to breathe properly.[25] Early signs of this injury may be that the baby prefers turning his head to one side when lying on his back or stomach (in fact, the baby may actually cry when his neck is turned in the non-favored direction), reacts as if in pain or discomfort when light pressure is put on the neck with a finger, or experiences above-average nasal drainage and frequent upper respiratory symptoms.[26] However, it is important to remember that while Dr. Mawhiney's observations do indicate that these infants have experienced some spinal damage, no one has studied the relationship between this spinal damage and instances of SIDS.[27]

A highly controversial article released in 1968 linked SIDS to post-partum depression. Dr. Stuart Asch proposed that a majority of the infants

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s/mplusdictionary.html.

[18] Brown fat is the fat of infancy. Retention of fat around the adrenal glands, two triangular shaped endocrine glands near the kidneys, has been associated with SIDS. *See* MERRIAM-WEBSTER'S MEDICAL DICTIONARY (2005), *available at* http://www.nlm.nih.gov/medlineplus/mplusdictionary.html.

[19] In the nervous system, there are several types of cells. One type is the nerve cells (neurons). Another type is the supporting cells called glial cells. Glial cells are the type that provides structure and nutrients, among other things, to the nerve cells. Gliosis is the overproduction of glial cells due to a particularly harmful stimulus. *See* MERRIAM-WEBSTER'S MEDICAL DICTIONARY (2005), *available at* http://www.nlm.nih.gov/medlineplus/mplusdictionary.html.

[20] Reece, *supra* note 9, at 424.

[21] The phrenic nerve is defined as "a general motor and sensory nerve on each side of the body that arises chiefly from the fourth cervical nerve, passes down through the thorax to the diaphragm, and supplies or gives off branches supplying especially the pericardium, pleura, and diaphragm." MERRIAM-WEBSTER'S MEDICAL DICTIONARY, (2005) *available at* http://www.nlm.nih.gov/medlineplus/mplusdictionary.html.

[22] MAWHINEY, *supra* note 7, at 17.

[23] *Id.*

[24] *Id.* at 18.

[25] *Id.* at 19, 25.

[26] *Id.* at 27.

[27] *Id.* at 25.

diagnosed as dying of SIDS had actually been murdered by mothers suffering from post-partum depression.[28] The article outraged both the public and the medical communities, which both refused to believe that SIDS was actually a mask for murder.[29] Dr. Asch's hypothesis was that "the etiological 'agent' [linking all SIDS cases] must be sought in another direction [from that of the infant's physical well-being] and that a large part of these sudden unexpected deaths are infanticides, perpetrated by the mother as a specific manifestation of a post-partum depression."[30] One interesting correlation that Dr. Asch pointed out is that infants who die sudden and unexpected deaths are most often found in the morning. This corresponds with the most difficult part of the day for those individuals suffering from depression. Therefore, Dr. Asch suggests that it is in the morning, when a post-partum mother is suffering the most, that she may ultimately try to kill her child.[31] Dr. Asch acknowledged the radical nature of his hypothesis, but felt it necessary to discuss the issue of infanticide so that it could potentially be avoided in the future.[32]

Shortly after Dr. Asch's article was released, Dr. Alfred Steinschneider released a less accusatory and controversial study suggesting that the use of apnea monitors could help prevent SIDS.[33] Because Dr. Steinschneider's study legitimized SIDS as a disorder, the public was more inclined to accept its findings, despite the fact that there was no scientific proof backing his conclusions and that the apnea monitors had not saved the children profiled in his article.[34] Dr. Steinschneider's article focused on five children, all known to have had serious apnea episodes shortly after their births.[35] Two of his five patients, M.H. and N.H., were siblings.[36] Prior to their inclusion in the study, three of M.H. and N.H.'s siblings had died suddenly and unexpectedly. Both M.H. and N.H. ultimately died after Dr. Steinschneider's study had concluded.[37] Dr. Steinschneider concluded his paper stating "[t]he occurrence of apnea appears to be influenced by some of the factors known to be related to the incidence of SIDS . . . . This study also suggests the possibility that infants might be identified who are

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[28] Stuart Asch, M.D., *Crib Deaths: Their Possible Relationship to Post-Partum Depression and Infanticide*, 35 J. MT. SINAI HOSP. 214, 214 (1968).

[29] Goldenberg, *supra* note 3, at 603.

[30] Asch, *supra* note 28, at 214.

[31] *Id*. at 219.

[32] *Id*. at 218.

[33] *See* Alfred Steinschneider, M.D., Ph.D., *Prolonged Apnea and the Sudden Infant Death Syndrome: Clinical and Laboratory Observations*, 50 PEDIATRICS 646 (1972).

[34] Goldenberg, *supra* note 3, at 603.

[35] Steinschneider, *supra* note 33, at 646.

[36] *Id*. at 649.

[37] *Id*. at 648–49. Despite the numerous deaths in the same family, M.H. and N.H. were the only two children in the family who were autopsied at death. *Id*.

at risk for becoming victims of SIDS."[38] Though greatly successful when published, Dr. Steinschneider's article gave credence to two notions that ultimately turned out to be inaccurate: first, that SIDS could be genetic, so a family with one SIDS death was more likely to have a second SIDS death; second, that apnea monitors could help predict a child susceptibility to SIDS.[39]

Ironically, some twenty years after the publication of Dr. Steinschneider's article, Waneta Hoyt, the matriarch of the Hoyt family and mother of M.H. and N.H., admitted that she had smothered her five children.[40] In reality, the mother whose plight had been the fueling force behind the success of Dr. Steinschneider's article was, in fact, a more accurate example of the type of mother described in Dr. Asch's article. Following this discovery, *Pediatrics*, the journal that initially published Dr. Steinschneider's report, immediately printed a retraction, stating that "new information concerning an original study by Steinschneider et al. that focused on apnea and sudden infant death syndrome (SIDS) has emerged."[41] After Hoyt's conviction, a new definition of SIDS that had recently been adopted by the National Institute of Child Health and Human Development, gained popularity. The new definition described SIDS as "[t]he sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and a review of the clinical history."[42] Many states, like Connecticut, already required that autopsies be conducted whenever someone dies a sudden and unexpected death,[43] but this new definition places the onus on the medical world to thoroughly examine all possibilities before ruling a death as SIDS-related.

When conducting an autopsy on an infant who has suddenly and unexpectedly died, there are important considerations that a medical examiner should keep in mind. The Committee on Child Abuse and Neglect released a list of six factors, all of which should be proven true before SIDS is listed as the cause of death. The first factor is that the doctor or medical examiner has performed a complete autopsy, including the cranium and cranial contents, and those autopsy findings are compatible with SIDS. Guntheroth elaborates on the Committee's first

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[38] *Id.* at 653.

[39] *See* Reece, *supra* note 9, at 424; George A. Little, M.D. & John G. Brooks, M.D., Editorial, *Accepting the Unthinkable*, 94 PEDIATRICS 748, 748 (1994).

[40] Goldenberg, *supra* note 3, at 604.

[41] Little & Brooks, *supra* note 39, at 748. The article went on to criticize the medical community for refusing to believe that infanticide could ever be the cause of an infant's death. *Id.* at 748–49.

[42] Goldenberg, *supra* note 3, at 605. *But see* GUNTHEROTH, *supra* note 2, at 1–2 (stating that this new definition was rejected at the 1992 conference on SIDS in Australia as a "considerable step backwards as far as international comparisons are concerned").

[43] CONN. GEN. STAT. ANN. § 19a-406(a)(2) (West 2005).

factor, stating that:

> It is also helpful to understand that there are several lethal diseases that leave no diagnostic markers on postmortem examination. Considering that the diagnosis of SIDS is a diagnosis of exclusion, and the means of exclusion are imperfect, the diagnosis of SIDS is one that is *compatible* with the disorder, never uniquely diagnostic.[44]

Other factors include: (1) the autopsy reveals no evidence of either gross trauma or a diagnosable disease; (2) the skeletal survey indicates no evidence of trauma; (3) all other causes of death are adequately ruled out, including meningitis, sepsis, aspiration, pneumonia, myocarditis, abdominal trauma, dehydration, fluid and electrolyte imbalance, significant congenital lesions, inborn metabolic disorders, carbon monoxide asphyxia, drowning, or burns; (4) the toxicology report reveals no evidence of drug or alcohol ingestion or other toxic exposures; and (5) the death scene and the infant's clinical history have been thoroughly reviewed and reveal no questionable results.[45]

However, it is possible that an infant may be suffering from a mild form of a specific condition. Technically speaking, even if the death is sudden, it should not be classified as a SIDS death, but it may be appropriate to inform the parents that SIDS was the cause of death. Otherwise, the parents may understand the death to have been preventable, and this would open up the doctors to potential lawsuits, despite the impossibility of preventing the sudden and unexpected death. This situation is the paradox of sudden infant death syndrome.[46]

III. MUNCHAUSEN BY PROXY SYNDROME: MOTHERS WITH ULTERIOR MOTIVES

The medical field succeeds in correctly diagnosing and treating illnesses largely because of a relationship built on trust. Doctors rely on patients and their guardians to explain symptoms, and from that information, doctors determine the proper course of action. When a young child is the patient, parents and guardians become responsible for adequately informing the doctor of the child's ailments. Dr. Marc Feldman explains this relationship as both an altruistic and a selfish one for doctors: "Having no cause to doubt their patients, physicians are motivated by a sincere desire to relieve the patient's suffering. Add to this benign intent the fear of malpractice litigation in an increasingly scrutinized profession

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[44] GUNTHEROTH, *supra* note 2, at 4.
[45] Committee, *supra* note 8, at 438.
[46] GUNTHEROTH, *supra* note 2, at 21.

and the result is a treatment approach that leaves no stone unturned."[47] What happens, however, when a patient or a parent is not entirely truthful with his or her doctor, either fabricating symptoms altogether or exaggerating the degree of the symptoms? How can this relationship based on trust continue? Individuals who fabricate or exaggerate symptoms in order to gain medical attention are said to suffer from factitious syndrome, the most extreme category being Munchausen Syndrome.[48] Parents who fabricate or exaggerate their child's symptoms are said to suffer from Munchausen by Proxy Syndrome (MBPS), a term coined in 1977 by British pediatrician Roy Meadow.[49]

Munchausen Syndrome and MBPS get their names from the Hieronymus Karl Friedrick Freiherr von Munchausen, a man notorious for telling tall tales of his various adventures, most of which ultimately proved to be false.[50] While exact data are not known, some estimate that between two hundred and one thousand cases of MBPS have been diagnosed since 1977.[51] Other scholars believe that nearly 1200 cases of MBPS are diagnosed or suspected each year.[52] Although the American Professional Society on the Abuse of Children has recently made tremendous strides in identifying, preventing, and encouraging prosecution of cases of MBPS, two major problems remain. First, there is a general reluctance to admit that MBPS exists; and second, there is a gross underestimation of occurrences.[53] Despite these obstacles, experts have managed to identify four main elements of MBPS: (1) the perpetrator is typically either the child's parent or someone acting in the paternal role; (2) the parent requests extensive medical evaluations and tests to be performed on the child; (3) the parent denies causing the child's illness; and (4) when the

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[47] MARC D. FELDMAN, M.D., PLAYING SICK? UNTANGLING THE WEB OF MUNCHAUSEN SYNDROME, MUNCHAUSEN BY PROXY, MALINGERING & FACTITIOUS DISORDER 11–12 (2004).

[48] *Id*. at 25. In his book, Dr. Feldman addresses both malingering and factitious disorder. Malingering disorder is defined as fabricating or exaggerating symptoms for purely material benefits. Factitious disorder differs from malingering disorder in that the benefits are purely emotional (such as empowerment among or attention of health care providers). *Id*. at 23. Malingering disorder is outside of the scope of this article and will not be addressed further. Additionally, factitious disorder will only be addressed in its most extreme form, Munchausen Syndrome.

[49] DAVID B. ALLISON & MARK S. ROBERTS, DISORDERED MOTHER OR DISORDERED DIAGNOSIS? MUNCHAUSEN BY PROXY SYNDROME XVIII (1998); *see also* Carol L. Rosen, M.D., et al., *Two Siblings with Recurrent Cardiorespiratory Arrest: Munchausen Syndrome by Proxy or Child Abuse?* 71 PEDIATRICS 715, 715 (1983) (referring to the disorder as Polle syndrome). Polle was Baron Munchausen's son who died a mysterious death before his first birthday. It is suspected by some that the Baron killed Polle, thus the syndrome being termed in some circles "Polle Syndrome."

[50] Michael T. Flannery, *Munchausen Syndrome by Proxy: Broadening the Scope of Child Abuse*, 28 U. RICH. L. REV. 1175, 1181 (1994).

[51] Melissa A. Prentice, Note, *Prosecuting Mothers Who Maim and Kill: The Profile of Munchausen Syndrome by Proxy Litigation in the Late 1990s*, 28 AM. J. CRIM. L. 373, 377 (2001).

[52] FELDMAN, *supra* note 47, at 123.

[53] Lynn H. Goldman & Beatrice C. Yorker, *Mommie Dearest? Prosecuting Cases of Munchausen Syndrome by Proxy*, 13 CRIM. JUST. 26, 27 (1999).

parent is no longer within close range of the child, the symptoms quickly disappear.[54]

Technically, MBPS is a misnomer. The problem lies in the fact that MBPS does not actually exist within any individual. The diagnosis, rather, is forced upon that individual by a doctor who believes that the person fits the profile of others who were said to also have the same syndrome.[55] In fact, some have suggested that syndrome be dropped from the name altogether since it suggests that Munchausen by Proxy is a group of symptoms rather than a horrendous form of child abuse that must be addressed as a criminal matter.[56] MBPS likewise differs from other factitious disorders because rather than setting him- or herself up as the victim, the individual with MBPS is actually the perpetrator who is abusing a child for seemingly unclear reasons.[57] Because MBPS is exacerbated by deception, it does not fit into traditional categories of child abuse where physical signs of neglect or abuse are often present.[58] This deception component of MBPS makes the discovery of its existence all the more difficult. Though MBPS may not be a diagnosable disorder, some suggest that those with MBPS may also have other diagnosable and treatable mental disorders. However, because one of the elements of MBPS is denial, it would be virtually impossible to convince a mother to admit that she had MBPS and then to agree to undergo additional psychological testing.[59]

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) defines MBPS; however, the fourth and most recent edition does little to clarify the disorder or confirm its existence. *DSM-III*, the penultimate edition of the manual, indicated that the syndrome is "not real, genuine or natural" and went on to suggest that the symptoms are entirely "produced by the individual and are under his voluntary control."[60] *DSM-IV* does away with the term "MBPS" altogether, instead including the disorder within the discussion of "factitious disorder by proxy."[61] "Factitious disorder by proxy" falls within the heading of "factitious disorder not otherwise specified," which includes individuals who have factitious symptoms that do not meet the criteria for a factitious disorder where an

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[54] Flannery, *supra* note 50, at 1184.

[55] ALLISON & ROBERTS, *supra* note 49, at 67.

[56] FELDMAN, *supra* note 47, at 124.

[57] *Id*. at 122.

[58] Flannery, *supra* note 50, at 1209–10.

[59] FELDMAN, *supra* note 47, at 127.

[60] ALLISON & ROBERTS, *supra* note 49, at 68.

[61] AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 726 (4th ed. 1994). Despite this change, for the purposes of this article, the term "Munchausen by Proxy Syndrome" will continue to be used, as it is more commonly used and recognized in the everyday vernacular.

individual fabricates or exaggerates his or her own symptoms.[62] Despite this name change, the diagnosis itself remains largely the same: "deliberate production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care."[63]

Assuming that MBPS should even be considered a syndrome, numerous questions surround it: Why would parents intentionally harm their children in order to gain attention? How can doctors and other medical staff recognize that a patient's parent suffers from Munchausen by Proxy? How can a doctor repair the damage done if a false accusation of Munchausen by Proxy is made? Though all of these questions cannot necessarily be answered, experts have managed to construct a "profile" of the typical individual with MBPS. Mothers are the perpetrators approximately seventy-five percent of the time. In the remaining twenty-five percent of cases, other female caregivers, such as relatives or babysitters, are the perpetrators. Rarely are men suspected of having MBPS, most likely because females spend more time with the infant in the caretaker role.[64] Typically the perpetrator is between the ages of twenty and twenty-five with a history of medical and mental health problems. She is often extremely or overly cooperative with medical staff and may suggest additional rigorous and painful testing of the child despite medical opposition. The goal of these additional tests is to prove to the medical staff that the child's illness is neither common not easily diagnosed, thus the mother deserves more sympathy for dealing with such a sick child.[65] Finally, many mothers with MBPS also have extensive medical knowledge, either from education or from work history.[66]

Once a mother has brought her child into the hospital for treatment, there are additional warning signs that doctors and medical staff may look for to help identify a mother with MBPS. First, it is important to remember that MBPS most commonly endangers infants and toddlers because the victims are too young to speak. It is very rare, although not

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[62] *Id*. at 475.

[63] *Id*. at 725. Other information contained in the diagnosis includes: the victim is usually a young child and the perpetrator is most often his or her mother; the motivation of the perpetrator is not external, but rather is a desire to obtain the role of being sick by proxy; types of symptoms most commonly induced affect gastrointestinal, genitourinary, and central nervous system; mental disorder simulation is far less common; life stresses may trigger the behavior; perpetrators often exhibit pathological lying with regards to everyday events as well as with regards to the victim's symptoms; perpetrators often have an abundance of knowledge about the medical field and thrive in the health care environment, though their concern does not appear to meet the level appropriate for someone with such a sick child; perpetrators may face criminal charges ranging from abuse to murder; and usually the perpetrator focuses on one victim at a time although other siblings may be past or future victims. *Id*. at 725–26.

[64] FELDMAN, *supra* note 47, at 124.

[65] ALLISON & ROBERTS, *supra* note 49, at 5.

[66] Flannery, *supra* note 50, at 1189–90; ALLISON & ROBERTS, *supra* note 49, at 5; Prentice, *supra* note 51, at 391.

impossible, for an older child to be subjected to MBPS.[67] Additional warning signs include: (1) symptoms disappear when the child is separated from the mother; (2) other children in the family have suffered from similarly unexplained illnesses or have died; (3) symptoms presented are not corrected by appropriate treatment; (4) data from tests conducted are inconsistent with information provided by the mother; (5) the mother has a history of faking her own illnesses and may even have Munchausen Syndrome; and (6) the only possible diagnoses are extremely rare diseases that are unlikely to be the source of the child's symptoms.[68]

Mothers with MBPS may use a variety of methods to convince the medical staff of their children's need for treatment. The two most basic distinctions between these methods are that symptoms may be completely fictitious, for example, nothing is actually wrong with the child, or alternatively, the mother may induce symptoms in her child, like by injecting the child with various substances.[69] For example, one study discovered that mothers had injected their children with insulin leading to severe hypoglycemia.[70] Two different researchers, Feldman and Allison & Roberts, narrow down these two distinctions into seven and four subcategories, respectively.[71] First, exaggerations occur when a mother claims that an actual problem exists to a degree much greater than is actually the case,[72] for example, that the child experiences frequent but mild headaches, but the mother describes intense migraines that last for hours that do not respond to over-the-counter medication. Second, false reports[73] or feigned diseases[74] are completely fictitious and all pain is fabricated by the mother. For example, if the mother brought the child to a new doctor and claimed that the child had previously battled cancer. Allison & Roberts' third category, factitious diseases, are those that are produced entirely by the mother's actions.[75] Feldman breaks this category into two separate categories: falsification of signs, where the mother may alter reports, manipulate thermometers, or spoil specimens with outside contaminants and simulations of signs or symptoms where the mother may cause the child to appear to have a particular symptom, but in reality the

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[67] FELDMAN, *supra* note 47, at 125.

[68] *See id*. at 140–41; Prentice, *supra* note 51, at 389–91.

[69] William A. Bauman, M.D. & Rosalyn S. Yalow, Ph.D., *Child Abuse: Parental Insulin Administration*, 99 PEDIATRICS 588 (1981). Bauman & Yalow discuss how they analyzed plasma samples taken from the children using guinea pig antiserum and human antiserum to determine that the insulin had been externally administered rather than internally manufactured. *Id*. at 588–90.

[70] *Id.* at 588.

[71] FELDMAN, *supra* note 47, at 20–21; ALLISON & ROBERTS, *supra* note 49, at 85.

[72] FELDMAN, *supra* note 47, at 20; ALLISON & ROBERTS, *supra* note 49, at 85.

[73] FELDMAN, *supra* note 47, at 20–21.

[74] ALLISON & ROBERTS, *supra* note 49, at 85.

[75] *Id*.

mother is creating it.[76] When falsifying a sign, the mother's actions are not directly hurting the child whereas falsification of symptoms might, for example, if the mother were forcing the child to drink excessive amounts of ipecac so he or she would vomit.

Finally, Feldman breaks Allison & Roberts' final category, aggravated diseases, which involves mother actively worsening a child's legitimate disease,[77] into three separate categories: dissimulations, aggravations, and self-induced signs or diseases.[78] Dissimulations occur when the mother conceals a child's actual illness so that it progresses significantly until any medical attention is sought. Aggravations are actual illnesses made worse by the mother's actions. The difference between aggravations and dissimulations is that a mother does not conceal the disease in an aggravation context. Self-induced signs or diseases are when the disease is created wholly by mother by injecting a bacteria or other substance into the blood stream of the child.[79]

When making the determination that a mother has MBPS and, as such, that the child's symptoms are not real, doctors must be very careful before making any accusations. In order to avoid making a potentially fatal misdiagnosis, doctors must balance several competing interests.

> First, in an attempt to treat a child without full disclosure from the parent creates a risk of error due to falsified information. Second, the physician must avoid causing greater harm to the child due to a misdiagnosis of the child's malady or a failure to accurately diagnosis [MBPS]. Finally, the physician must be aware of the possibility of alienating a wrongly accused or suspected parent.[80]

However, despite a need to take these various interests into consideration, many doctors do not even consider MBPS as a possibility until they perform a number of rigorous and unnecessary tests and are unable to find anything wrong with the child.[81] To address this potential problem, the medical profession could establish procedures for a doctor to follow before making a diagnosis. For example, highly invasive, dangerous, and painful testing should be reserved for only the most extreme circumstances and hospitals could conduct thorough observations

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[76] FELDMAN, *supra* note 47, at 21 (citing as an example of simulations of signs or symptoms if a mother were to claim that a child was vomiting blood, but mother had actually placed a pouch of red fluid in the child's mouth).

[77] ALLISON & ROBERTS, *supra* note 49, at 85.

[78] FELDMAN, *supra* note 47, at 20–21.

[79] *Id.* at 21.

[80] Corey M. Perman, *Diagnosing the Truth: Determining Physician Liability in Cases Involving Munchausen Syndrome by Proxy*, 54 WASH. U.J. URB. & CONTEMP. L. 267 (1998).

[81] Prentice, *supra* note 51, at 389.

of children outside of their parent's care in order to verify the presence of symptoms. Unfortunately, no procedure would be failsafe, and labeling a child as falsely ill while the doctor performs a thorough examination creates a number of other problems in addition to the potentially deadly consequences of the mother's actions. Such consequences may include: the child being forced to undergo many unnecessary and possibly harmful tests and medical procedures; the mother's actions could cause the child to become truly sick; the child may die if the mother does not realize how much harm her continued actions are causing; the child may become a chronic invalid, believing that he or she is disabled and therefore unable to work or function at a normal level; and the child may ultimately develop Munchausen Syndrome as an adult.[82]

There is still much to learn about MBPS and it is possible that a mother's motives for harming her child in such a despicable manner may never be known. When Asher first wrote about Munchausen Syndrome in the mid-twentieth century, he suggested five potential motives for the disorder, although few, if any, make sense as motives for MBPS.[83] Additionally, a mother's goal is also likely not to kill the child because if that were the case, it is unlikely that she would first engage in such long-term deception tactics.[84] The primary, and possibly only, understood motive of mothers with MBPS is to obtain the attention and sympathy of individuals working within the medical community.[85] The most concrete advice that can be given is that individuals within the medical field must be cognizant of MBPS's existence and diligent about noticing unusual activity and investigating all the facts prior to making any type of diagnosis.

IV. THE INTERSECTION OF SUDDEN INFANT DEATH SYNDROME AND MUNCHAUSEN BY PROXY SYNDROME

A. Child Abuse Masquerading as Sudden Infant Death Syndrome

The Federal Child Abuse Prevention and Treatment Act of 1974 defines child abuse and neglect as, "at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or

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[82] Perman, *supra* note 80, at 276.

[83] ALLISON & ROBERTS, *supra* note 49, at 113 (quoting Asher's five proposed motives for Munchausen Syndrome: (1) a desire to be the center of attention for the hospital staff; (2) a grudge against hospital staff that is satisfied by deceiving them; (3) a desire to procure drugs; (4) a desire to hide from the police; and (5) a desire for free room and board).

[84] E. Selene Steelman, Note, *A Question of Revenge: Munchausen Syndrome by Proxy and a Proposed Diminished Capacity Defense for Homicidal Mothers*, 8 CARDOZO WOMEN'S L.J. 261, 272 (2002).

[85] ALLISON & ROBERTS, *supra* note 49, at 5.

failure to act which presents an imminent risk of serious harm."[86] MBPS without doubt falls into this category of abuse because the mother is both physically and mentally injuring the child by creating various diseases and ailments. As the general public became more aware of child abuse and states passed mandated reporter statutes throughout the 1980s and 1990s, reported suspected child abuse situations rose dramatically. That awareness also prompted doctors to reinvestigate diseases such as SIDS that continued to baffle the medical profession, and suddenly, MBPS became "a focal point in the diagnosis of these confusing types of disorders."[87]

Physicians are mandated reporters under Connecticut state statute; thus, they are obligated to report to the Department of Children and Families any suspected case of child abuse or neglect that they encounter.[88] However, it is crucial for physicians to understand that certain signs and symptoms often related to child abuse may be exhibited by the children for reasons that are not necessarily abuse-related.[89] The existence of MBPS forces physicians to determine whether a parent is being truthful about her child's symptoms, yet at the same time, the doctor must also be careful to avoid over-diagnosing mothers with MBPS.[90] Over-diagnosing MBPS can be fatal in cases when the child does, in fact, have an illness, and rather than focusing on the child's treatment, the doctor refuses to believe that the symptoms are real. Although it is rare, a 1999 report demonstrated that in 3.5% of MBPS cases, the mother is erroneously diagnosed as having the disorder. Typically the mistake is realized when, although the mother presses for additional tests and examinations, she is ultimately elated to find out that nothing is in fact wrong with the child.[91] A misdiagnosis such as this could irreparably damage the physician-parent relationship, and thus should be avoided whenever possible.[92]

When a mother does exhibit MBPS behavior, the mortality rate for the children in her care is between nine and ten percent, making MBPS one of the deadliest forms of child abuse.[93] Perhaps even more shocking is that most deaths resulting from MBPS are accidental.[94] The fact that most

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[86] 42 U.S.C. § 5106(g)(2) (2006).

[87] ALLISON & ROBERTS, *supra* note 49, at XIX.

[88] CONN. GEN. STAT. ANN. § 17a-101 (2005).

[89] J. Martin Kaplan, M.D., *Pseudoabuse—The Misdiagnosis of Child Abuse,* 31 J. FORENSIC SCI. 1420, 1420–21 (Oct. 1986). Dr. Kaplan states that injuries such as broken bones or bruises should never be taken as per se evidence of child abuse. It is imperative that the doctors investigate all potential causes of injury before making the determination that a parent has been intentionally harming her child. *Id*. at 1425.

[90] Perman, *supra* note 80, at 269.

[91] FELDMAN, *supra* note 47, at 144.

[92] Kaplan, *supra* note 88, at 1420.

[93] FELDMAN, *supra* note 47, at 124.

[94] Steelman, *supra* note 84, at 271.

mothers with MBPS do not intend to kill their children demonstrates how deadly the syndrome truly is. It is difficult, however, to gauge the real impact of MBPS since the abuse may go unnoticed, with the cause of the child's death being listed as SIDS.[95] It is estimated that between two and ten percent of SIDS cases each year are actually the result of child abuse.[96] Because approximately 5000 infant deaths are attributed to SIDS each year, anywhere from 100 to 500 of those deaths may actually be undetected homicides.[97]

In approximately ten percent of MBPS cases, the mother is not suspected of having the disorder or of abusing her children until after one or more of her children has already died.[98] Medical investigators are quick to warn doctors that MBPS does not necessarily affect only one child in a household, and special attention should be paid to a child who has siblings who have either died or are chronically sick.[99] It is not uncommon that once a mother becomes the target of an investigation for the murder of one child, the deaths of other siblings are then investigated for the first time.[100] Dr. Steinschneider's article helped perpetuate the longstanding myth that SIDS could be a genetic occurrence, and thus that it was not unlikely for many infants within the same family to die of SIDS.[101] However, the medical community now understands that the odds of multiple SIDS deaths in one family are relatively low.[102] As Robert Reece points out:

> [W]hen SIDS occurrences among siblings of SIDS cases were compared with those among non-SIDS siblings in maternal age—and birth rank—matched control families, there was no statistically significant difference in SIDS rates or in total infant mortality rates in families with a history of SIDS compared with families with no SIDS. Thus, the notion that having a SIDS baby makes having another more likely was dispelled.[103]

Statistics reveal a less than one percent chance that siblings will die of

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[95] Brenda Barton, Comment, *When Murdering Hands Rock the Cradle: An Overview of America's Incoherent Treatment of Infanticidal Mothers*, 51 SMU L. REV. 591, 612 (1998).

[96] Prentice, *supra* note 51, at 393.

[97] Goldenberg, *supra* note 3, at 600. Of course, it is possible that a mother kills her child intentionally and does not have MBPS; however, those killings will not be addressed in this article.

[98] Prentice, *supra* note 51, at 377.

[99] FELDMAN, *supra* note 47, at 130.

[100] Barton, *supra* note 95, at 614.

[101] Goldenberg, *supra* note 3, at 602.

[102] *Id*. at 606.

[103] Reece, *supra* note 9, at 424. For more research on the relationship between SIDS, suffocation, and poisoning, see R.J. McClure et al., *Epidemiology of Munchausen Syndrome by Proxy, Non-Accidental Poisoning, and Non-Accidental Suffocation*, 75 ARCHIVES OF DISEASE IN CHILDHOOD 57 (July 1996).

SIDS.[104] It is hoped that by understanding that SIDS is not a genetic disorder a physician will become suspicious when multiple infants in the same family die with an indeterminable cause of death.

One tremendous roadblock to differentiating SIDS cases from Munchausen by Proxy cases is that even an autopsy cannot really distinguish between SIDS and a case of accidental or intentional suffocation.[105] Additionally, a doctor may diagnose a death as SIDS without even performing an autopsy. Allison & Roberts suggest that an autopsy should always be performed, whenever the cause of an infant's death is not completely explained.[106] Assuming an autopsy is performed, there are some subtle warning signs that may indicate an infant's death was caused, not by SIDS, but rather by abuse. Infants whose deaths were caused by MBPS may have bruises or blood on their faces, which would not be present in a true SIDS death.[107] However, postmortem lividity and skin mottling can sometimes be confused with bruises or lesions associated with child abuse.[108] Aside from autopsy, an examination of the death scene may also reveal clues as to whether the death was due to abuse or SIDS, but in nearly fifty percent of cases, SIDS is not suspected until the infant arrives at the hospital, and at that point, the death scene no longer exists.[109] Finally, Reece sets forth thirteen criteria for determining whether a child's death was due to child abuse or SIDS. Those criteria include: performing a clinical appraisal of the infant prior to autopsy; collection of previous medical records from all sources of prior medical cause, including interviews with medical providers; creation of a support system for parents during the death review process; gathering an accurate history of the events leading to the infant's death; and conducting a protocol postmortem examination of the infant within twenty-four hours of death.[110] Though none of these suggestions can clearly indicate whether a death was due to SIDS or child abuse, the medical community can utilize them to the best of their ability and will hopefully detect some of the homicides masquerading as SIDS.

B. Taking Munchausen by Proxy Syndrome to Court

As the medical profession grows more aware of MBPS, so too does the legal system, which has begun to prosecute mothers, who as a result of their behavior, kill their children. Between 1997 and 2000, prosecutors in

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[104] Goldenberg, *supra* note 3, at 606.
[105] GUNTHEROTH, *supra* note 2, at 9.
[106] ALLISON & ROBERTS, *supra* note 49, at 147.
[107] FELDMAN, *supra* note 47, at 126.
[108] Reece, *supra* note 9, at 425.
[109] GUNTHEROTH, *supra* note 2, at 90.
[110] Reece, *supra* note 9, at 428.

fifteen states and the District of Columbia brought criminal homicide charges against mothers, accusing them of MBPS-related child abuse or killings.[111] Causing death by MBPS is not a formal charge, so mothers in this situation face traditional homicide charges.[112] Connecticut law establishes four potential charges for a mother who has killed her child because she had MBPS. First, a person may be charged with murder when "with intent to cause the death of another person, he causes the death of such person or of a third person . . . ."[113] Because mothers with MBPS do not intend to kill their children, it is highly unlikely that they will be charged with murder in the state of Connecticut. Second, a person may be charged with manslaughter in the first degree when "with intent to cause serious physical injury to another person, he causes the death of such person or of a third person . . . ."[114] Manslaughter in the second degree would be the charge if a person "recklessly causes the death of another person . . . ."[115] Finally, criminally negligent homicide would be the charge if a person "with criminal negligence . . . causes the death of another person . . . ."[116]

One of the biggest obstacles to both the prosecution and the defense of an MBPS homicide case is that judges and juries are reluctant to acknowledge that the disorder actually exists.[117] This is despite the fact that *DSM-IV* lists factitious disorder by proxy as a medically recognized disease.[118] For whatever reason, the legal community is not willing to accept *DSM-IV*'s inclusion of factitious disorders as proof of their existence. Failure to recognize MBPS hurts the defense because it disallows any diminished capacity defense.[119] Alternatively, without recognition of MBPS as an actual disorder, the prosecution may have difficulty convincing the judge to admit expert testimony or evidence suggesting that the mother has MBPS. Even if the prosecution's case does not center on the mother having MBPS, much of the evidence it wishes to present may implicitly assume the existence of such a disorder. Often, prosecutors are faced not only with the task of proving that the child was abused or murdered by the mother, but also with proving that MBPS exists

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[111] Prentice, *supra* note 51, at 377. Those fifteen states are Alabama, Arizona, California, Florida, Illinois, Indiana, New York, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Washington, and West Virginia. *Id*. at 377–80.

[112] Goldman & Yorker, *supra* note 53, at 29.

[113] CONN. GEN. STAT. ANN. § 53a-54(a) (West 2005).

[114] CONN. GEN. STAT. ANN. § 53a-55 (West 2005).

[115] CONN. GEN. STAT. ANN. § 53a-56(a)(1) (West 2005).

[116] CONN. GEN. STAT. ANN. § 53a-58(a) (West 2005).

[117] Michael T. Flannery, *First, Do No Harm: The Use of Covert Video Surveillance To Detect Munchausen Syndrome by Proxy—An Unethical Means of "Preventing,"* 32 U. MICH. J.L. REFORM 105, 105 (1998).

[118] *See supra* notes 61–63.

[119] *See* discussion *infra* Part IV-B-2; *see generally* Steelman, *supra* note 84.

at all.[120] However, it is generally accepted that if a prosecutor does manage to succeed in convincing the judge and jury that MBPS exists, his or her case against the mother for the murder of her child gains tremendous strength.[121] Thus, at first glance, it appears to be in the best interest of both the prosecution and the defense that the legal system recognizes MBPS as a valid disorder.

1. Prosecuting Munchausen by Proxy Mothers Who Kill

When deciding whether to prosecute a mother for homicide or for MBPS homicide, the prosecutor must look at a variety of factors. While similarities between the two choices exist, ultimately the decision made has a tremendous impact on the direction of the prosecution. When prosecuting a mother for a Munchausen by Proxy homicide, the charge of murder is a near impossibility because in most jurisdictions, including Connecticut, intent to kill is an element of murder.[122] Therefore, if the prosecution chooses to introduce the fact that the mother suffered from MBPS, the most serious crime that the mother may be charged with would be manslaughter in the first degree.[123] However, because manslaughter in the first degree includes the element of "intent to cause serious physical injury" and a MBPS mother does not necessarily have that intent either, a prosecutor could end up with only a charge of manslaughter in the second degree, the equivalent of reckless homicide.[124] Alternatively, if the prosecution opts not to introduce the possibility of the mother having MBPS, it would be able to charge the mother with murder, assuming that it believes it could prove all elements of the crime. Therefore, assuming the state is even aware of the MBPS evidence, the prosecution must make the decision of whether to introduce MBPS evidence even before they file charges against the mother.

Another consideration for a prosecutor deciding whether to address MBPS in the courtroom is whether the court will even allow expert testimony on MBPS. Expert testimony is crucial to an MBPS prosecution because it helps prove beyond a reasonable doubt that the mother was responsible for the murder, it aids juries in understanding the nature of the crime and aids judges in sentencing the defendant mother appropriately, it helps create uniformity because as more courts agree to allow expert testimony on MBPS, other courts will be inclined to do the same, and it preserves the record if the case is appealed.[125] In order to introduce

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[120] Goldman & Yorker, *supra* note 53, at 27.
[121] Steelman, *supra* note 84, at 289.
[122] CONN. GEN. STAT. ANN. § 53a-54(a) (West 2005).
[123] CONN. GEN. STAT. ANN. § 53a-55 (West 2005).
[124] CONN. GEN. STAT. ANN. § 53a-56 (West 2005).
[125] Goldman & Yorker, *supra* note 53, at 32–33.

evidence of MBPS, a prosecutor will have to follow his or her state's statutes regarding admission of expert testimony. In Connecticut, the Code of Evidence governs such admissions and states that:

> A witness qualified as an expert by knowledge, skill, experience, training, education or otherwise may testify in the form of an opinion or otherwise concerning scientific, technical or other specialized knowledge, if the testimony will assist the trier of fact in understanding the evidence or in determining a fact in issue.[126]

Though each state statute varies, many are based on the Federal Rules of Evidence.[127] Connecticut's Code of Evidence differs from the Federal Rules of Evidence in that it does not contain the requirement that the expert base his testimony on reliable principles and methods. However, the Connecticut Supreme Court interpreted the rule to contain the same general components as the federal rule. In *State v. Porter*,[128] the Court followed the U.S. Supreme Court's decision in *Daubert v. Merrell Dow Pharmaceuticals* ruling that the evidence presented by the expert must be reliable.[129] Scientific evidence may be considered reliable when the principles and methods underlying the testimony are scientifically valid.[130]

With regard to MBPS evidence, judges often refuse to admit testimony because it does not comport with this requirement. For example, in the trial of Kathy Bush in Ft. Lauderdale, Florida, the judge refused to allow expert testimony on MBPS, calling the testimony unreliable due to the wide disagreement among experts on what the syndrome was and how it could be diagnosed.[131] In another case, experts for both the prosecution and defense produced more than 8000 pages of documents disagreeing over whether the mother had MBPS.[132] Ultimately, the judge ruled that the expert testimony was not admissible.[133] While some courts have held that a chronically ill or deceased child with puzzling symptoms and a mother who "fits the profile" of a MBPS offender is all the state must show to prove Munchausen by Proxy,[134] most courts are more stringent in their

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[126] CONN. CODE EVID. § 7-2 (2006).

[127] FED. R. EVID. 702 ("If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise, if (1) the testimony is based upon sufficient facts or data, (2) the testimony is the product of reliable principles and methods, and (3) the witness has applied the principles and methods reliably to the facts of the case.").

[128] 241 Conn. 57 (1997).

[129] 509 U.S. 579 (1993).

[130] *Porter*, 241 Conn. at 64.

[131] Prentice, *supra* note 51, at 382.

[132] *Id.* at 385.

[133] *Id*.

[134] ALLISON & ROBERTS, *supra* note 49, at XI.

requirements of proof. Therefore, in making his decision, a prosecutor must check the rules of his or her jurisdiction to determine whether he or she would even be permitted to introduce evidence of MBPS at trial.

During trial, the prosecution may encounter a number of different difficulties in proving that the mother killed her child, whether she suffered from MBPS or not. A prosecutor typically relies upon two different types of evidence in a homicide case: direct evidence and circumstantial evidence. *Black's Law Dictionary* defines direct evidence as "evidence that is based on personal knowledge or observation and that, if true, proves a fact without inference or presumption."[135] Direct evidence of MBPS leading to death of the child could be a video surveillance recording of the mother inducing symptoms in the child,[136] eyewitness accounts of the mother tampering with child's treatment or condition, autopsy results, foreign matter found in a syringe in the child's room or in the child's intravenous bag, or confessions.[137] Direct evidence of murder would include an eyewitness account of the murder or a confession. Often, however, direct evidence is not available, meaning that prosecutors must prove criminality without any tangible, non-circumstantial evidence.[138]

Circumstantial evidence is "evidence based on inference and not on personal knowledge or observation."[139] Circumstantial evidence of a Munchausen by Proxy homicide could be that the child experiences symptoms only when the mother has just been alone with him or her, that toxic drug levels are present in the child's urine or bloodstream, or that tiny holes are discovered in the intravenous tubing and a syringe is found in mother's purse.[140] Circumstantial evidence of a murder would include the child's DNA being found on a pillow that may have been used to suffocate him or that the defendant had taken out a large insurance policy on the victim only days before the murder. Sometimes courts may permit the prosecution to demonstrate that other children in the family have also died mysterious deaths or had been permanently incapacitated. This evidence could show either that the mother does in fact have MBPS or alternatively, if MBPS evidence will not be admitted by the court, the mother's modus operandi of harming her children in a specific way.[141] In many cases, there is a lack of direct evidence, thus forcing the prosecution to rely on

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[135] BLACK'S LAW DICTIONARY 596 (8th ed. 2004).

[136] *See* Prentice, *supra* note 51, at 385. Cynthia Lyda of San Antonio, Texas ultimately pled guilty to murdering her child after evidence was presented in the courtroom of a videotape of Lyda blowing forcefully into her son's feeding tube, causing detrimental side effects. *Id.*

[137] *See* Goldman & Yorker, *supra* note 53, at 29; Prentice, *supra* note 51, at 405.

[138] Prentice, *supra* note 51, at 404.

[139] BLACK'S LAW DICTIONARY 595 (7th ed. 1999).

[140] Goldman & Yorker, *supra* note 53, at 29.

[141] *Id*. at 32; *see also* Estelle v. McGuire, 502 U.S. 62 (1991); United States v. Woods, 484 F.2d 127 (4th Cir. 1973); United States v. Welch, 36 F.3d 1098 (S.D. Ohio 1994).

circumstantial evidence alone.[142] This may be because the mother has been so careful in covering her abuse that no direct evidence exists or because all direct evidence points to the mother having MBPS and therefore does not support the prosecution's charge of murder.

Because of the tremendous burden on the prosecution in proving an MBPS homicide case and the corresponding mitigating factor that the presence of the issue creates, the prosecutor will most likely not prosecute the mother on the theory that she has MBPS. One possibility is that a prosecutor might decide to prosecute a MBPS homicide if he or she is sure that there is insufficient evidence for a murder charge and the only evidence available alludes to the presence of Munchausen by Proxy. Assuming the prosecutor decides to not introduce the idea of the mother having MBPS does not necessarily mean that he or she will not address the idea in court. The defense may raise the issue of MBPS in the hopes that it will mitigate the charges against the mother.[143] If that is the case, the prosecution must be careful not to stipulate that the mother has MBPS because the offense would be mitigated to, at most, manslaughter in the first degree.[144]

Regardless of a prosecutor's decision on whether to introduce evidence of MBPS, he or she will face some of the same difficulties that exist in many other homicide prosecutions. Those problems may include lengthy delay between the killing and the trial which may cause witnesses to forget details of their stories, or evidence to be unknowingly destroyed;[145] simultaneous child custody cases; high costs and difficulty in understanding or explaining complex cases; and dealing with sympathetic defendants who continually deny having anything to do with their children's deaths.[146]

Though the role of the prosecutor is to convict guilty parties and he or she may not be interested in raising the issue him- or herself, perhaps a prosecutor should spend some time educating him- or herself on MBPS before he or she launches a full scale attack on a mother who claims to suffer from the disorder. A prosecutor cannot possibly understand the mentality of the mother or the difficulty of the road ahead if he or she does not thoroughly investigate MBPS and its implications when introduced in

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[142] Prentice, *supra* note 51, at 407.

[143] *See* discussion *infra* Part V.B.

[144] *See* discussion *supra* Part IV.B.1.

[145] *See* Maryclaire Dale, *Syndrome Blamed in 15-year-old Case*, CHARLESTON GAZETTE, Nov. 13, 1996 at P1A (describing how Mary Beth Davis was not charged with the murder and poisoning of her two children until fifteen years after the alleged incident); *see also* Prentice, *supra* note 51, at 386 (explaining that Davis only became the target of investigation after one of the doctors who had worked with her daughter wrote an article on Munchausen by Proxy Syndrome and mentioned Davis as a prime candidate for someone with the disorder).

[146] Prentice, *supra* note 51, at 407.

the courtroom. Prosecutors often view the disorder not as a disease, but rather as a series of acts by the defendant mother against the child victim;[147] however, they would be remiss to disregard the mental illness aspect of a person with MBPS.[148] Rather than acknowledge the mental aspect component of MBPS, attorneys who prosecute under the umbrella of MBPS prefer to use the disorder against the mothers because it portrays her as a manipulative individual with complete disregard for the medical community as well as for her child.[149] However, as previously mentioned, prosecuting a case of MBPS homicide is not an easy task and prosecutions must analyze the situation completely before addressing MBPS in a courtroom.

2. Defending the Unthinkable

When a mother is charged with killing one or more of her infant children, she and her lawyer have some serious decisions to make.[150] Of course, a defense strategy is affected by the prosecution's case. If the prosecution does not introduce the issue of MBPS, the defense must determine whether it wants to raise it. Alternatively, if the prosecution does accuse the mother of having MBPS that led to the death of her child then the defense must establish a strategy for refuting that assertion. Ultimately, it is the defense attorney's responsibility to be prepared to address the issue of MBPS if there is even the slightest possibility that it will be raised at trial.

The most common defense strategy for a mother accused of homicide due to MBPS is to deny having MBPS altogether. This entails portraying the mother as a loving and concerned caregiver whose eagerness for additional testing was only because she was so worried about the welfare of her child.[151] Each defense team hopes to convince the judge and jury that their client has been falsely accused and that her deceased children suffered from undetectable or rare disorders exhibiting symptoms similar to a death by poisoning or suffocation.[152] However, defenses of complete

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[147] Steelman, *supra* note 84, at 279.

[148] *Id*. at 275. *But see* discussion *supra* Part III.

[149] Steelman, *supra* note 84, at 288.

[150] In England, a mother can never be prosecuted for murder if she is suspected of having post-partum depression that led to the act of killing her child under the age of twelve months. Infanticide Act, 1938, 16 Geo. 7, c. 36, § 1 (Eng.). Because Munchausen by Proxy Syndrome is not affiliated with post-partum depression, it is unclear whether it would fall within the perimeters set forth by this act.

[151] Prentice, *supra* note 51, at 410.

[152] *See* Flannery, *supra* note 50, at 1231–32 (telling the story of Ryan Stallings, a young infant who died suddenly and whose mother was arrested soon thereafter because authorities suspected that she injected ethylene glycol into his system. Five months later, the mother gave birth to another child who began to demonstrate symptoms identical to Ryan's though he was not in his mother's care. The infant was ultimately diagnosed with a rare genetic disorder that causes the body to produce propylene glycol, often confused with ethylene glycol).

denial typically fail for a number of reasons. First, MBPS goes so completely against cultural ideas of a mother's role that judges and juries do not believe that the term would be thrown around lightly by the prosecution.[153] Second, because deception is at the core of MBPS, prosecutors may attempt to emphasize that denial of having the disorder is a typical characteristic of someone with the disorder.[154] Finally, in most cases, prosecutors focus only on the physical appearance of child abuse on the child's body rather than the mental aspect of the disorder, thus denying that the mother suffers from MBPS does not adequately respond to the prosecution's claim that the mother abused the child, which obviously could have occurred whether the mother had MBPS or not.[155]

At this point, the defense is put into a rather difficult situation. It cannot deny that mother has MBPS, but additionally, if the defense attempts to show that MBPS is not an actual disorder, the prosecution will likely have a number of expert witnesses prepared to testify that it is.[156] The defense could attempt to point fingers at the medical staff for not realizing sooner that the child was not ill and did not require the testing requested by the mother. However, it is generally agreed that MBPS mothers, not physicians, should be held responsible for injuries or deaths occurring because of the mother's deceptiveness.[157] If the mother is ultimately absolved of all guilt, she may be able to file a medical malpractice suit against the hospital if it treated her poorly during the last hours of her child's life by refusing to allow her to visit with the infant.[158] Further an insanity defense cannot succeed since MBPS mothers are deceptive about causing harm to their children because they know that what they are doing to their children is wrong, thus failing to exhibit the primary element of an insanity defense.[159]

One alternative solution suggested by Steelman is that MBPS should be available as a diminished capacity defense, an alternative form of an insanity defense.[160] A diminished capacity defense suggests that the defendant was suffering from an abnormal mental illness, less than that

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[153] *See* Steelman, *supra* note 84, at 263–64.

[154] *Id*. at 264.

[155] *Id*.

[156] *Id*. at 289.

[157] Perman, *supra* note 80, at 269–70.

[158] *See* Prentice, *supra* note 51, at 384 (describing the story of Julie Patrick, a mother who was erroneously believed to have Munchausen by Proxy Syndrome and was banned from visiting her son as he grew sicker and eventually died. Though she was never charged with a crime, she went on to sue the hospital claiming her civil rights had been violated by the hospital's outrageous conduct and medical malpractice.).

[159] Steelman, *supra* note 84, at 296 (explaining that another reason an insanity defense will likely fail is because it would absolve the mother of all guilt and a reasonable jury would not feel sympathy for a mother who killed one or more of her children because she wanted to draw attention and sympathy to herself).

[160] *Id*.

present in someone who is legally insane, while she committed the acts for which she is currently on trial. In Connecticut, a demonstration that at the time when the offense was committed, the defendant "lacked substantial capacity, as a result of mental disease or defect, either to appreciate the wrongfulness of his conduct or to control his conduct within the requirements of the law" is considered an affirmative defense.[161] This mental illness may be considered when determining whether the defendant is guilty of the crime for which she is charged.[162] A diminished capacity defense would embrace MBPS and use it to the defense's advantage, rather than denying its existence.

Because diminished capacity is an affirmative defense, the defense has the burden of "establishing such defense by a preponderance of the evidence."[163] Testimony should be presented indicating that the mother is mentally ill, requiring treatment, not prison.[164] Using such testimony would create a battle of the experts where the defense could use MBPS as a shield to defend against the prosecution's claim that the mother committed murder, not manslaughter.[165] Though unavailable in Connecticut, even if another state were to allow a diminished capacity defense, there is no guarantee that it will be successful. One major barrier could be that society is usually skeptical of unknown mental illnesses that could mean many criminals could avoid the punishment that the public feels they deserve.[166]

However, a mother, especially one that is truly innocent, may be uncomfortable adopting the claim that she suffers from a mental illness, especially when that mental illness is one that leads to the abuse and death of her children. Although a defense of complete denial of MBPS may not ultimately be successful, it surely seems more appealing than the currently available alternatives. In the end, a mother charged with homicide because she is suspected of having MBPS might be forced to base her entire defense on the hope that the prosecution will be unable to meet its burden of beyond a reasonable doubt.[167]

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[161] CONN. GEN. STAT. ANN. § 53a-13 (West 2005).

[162] Steelman, *supra* note 84, at 291.

[163] CONN. GEN. STAT. ANN. § 53a-12 (West 2005).

[164] Steelman, *supra* note 84, at 299.

[165] *Id*. at 300.

[166] *Id*. at 303–04 (writing that other barriers may include the fear that judicial sympathy for Munchausen by Proxy Syndrome mothers would lead to general acceptance of infanticide and that society refuses to part with the idea of the mother as the ideal caretaker of the child and are thus outraged with the idea that a mother would kill or injure her children).

[167] *See* Prentice, *supra* note 51, at 382–83 (pointing out that in the respective trials of Kathy Bush and Sharon Hicks of Gallatin, Tennessee, the prosecution only had circumstantial evidence available to them and the judges refused to allow expert testimony on Munchausen by Proxy Syndrome).

V. ANALYSIS OF EMMA CURRY'S CASE

A. The Prosecution's Options

In Emma Curry's case, there is little evidence implicating her in the murder of her sons, Alex and Oliver Curry. While it is true that both Alex and Oliver visited the emergency room on numerous occasions before their deaths, there is no indication that Emma requested highly invasive medical treatments during their stays at the hospital. Additionally, the medical examiner did not find any signs of foul play in his examination of Alex's and Oliver's bodies. The State's strongest evidence is the testimony of Dr. Michael Roberts, Oliver's attending physician, who stated in his interview with the police that he believed Emma had MBPS. In order to make a case against Emma, the prosecution would need to convince the jury that she killed her children based mostly on the testimony of Dr. Roberts and Emma fitting the profile of a typical MBPS offender.

Because there is relatively weak evidence, independent of a MBPS diagnosis, to convict Emma Curry, this case represents one in which the prosecutor may ultimately decide to prosecute a MBPS homicide. According to Connecticut statute, even if Emma Curry is convicted of two charges of manslaughter in the first degree other than with a firearm, she would be sentenced to a term of not less than one year and not more than twenty years.[168] Because the court has the authority to impose the sentences,[169] the judge has the discretion to impose the two sentences concurrently or consecutively, which means that, if convicted, Emma could spend forty years behind bars. If Emma is convicted of manslaughter in the second degree, a class C felony in Connecticut, the court may sentence her for no less than one year and no more than ten years.[170] Therefore, if the prosecution succeeds in convicting Emma Curry, she will serve at least one year of jail time, and most likely more because of the severity of her crime. This is a better outcome for the prosecution than if she is acquitted of a murder charge and MBPS is not made a part of the prosecution's case.

In Connecticut, precedent suggests that a court would allow either the prosecution or the defense to introduce evidence of MBPS in Emma Curry's trial. Though the Connecticut Supreme Court has yet to address the issue, a number of Connecticut Superior Courts have allowed expert testimony on MBPS to be admitted in termination of parental rights hearings as well as neglect petitions.[171] Additionally, the state has also

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[168] CONN. GEN. STAT. ANN. § 53a-35a (West 2005).

[169] *Id.*

[170] *Id.*

[171] *See In re* Kimber G., 2005 WL 2276986 (Conn. Super. Ct. Sept. 1, 2005); *In re* Joseph P., No. H12 CP00007200A, 2000 WL 528171 (Conn. Super. Ct. Apr. 14, 2000); *In re* Aida M., 1997 WL 178063 (Conn. Super. Ct. Mar. 25, 1997).

been permitted to present evidence in the form of a videotape showing a mother injecting a substance through a gastrostomy tube that had been placed, at the mother's request, in the child's stomach.[172] The court listed several factors that led to its determination that the parental rights should be terminated: that the mother had requested the insertion of the gastrostomy tube, a highly invasive procedure that most parents would not encourage physicians to put their child through; that the dad reported that seizures the child suffered at home were not nearly as bad as the mother claimed them to be; that the condition of the child improved tremendously once it was removed from the mother's care; and finally that a pediatrician with an extensive background in MBPS believed that the mother had the disorder.[173]

The prosecution will try to demonstrate that Emma Curry fits the profile of a person with MBPS. Obviously, she is female and the mother and primary caretaker of her two sons, Alex and Oliver. Additionally, because Oliver died at eleven months old, he falls outside the age of a typical SIDS victim. Emma's husband works long hours as an accountant and the prosecutors may try to argue that she developed MBPS as a way to draw attention to herself as a stay-at-home mother with two sick boys. The fact that two of Emma's children died of mysterious illnesses will likely be used as evidence of Emma's guilt due to the tremendous unlikelihood that two infants in one family die of SIDS. Also, prior to both children's deaths, Emma rushed them on several occasions to the emergency room for their symptoms, yet doctors were unable to find a specific problem. Dr. Roberts's testimony will bolster the prosecution's case as well. He meets the standard set by the Connecticut Code of Evidence for expert testimony in that: (1) he is qualified as an expert because as a licensed medical professional he is familiar with a variety of disorders and diseases, and (2) his testimony will assist the jury in understanding the profile of MBPS described by the prosecution and explaining to them how Emma Curry fits that profile based on the actions that he observed during Oliver's time in the hospital.[174] All these factors taken together present the prosecution's case that Emma had MBPS and killed both of her young sons.

B. The Defense's Options

The defense in Emma's case has a relatively strong case since Emma does not exhibit all typical characteristics of a mother with MBPS. Emma has no known educational or work history in the medical profession, a

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[172] *In re* Joseph P., 2000 WL 528171, at *1 (Conn. Super. Ct. Apr. 14, 2000).

[173] *Id*. at *1–*2.

[174] Analysis under *State v. Porter*, 241 Conn. 57 (1997), is also required here to ensure that the expert testimony is reliable.

common characteristic of MBPS mothers. None of the doctors who examined either Oliver or Alex made any mention of Emma requesting unnecessary or invasive procedures on the children though they do claim that she was concerned about their well-being and wanted to determine the cause of their ailments. The medical examiner performed full autopsies on both of the boys, but found no signs of child abuse. Though it is true that it is nearly impossible to distinguish between a SIDS death and a death by suffocation, some tangible sign of abuse could have been found yet was not. Additionally, though Oliver was older than the majority of infants that die from SIDS, it is possible, regardless of how uncommon, for an eleven-month-old child to die from SIDS.[175] Emma acknowledges that the deaths may not have been SIDS and the children could have had another disorder, perhaps genetic, that lead to their deaths. There have been cases in which a rare disorder was found to exist only after the body had been examined numerous times.

C. The Verdict

In this particular case, unless the prosecution manages to produce some compelling direct evidence, it will likely not meet its burden of proof beyond a reasonable doubt that Emma Curry murdered her two sons. Though Emma does exhibit some of the characteristics typical of MBPS, there are many other crucial characteristics that she does not possess. Moreover, because MBPS is not a detectable disorder, it is possible that Dr. Roberts has falsely diagnosed Emma with the syndrome. There is also a chance, though small, that SIDS may occur more than once in the same family; however, other genetic disorders should also be considered when the real cause of death for Alex and Oliver is determined. Giving Emma the benefit of the doubt on both of these possibilities might be a stretch, but since the bodies of Alex and Oliver were reexamined, with doctors on the lookout for signs of abuse, it seems plausible that Emma Curry did not kill her children and that they did, in fact, suffer from some undiagnosed disease. Therefore, a jury will likely acquit Emma Curry of all charges.

VI. CONCLUSION

Both SIDS and MBPS remain mysteries to a certain degree. It is most curious that SIDS suddenly stops once infants are older than one year old. The syndrome essentially appears and then disappears with no explanation and leaves no evidence as to its cause. Similarly, MBPS is such an unusual form of child abuse because the mother draws attention to the abuse yet at

[175] *See* Committee, *supra* note 8, at 437 (stating that ninety percent of SIDS cases occur before an infant's six-month birthday, implying that the remaining ten percent of cases occur after the child's six-month birthday).

the same time constructs an elaborate lie about the abuse. Proving that SIDS and MBPS exist is so uncertain, it is hard to imagine how any prosecutor or defense attorney can ever win such a case. It is particularly a heavy burden on the prosecution to prove beyond a reasonable doubt that one misunderstood and rare disorder (MBPS) was the cause of death rather than a second equally misunderstood and rare disorder (SIDS). Prosecutors are faced with the difficult task of demonstrating that the mother suffers from MBPS that led to the death of a child while, in contrast, the defense attorney should present evidence to show that SIDS, not abuse, was the true cause of the infant's death. This is a nearly impossible task when it is considered that even the most experienced medical examiners cannot definitively identify the differences between death by abuse and death by suffocation, accidental or intentional. Thus, it is conceivable that even if the medical examiner can prove that that child was suffocated, the prosecutor must then convince the jury that the suffocation was intentional, not accidental. Prosecutors, defense attorneys, and the medical community must remain diligent to ensure that cases of true child abuse are detected and prosecuted, while at the same time, innocent mothers are not subjected to the further grief of facing a homicide charge after the death of their infant children.