R v Dickason: New Zealand's Infanticide Law

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This article considers the example of R v Dickason *to investigate New Zealand's infanticide regime under s 178 of the Crimes Act 1961. It argues that the legal interpretation of infanticide is increasingly out of step with contemporary scientific understandings of postpartum mental illness, in particular postpartum depression (PPD). Drawing on recent scientific research, the article highlights the multifactorial and epigenetic nature of PPD, challenging the binary legal framework that pits biological causes against psychosocial stressors. It critiques both narrow prosecutorial interpretations of infanticide as a bio-psychiatric defence and feminist legal scholarship that denies biological causation altogether. The article also exposes the reliance on outdated scientific literature within legal discourse, revealing an ouroboric discourse that perpetuates misconceptions about maternal mental health. In response, the article proposes a legislative amendment to s 178 that is better able to accommodate the complex interplay of the biological, psychological and environmental factors contributing to infanticide.*

I INTRODUCTION

On 16 September 2021, Lauren Dickason killed her three daughters.[1] Her eldest daughter, Liané, was six years old; her twins, Maya and Karla, were aged two years and 10 months. On 11 September, Dickason and her family had cleared MIQ and arrived in Timaru after emigrating to New Zealand from South Africa.[2] The case shocked and fascinated the nation over time. There was a flurry of media

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1 Jamie Dierick "Mother suffering from major depression avoids life imprisonment for murder of three daughters" *Law News* (online ed, 12 Jul 2024).

2 Molly Swift "The mum who murdered her three children: Inside the Lauren Dickason trial" *Stuff* (New Zealand, 19 August 2023).

reporting, with *The New Zealand Herald* alone dedicating more than 90 articles and an entire podcast to the "murdering mother".[3]

At trial in August 2023, Dickason pleaded not guilty by reason of insanity to three counts of murder under s 23 of the Crimes Act 1961. She also pleaded an infanticide defence under s 178. The jury returned three murder verdicts on 16 August 2023. In June 2024, Mander J concluded that it would be manifestly unjust to sentence Dickason to life imprisonment, instead imposing a finite term of 18 years in prison and committing her to hospital due to her heightened risk of suicide.[4] In August 2024, Dickason's legal team lodged an appeal against her convictions.[5]

Dickason is a useful example with which to consider whether Aotearoa's infanticide regime is fit for purpose. Several aspects of the case—the defendant's history of mental illness, her anger and the age of her children—test the boundaries of both s 178 of the Crimes Act and our capacity for compassion. Section 178 comes before the New Zealand courts "comparatively infrequently",[6] which means there have been few opportunities to test its elements judicially.[7] The provision requires the "balance" of a woman's mind to be "disturbed, by reason of her not having fully recovered from the effect of giving birth … or by reason of any disorder consequent upon childbirth".[8] The question this article poses is therefore whether that wording accommodates or contradicts contemporary understandings of maternal mental health.

This article argues that *Dickason* exposes the fundamental disconnect between legal interpretations of infanticide and contemporary scientific understandings of postpartum mental illness. It begins by considering the case brought by the prosecution to disprove the defendant's infanticide defence and primarily focuses on contesting that Dickason was suffering from postpartum depression (PPD) at the time of the killings. It then demonstrates that the prosecution's case was out of step with contemporary understandings of PPD and its link to infanticide. It does this by considering recent scientific scholarship highlighting that the aetiology of PPD and the causes of infanticide are inherently multifactorial. The prosecution's focus on biological causes to the exclusion of a more

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3 "Murdering mother Lauren Dickason posts tribute to slain children to mark three years since they died" *The New Zealand Herald* (online ed, New Zealand, 16 September 2024).

4 *R v Dickason* [2024] NZHC 1704 at [71], [73]–[78] and [80]–[81].

5 Anna Leask "Timaru triple murder: Killer mum Lauren Dickason appeals convictions" *The New Zealand Herald* (online ed, New Zealand, 5 August 2024). The grounds were not yet known at the time of writing.

6 *R v RLT* HC Dunedin CRI 2008-012-005987, 18 December 2008 at [1].

7 In the Australian context, see JJ Bargen "Infanticide" in *The Laws of Australia* (Law Book Company, Melbourne, 1992) 241 at 245, cited in Lorana Bartels and Patricia Easteal "Mothers who kill: the forensic use and judicial reception of evidence of postnatal depression and other psychiatric disorders in Australian filicide cases" (2013) 37 MULR 297 at 306.

8 Crimes Act 1961, s 178.

contemporary understanding is one side of a biological/psychosocial dichotomy that has taken hold of the legal discussion of infanticide. The other side is a largely feminist critique that goes so far as to completely deny any biological causation.

This biological/psychosocial dichotomy says much about law's uneasy relationship with science, with legal scholars relying on outdated research and perpetuating an ouroboric discourse that has little to do with scientific reality. Moreover, in addition to contradicting more recent scientific findings, the biological/psychosocial dichotomy stands in contrast to the historical origins of infanticide legislation which, perhaps unconsciously, seems to have taken both biological and psychosocial factors into account. I will therefore briefly consider the legislative history of infanticide before enquiring into how New Zealand's infanticide regime might best be reformed to serve the women in need of its protection.

A R v Dickason*: The Prosecution's Case*

Dickason had suffered from bouts of major depression since adolescence.[9] In adulthood, she experienced difficulties conceiving and went through seventeen rounds of IVF treatment.[10] Dickason gave birth to Liané in September 2014 and to Karla and Maya in November 2018.[11] She was diagnosed with PPD in both postpartum periods.[12]

At trial, there was no contest that the balance of Dickason's mind was disturbed when she killed her three daughters.[13] The only issue, then, was causation: whether the balance of her mind could be considered disturbed:[14]

> … *by reason* of her not having fully recovered from the effect of giving birth to that or any other child, or by reason of the effect of lactation, or by reason of any disorder consequent upon childbirth or lactation, to such an extent that she should not be held fully responsible.

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9 *R v Dickason*, above n 4, at [5].

10 Adam Burns "Lauren Dickason sentencing: How the case unfolded" *RNZ* (online ed, New Zealand,16 June 2024).

11 Burns, above n 10.

12 *R v Dickason*, above n 4, at [5]–[6]; Anna Leask "Lauren Dickason trial: Psych expert reveals killer's last words to daughters" *The New Zealand Herald* (online ed, New Zealand, 27 July 2023); Anna Leask "Lauren Dickason trial: Final witness finishes evidence—Crown and defence to address jury tomorrow before deliberations" *The New Zealand Herald* (online ed, New Zealand 10 August 2023); and Anna Leask "Lauren Dickason trial: alleged child murderer stopped taking antidepressants 'for immigration purposes'" *The New Zealand Herald* (online ed, New Zealand 9 August 2023).

13 *R v Dickason*, above n 4, at [42].

14 Crimes Act, s 178(1) (emphasis added).

Ultimately, the key issue in her s 178 defence was whether she was suffering from PPD at the time of the homicides.

Three of the five experts called to give evidence about Dickason's mental health said she was suffering from PPD when she killed her children.[15] Ghazi Metoui, for example, stated that the severe depressive disorder that Dickason was suffering from at the time of the killings was likely "an extension and part of her chronic postnatal depression since 2015 after having Liane and re-emerg[ed] in 2019 after having Karla and Maya and episodically thereafter".[16]

There were three main elements to the Crown's evidence regarding Dickason's PPD—or lack thereof:

(1) that Dickason had a history of mental illness and therefore was not suffering from PPD;
(2) that the depression she was suffering from was caused by psychosocial stressors rather than the physiological changes brought about by childbirth; and
(3) that Dickason's offending was primarily motivated by anger.

I will now briefly consider each of these elements.

1 Pre-existing mental illness

Crown expert witnesses Erik Monasterio and Simone McLeavey, both stated that the balance of Dickason's mind was not disturbed as required by s 178 because Dickason had a history of depression.[17] Monasterio argued that Dickason's depression was "not connected to childbirth—how could it be? It started before that".[18] He said that "the effects of pregnancy and adaptation to the demands of motherhood and the care of three young children contributed to—but did not fully account for"—the depression Dickason suffered from in the postpartum period.[19]

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15 See for example Lisa Davies and Laura James "Lauren Dickason psychotic at time of alleged murders—expert" (28 July 2023) 1News <www.1news.co.nz>; Lisa Davies and Laura James "Dickason 'considered her actions morally correct'—defence expert" (8 August 2023) 1News <www.1news.co.nz>; and Lisa Davies and Laura James "Dickason thought 'kindest thing was for them to check out—defence expert" (10 August 2023) 1News <www.1news.co.nz>.

16 Leask "Lauren Dickason trial: Final witnesses finishes evidence", above n 12.

17 Anna Leask "Lauren Dickason trial: Accused felt like 'a useless mother' and 'there was no turning back' once she started killing her children" *The New Zealand Herald* (online ed, New Zealand, 3 August 2023); and Anna Leask "Lauren Dickason trial: Triple murder-accused claims 'I miss my girls so much'—expert says killing amid 'grips of rapidly worsening depression'" *The New Zealand Herald* (online ed, New Zealand, 8 August 2023).

18 Anna Leask "Lauren Dickason trial: Crown psych expert says 'no evidence' of insanity, no basis for infanticide defence" (online ed, New Zealand, 1 August 2023).

19 Leask "Lauren Dickason trial: Accused felt like 'a useless mother' and 'there was no turning back' once she started killing her children", above n 17.

2 *Psychosocial stressors*

Monasterio and McLeavey both testified that, after remitting between November 2020 and June 2021, Dickason's depression was followed by an entirely new illness. However, when pressed about social media messages exhibiting considerable distress written during the supposed period of remission, Monasterio admitted that he could not be sure Dickason's PPD (if it was that) had remitted.[20] The argument was reiterated by Crown prosecutor Andrew McRae, who in his closing remarks argued that Dickason was not suffering from PPD and reminded the jury of the multiple stressors that had manifested in Dickason's life by July 2021:[21]

> It's Covid, it's immigration stress, the stress of moving, the life situation in South Africa, living with the mother in law [sic], the container problems they had in terms of moving their property away. And it's those stresses that caused a further bout of depression, they were the stressors in the context of her vulnerable personality, her perfectionist nature and her need to control everything that was around her. Those stressors were nothing to do with any distress caused by childbirth.

Apparent in this quote is a strict separation between the psychosocial stressors in Dickason's life and the stress brought about by childbirth.

3 *Anger*

McRae then told the jury that, even if she was suffering from PPD, Dickason "wasn't so unwell that she has a medical defence available to her", meaning she would not satisfy the third requirement of s 178:[22]

> On the contrary … her actions are actually explained by two primary drivers—her anger at her children's behaviour and her need for control—in that moment, that isolated moment, there was a loss of control in the context of the situation that she found herself in.

These statements emphasise the Crown's apparent conviction that Dickason's anger was something extraneous to her depression.

Whether the jury accepted the prosecution's theory that Dickason was "motivated primarily or directly by anger, resentment, or the need for control of [her] children and husband",[23] or because

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20 Adam Burns "Lauren Dickason: Postpartum depression possible but mum did not kill 'out of love'—expert" RNZ (online ed, New Zealand, 3 August 2023).

21 Lisa Davies "Crown argues anger, need for control caused Dickason to kill girls" (11 August 2023) 1News <www.1news.co.nz>; see also Anna Leask "Lauren Dickason trial: Crown tells jury 'you will be sure' this is a case of murder in closing address" *NZ Herald* (online ed, New Zealand, 11 August 2023).

22 Leask "Lauren Dickason trial: Crown tells jury 'you will be sure' this is a case of murder in closing address", above n 21.

23 *R v Dickason*, above n 4, at [45].

they simply did not accept that the balance of her mind was disturbed as per s 178, will remain unknown. However, the fact that the prosecution ran its case this way and relied on the testimony of the experts highlights some of the difficulties in the discourse surrounding postpartum mental illness (PMI). Given the prosecution's narrow interpretation of PPD, it is therefore essential to consider what the science says about the causes, duration and potential consequences of PPD.

II WHAT DOES THE SCIENCE SAY?

A Postpartum depression (PPD)

This section cannot present and describe the aetiology and symptomology of PPD in their full complexity and instead outlines some recent scientific discussions surrounding PPD and its link to infanticide.

Women are more likely to develop psychiatric illness in the year after giving birth than at any other time in their lives.[24] Up to 80 per cent of new mothers suffer from the "baby blues",[25] which generally subside without treatment within ten days. However, PPD "lasts for at least two weeks, creates significant impairment in functioning, and typically requires professional treatment".[26] The debate about PPD is occurring alongside the debate about "what constitutes the postpartum period":[27] the American Psychiatric Association (APA) defines major depression with "peripartum onset" as an episode with mood symptoms occurring "during pregnancy or in the 4 weeks following delivery",[28] while others believe it can begin six weeks or even up to twelve months postpartum.[29]

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24 Margaret G Spinelli "A Systematic Investigation of 16 Cases of Neonaticide" (2001) 158 American Journal of Psychiatry 811 at 811; Margaret G Spinelli "Maternal Infanticide Associated with Mental Illness: Prevention and the Promise of Saved Lives" (2004) 161 American Journal of Psychiatry 1548 at 1551; and Susan Friedman, James Cavney and Phillip J Resnick "Mothers Who Kill: Evolutionary Underpinnings and Infanticide Law" (2012) 30(5) Behav Sci & L 585 at 590.

25 C Henshaw "Mood disturbance in the early puerperium: A review" (2003) 6 (Suppl 2) Archives of Women's Mental Health 33, cited in S Trifu, A Vladuti and A Popescu "The Neuroendocrinological Aspects of Pregnancy and Postpartum Depression" (2019) 15(3) Acta Endocrinologica 410 at 412.

26 Ilona S Yim and others "Biological and Psychosocial Predictors of Postpartum Depression: Systematic Review and Call for Integration" (2015) 11 Annual Review of Clinical Psychology 99 at 100.

27 Melissa M Batt and others "Is Postpartum Depression Different from Depression Occurring Outside of the Perinatal Period? A Review of the Evidence" (2020) 18(2) Focus 106 at 106.

28 American Psychiatric Association (APA) *Diagnostic and statistical manual of mental disorders* (5th ed, American Psychiatric Association, Arlington (VA), 2013) at 186.

29 See for example Zawn Villines "When does postpartum depression start?" (12 September 2022) Medical News Today <www.medicalnewstoday.com>; Karen Carlson and others "Perinatal Depression" (22 January 2025) National Library of Medicine <www.ncbi.nlm.nih.gov> and Cheryl L Robbins and others "Timing of Postpartum Depressive Symptoms" (2023) 20 Preventing Chronic Disease 230107.

The prevalence of PPD is also widely contested. The APA estimates the figure to be seven per cent.[30] However, Russ Scott writes that while reviews show the prevalence of PPD to be "at least 10 per cent among women in high-income countries and up to 20 per cent in low-and middle-income countries, the prevalence of [PPD] is likely to be higher than reported".[31] Uriel Halbreich and Sandhya Karkun similarly concluded in their 2006 review that cited rates were "not representative of the actual global prevalence and magnitude of the problem".[32] In contrast, reviews of the prevalence of depression in the general population put the incidence at five to ten per cent.[33] One factor in the wildly differing findings regarding prevalence is study design, with some studies only considering depression with first onset in the postpartum period as PPD and others also counting women who have experienced an episode of major depression before becoming pregnant.[34] Clearly, when the latter are incorporated into study samples, the prevalence of PPD is considerably higher.[35]

For over a century, scientists have been debating whether PPD has an aetiology distinct from that of major depression occurring in the general population as it is difficult to determine whether women with PPD "are experiencing an etiologically distinct major depressive episode unique to the postpartum period or a relapse of a preexisting depressive illness".[36] But one group at particularly high risk of developing PPD is considered to be women with a history of depression or anxiety,[37] with one study involving 700,000 women finding that women with such pre-existing mental health

30 APA, above n 28, citing BN Gaynes and others "Perinatal Depression: Prevalence, Screening Accuracy, and Screening Outcomes; Evidence Report/Technology Assessment, No. 19" (Agency for Healthcare Research and Quality, AHRQ Publication No. 05-E006-2, 2005).

31 Russ Scott "Infanticide and Infanticide Statutes in Australia and New Zealand" (2020) 27(4) JLM 1014 at 1017.

32 Uriel Halbreich and Sandhya Karkun "Cross-cultural and social diversity of prevalence of postpartum depression and depressive symptoms" (2006) Journal of Affective Disorders 91 at 97.

33 Guillaume Fond and others "Prévalence de la dépression majeure en France en population générale et en populations spécifiques de 2000 à 2018: une revue systématique de la literature" (2019) 48(4) La Presse Médicale 365; Elmars Rancans and others "Prevalence of major depression and associated correlates in Latvian primary care population: results from the National Research Program BIOMEDICINE 2014–2017" (2019) 74(1) Nordic Journal of Psychiatry 60; see also "Depressive disorder (depression)" (31 March 2023) World Health Organization <www.who.int>; "Major Depression" (July 2023) National Institute of Mental Health <www.nimh.nih.gov>.

34 Batt and others, above n 27, at 107.

35 At 107.

36 At 107.

37 Scott, above n 31, at 1016.

conditions were 20 times more likely to develop PPD.[38] This poses a challenge in the interpretation of infanticide provisions that require causation between childbirth and PMI.

In addition, there has been considerable inquiry into the duration of PPD. There is now apparent consensus that PPD can last much longer than the one year that underpins many infanticide provisions.[39] One 2014 review found that 30 per cent of PPD sufferers were still afflicted three to three-and-a-half years after giving birth.[40] On the other hand, a longitudinal study published in 2015 tracked 2,991 women over 21 years, finding that 21.1 per cent of mothers experienced continuing or escalating depressive symptoms for the full 21 years.[41] Dickason's twins were two years, 10 months old when she killed them.

Thus, Dickason's history of mental illness before childbirth and the fact that her children were older than the one year traditionally associated with infanticide provisions do not appear to immediately preclude a diagnosis of PPD.

B Factors in the Aetiology of PPD

Biological links between childbirth and PMIs/infanticide have been suspected and discussed in scientific texts since Hippocrates.[42] From the 1980s up until roughly 2015, scientific research into PPD was bifurcated, with some researchers concentrating on the biological aetiology of PPD and others on psychosocial factors.[43]

1 Biological and psychosocial factors

As Yim and others describe, the biological factors involved in the aetiology of PPD include an increase and rapid drop in reproductive and stress hormones prior to and at delivery, which is thought "to trigger system dysregulation and depressive symptoms in a subset of vulnerable women".[44] A

38 Michael E Silverman and others "The Risk Factors for Postpartum Depression: A Population Based Study" (2017) 34(2) Depression and Anxiety 178.

39 See for example Crimes Act 1900 (NSW), s 22A; Infanticide Act 1938 (UK); Canadian Criminal Code, RSC 1985 c 46, s 233 and s 2.

40 Nicole Vliegen, Sara Casalin and Patrick Luyten "The Course of Postpartum Depression A Review of Longitudinal Studies" (2014) 22(1) Harvard Review of Psychiatry 1 at 10–11.

41 Kingsbury and others "Trajectories and Predictors of Women's Depression Following the Birth of an Infant to 21 Years: A Longitudinal Study" (2015) 19 Maternal and Child Health Journal 877 at 882.

42 Spinelli "Maternal Infanticide", above n 24, at 1550.

43 Yim and others, above n 26, at 100.

44 At 102.

hormonal link has been established at the latest since Bloch and others published their paper in 2000.[45] Moreover, the US Food and Drug Administration approved brexanolone in 2019, "the first specific hormonal treatment for postpartum depression".[46] More recently, US researchers found that PPD is also associated with altered extracellular RNA communication,[47] impairing the "body's ability to clean up old genetic material and other cellular debris".[48]

In contrast to biological models, research into psychosocial factors as predictors of PPD emphasises the role played by, for example, "underlying cognitive vulnerabilities",[49] psychological stressors, a lack of social support and the mode of childbirth.[50]

2 *Multifactorial aetiology*

It must be noted that these psychosocial factors do not just exist alongside PPD but fundamentally contribute to its development. Recent research into major depression, whether postpartum or otherwise, suggests that its aetiology is multifactorial. For example, both PPD and major depression in the general population are frequently triggered by exposure to periods of stress:[51]

> these exposures can have an enduring impact on hypothalamic-pituitary-adrenal (HPA) axis function and contribute more broadly to risk for depression. … Patients with PPD and patients with major depressive disorder both present with dysregulated HPA axis function, and this dysregulation is thought to play a role in the pathogenesis of depression.

The premise that PPD is either caused by biological processes or is the result of psychosocial factors is therefore inherently flawed. Indeed, "PPD is driven by a complex interplay of hormonal changes, neurotransmitter imbalances, inflammation, genetic factors, psychosocial stressors, and [HPA] axis dysregulation."[52]

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45 M Bloch and others "Effects of gonadal steroids in women with a history of postpartum depression" (2000) 157 American Journal of Psychiatry 924; Spinelli "Maternal Infanticide", above n 24, at 1551–1552; and Keyi Zhang and others "Bridging Neurobiological Insights and Clinical Biomarkers in Postpartum Depression: A Narrative Review" (2024) 25 International Journal of Molecular Science 8835.

46 IP Hulubă and others "The link between sex hormones and depression over a woman's lifespan (Review)" (2025) 22(4) Biomedical Reports 71.

47 Lauren M Osborne and others "Altered extracellular mRNA communication in postpartum depression is associated with decreased autophagy" (2022) 27 Molecular Psychiatry 4526.

48 "Potential Biological Cause for Postpartum Depression Found" (4 October 2022) UVA Health <www.uvahealth.com>.

49 Yim and others, above n 26, at 102.

50 At 102; and Batt and others, above n 27, at 106.

51 Batt and others, above n 27, at 109.

52 Zhang and others, above n 45; see also Scott, above n 31, at 1016.

The latest findings go one step further, suggesting that PPD aetiology is not only multifactorial but also epigenetic, meaning that the interaction between biological and environmental/psychosocial factors actually affects gene expression.[53] Among a range of other factors, early life stressors can cause epigenetic changes, with women suffering from childhood trauma more likely to later develop PPD."[54]

Thus, while PPD and major depression are not necessarily aetiologically distinct, women are more susceptible to developing depression in the postpartum period, which is then generally regarded as PPD. There is widespread scientific understanding that physiological changes caused by childbirth play a role in the development of PPD. Moreover, as the most recent multifactorial and epigenetic research shows, there is no such thing as a purely environmental factor. External psychosocial stressors have epigenetic impacts, which can likewise lead to the development of PPD or other PMIs. Stress is physiological. The either/or thinking expressed in the quote from McRae above is therefore problematic.

C The link between PPD and infanticide

But why does it matter that there is a link between having children and PPD?

Given that PPD is symptomologically almost indistinguishable from major depression,[55] it is notable that a 2015 study of 47,158 individuals found that depression was associated with three times higher odds of being prosecuted for violent crimes, even after adjusting for sociodemographic factors.[56] This suggests a statistical association between depression and violent behaviour that potentially contextualises the risk of infanticide in mothers with PPD.

Infanticide is widely considered to be one of the most dangerous "symptoms" or "complications" of untreated PPD, especially with attendant psychosis.[57] Its incidence in developed countries ranges

53 Batt and others, above n 27, at 108.

54 At 110; see also Anne M Nielsen, Catherine S Stika and Katherine L Wisner "The pathophysiology of estrogen in perinatal depression—conceptual update (review)" (2024) 27 Archives of Women's Mental Health 887 at 887; and Hulubă and others, above n 46.

55 Batt and others, above n 27, at 107–108.

56 Seena Fazel and others "Depression and violence: a Swedish population study" (2015) 2(3) The Lancet Psychiatry 224; confirmed and expanded in Nilo Tayebi and others "The association between depression and crime outcomes: A Swedish population-based study" (2024) 94 Journal of Criminal Justice 102271.

57 Trifu, Vladuti and Popescu, above n 25, at 412; SJ Umboh, CH How and H Chen "Postnatal depression: a family medicine perspective" (2013) 54(9) Singapore Medical Journal 477 at 477; and Narges Shaifzadeh, Fateme Farhoudi and Ali Saghebi "Twin filicide: a tragedy of postpartum depression with suicidal ideation" (2022) 26(3) Progress in Neurology and Psychiatry 20 at 20.

from 2.4 to 8.0 per 100,000 births.[58] But the question of precisely how many women who commit infanticide are suffering from mental illness remains undetermined.[59] Nevertheless, Scott states that the mothers most likely to commit infanticide are those with a history of mental illness:[60]

> In psychiatric samples, filicidal mothers are frequently diagnosed with depression or psychosis and have a history of previous mental health care while others are intellectually impaired or personality disordered. Psychotic mothers often kill their children without much planning, whereas some depressed mothers may ruminate about killing their children for days or even weeks.

It is therefore unsurprising that children in the first year of life—the very year that women are most likely to develop a psychiatric illness—are overrepresented in homicide statistics.[61] Back in 1987, RE Kendell and others made a connection between the fact that the peak period for psychiatric disorders and hospitalisation for women was within the first three months postpartum and that 58 per cent of maternal infanticides occurred in the same period.[62] However, as with PPD, the infanticide rate is thought to be underestimated.[63]

Many postpartum mothers experience intrusive thoughts, with 50 per cent in one study reporting "unwanted thoughts of intentionally harming their infants".[64] Moreover, PPD sufferers have thoughts of killing their children at alarming rates, with another study finding a filicidal ideation rate of 41 per cent among mothers with PPD compared with 7 per cent of non-depressed mothers.[65] Yet another

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58 Alexandria Y Alford and others "A systematic review of postpartum psychosis resulting in infanticide: missed opportunities in screening, diagnosis, and treatment" (2025) 28 Archives of Women's Mental Health 297 at 299; and Lillian De Bortoli, Jan Coles and Mairead Dolan "Maternal Infanticide in Australia: Mental Disturbance During the Postpartum Period" (2013) 20(2) Psychiatry, Psychology and Law 301 at 303.

59 De Bortoli, Coles and Dolan, above n 58, at 308; Jessie Heath "Aotearoa's Approach to Infanticide: Ahead of Its Time or Antiquated?" (LLB(Hons) Dissertation, University of Otago, 2023) at 22; and Bartels and Easteal, above n 7, at 299.

60 Scott, above n 31, at 1025; see also 1023; see also Phillip J Resnick "Child Murder by Parents: A Psychiatric Review of Filicide" (1969) 126(3) American Journal of Psychiatry 325 at 325, 328 and 329.

61 Allison Wallace *Homicide: The Social Reality* (New South Wales Bureau of Crime Statistics and Research, Sydney, 1986) at 124; Daniel Maier-Katkin and Robbin Ogle "A Rationale for Infanticide Laws" (1993) Crim L R 903 at 903; De Bortoli, Coles and Dolan, above n 58, at 303; and Scott, above n 31, at 1021.

62 RE Kendell, JC Chalmers and C Platz "Epidemiology of puerperal psychoses" (1987) 150(5) British Journal of Psychiatry 662; and RE Kendell and others "The social and obstetric correlates of psychiatric admission in the puerperium" (1981) 11(2) Psychological Medicine 341; both cited in Spinelli "Maternal Infanticide", above n 24, at 1554.

63 De Bortoli, Coles and Dolan, above n 58, at 303.

64 Scott, above n 31, at 1018.

65 Kay Donahue Jennings and others "Thoughts of Harming Infants in Depressed and Non-depressed Mothers" (1999) 54 Journal of Affective Disorders 21, cited in Friedman, Cavney and Resnick, above n 24, at 590; and Scott, above n 31, at 1024.

study determined that 70 per cent of mothers of babies suffering from colic—a major stressor—experienced violent ideation towards their infant, with 26 per cent experiencing infanticidal ideation.[66]

In addition, even though the prosecution cited Dickason's anger towards her children as a key piece of evidence disproving her infanticide defence, it is widely acknowledged that anger can be a symptom of depression.[67] Depressed mothers have been found to exhibit anger towards preschoolers in particular.[68] Dickason reported that Karla had been:[69]

> really horrible to me lately … She has been biting me and hitting me and scratching me and throwing tantrums 24 hours a day—and I just don't know how to manage that. That's why I did her first.

Those words are hard to read, but they are not inconsistent with PPD.

Mirroring the medical discussion, recent decades have seen the rise of biosocial criminology, which draws on a range of fields, including biology, psychology and behavioural genetics, positing that the origins of crime—like those of PPD—are multifactorial.[70] Lillian De Bortoli, Jan Coles and Mairead Dolan ostensibly anticipated this trend when they wrote in 2013 that "understanding the impact of a sufficiently severe mental disturbance in the context of co-occurring stressors" would be

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66 S Levitzky and R Cooper "Infantile Colic Syndrome: Maternal Fantasies of Aggression and Infanticide" (2000) 39 Clinical Pediatrics 395, cited in Scott, above n 31, at 1024.

67 See for example Fredric N Busch "Anger and Depression" (2009) 15(4) Advances in Psychiatric Treatment 271; Lewis L Judd and others "Overt Irritability/Anger in Unipolar Major Depressive Episodes: Past and Current Characteristics and Implications for Long-term Course" (2013) 70(11) JAMA Psychiatry 1171; T Genovese and others "Subjective anger and overt aggression in psychiatric outpatients" (2017) 73 Comprehensive Psychiatry 23; and Nienke J de Bles and others "Trait anger and anger attacks in relation to depressive and anxiety disorders" (2019) 259 Journal of Affective Disorders 259.

68 Qiong Wu "Fluctuations in Maternal Depressive Symptoms, Anxiety, and Anger and Children's Depression Risks in Middle Childhood" (2024) 52 Research on Child and Adolescent Psychopathology 1247 at 1249, citing T Field and others "Anxiety and anger effects on depressed mother-infant spontaneous and imitative interactions" (2005) 28(1) Infant Behavior and Development 1; DW Leung and AMS Slep "Predicting inept discipline: The role of parental depressive symptoms, anger, and attributions" (2006) 74(3) Journal of Consulting and Clinical Psychology 524; Theodore Dix, Anat Moed and Edward R Anderson "Mothers' Depressive Symptoms Predict Both Increased and Reduced Negative Reactivity: Aversion Sensitivity and the Regulation of Emotion" (2014) 25(7) Psychological Science 1353; and Q Wu and others "Mothers' depressive symptoms and responses to preschooler's emotions: Moderation by child expression" (2019) 60 Journal of Applied Developmental Psychology 134; see also Nicole L Shay and John F Knutson "Maternal Depression and Trait Anger as Risk Factors for Escalated Physical Discipline" (2008) 13(1) Child Maltreatment 39.

69 Anna Leask "Lauren Dickason trial: 'Not a terrible person'—jury to hear defence case for triple murder-accused mum" *The New Zealand Herald* (online ed, New Zealand, 26 July 2023).

70 See for example AnaCristina Bedoya and Jill Portnoy "Biosocial Criminology: History, Theory, Research Evidence, and Policy" (2023) 18(8) Victims & Offenders 1599.

essential to determining the link between maternal mental health and infanticidal offending.[71] That same year, Lorana Bartels and Patricia Easteal examined 28 cases of infanticide in Australia, concluding that, in most cases:[72]

> the mother had often experienced violence or trauma during their childhood, or in their adult relationships, or suffered from a lengthy history of psychiatric disorders or addiction. In fact, there were very few defendants with backgrounds of "clean" mental health and drug/violence-free upbringings and adult lives. In this context, it is important to note that most of those in our sample who were diagnosed with [PPD] had histories of psychiatric problems.

Similar histories of trauma and violence can be found in the sentencing reports of women convicted of the infanticide, manslaughter and murder of their children in Aotearoa.[73] While the causes of PPD are inherently multifactorial, it seems the same can be said about the causes of infanticide.

III THE BIOLOGICAL/PSYCHOSOCIAL DICHOTOMY

Despite the increasingly multifactorial understandings of PPD and infanticide in the scientific discourse, one key element of the legal discussion is the persistence of a binary framework that pits biological causes (eg, hormonal, neural or genetic)[74] against psychosocial factors (eg, stressors),[75] often to the exclusion of more complex, integrative understandings. The case put forward by the prosecution in *Dickason* can be considered one example of this.

I will now consider this biological/psychosocial dichotomy and how it has manifested in both New Zealand infanticide cases and feminist critiques of infanticide regimes. While suggestions of a prosecutorial and judicial trend can be discerned towards stressing the biological and physiological causes of infanticide to the exclusion of psychosocial stressors, the feminist critique—in its well-meaning attempt to scrutinise such biological determinism—has come to favour psychosocial factors

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71 De Bortoli, Coles and Dolan, above n 58, at 308.

72 Bartels and Easteal, above n 7, at 338.

73 See for example *R v Tauwhare* HC Greymouth T 1/93, 23 July 1993; *R v Moke* HC Wellington T46/97, 12 September 1997; *R v Wright* [2001] 3 NZLR 22 (CA); *R v Harrison-Taylor* HC Auckland CRI 2004-092-001510, 12 September 2005; *R v JRH* HC Wellington, 31 July 2009, CRI-2007-032-2799; *R v E* HC Auckland CRI-2009-090-12059, 28 September 2010; *E v R* [2011] NZCA 13; *R v CRS* [2012] NZHC 709; *R v Paea* [2016] NZHC 822; *R v Ngawhika* [2023] NZHC 520; and *R v JB* [2024] NZHC 2033; *JB v R* [2024] NZCA 669; see also the attempted murder case *R v X* [2016] NZHC 840; as well as section III.A "Prosecutorial and judicial trends" of this article.

74 Batt and others, above n 27, at 108.

75 At 108.

to the point of biological denial. The following sections will consider these two sides of this dichotomy before investigating what they say about the relationship between law and science.

A Prosecutorial and Judicial Trends: Infanticide as a Bio-psychiatric Defence

The Centre for Criminal Law and Criminal Justice at Durham University has identified a trend in UK courts towards "taking a more restrictive approach".[76] This has led to murder or manslaughter convictions, typically accompanied by custodial sentences, in cases where, "in the past, women would have been able to avail of the infanticide law".[77] In the New Zealand context, this raises the question of whether s 178, though it could be utilised flexibly,[78] has likewise come to be interpreted as a solely "bio-psychiatric defence".[79]

To explore how s 178 has been applied in practice, I examined 17 cases from the period 1993–2024 where a mother was prosecuted for killing her child. The prosecution charged infanticide in seven of those cases;[80] in six, the defendant either pleaded guilty to or was found guilty of murder or manslaughter (without the jury being asked to consider infanticide);[81] and in all four cases where it was attempted, the jury rejected the defendant's infanticide defence.[82] While the sample size is small, these cases prompt consideration of whether New Zealand courts are adopting a more restrictive approach to infanticide than in the past, or whether these outcomes reflect only the facts of those individual cases.

In 1991, Heron J observed that, without a diminished responsibility regime, the law needed:[83]

> to recognise a lesser offence of infanticide as an alternative to murder to meet the circumstances that may confront a woman following recent childbirth. Those circumstances may be a mixture of social, economic,

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76 Centre for Criminal Law and Criminal Justice "Interpreting the Infanticide Act 1938" Durham University <www.durham.ac.uk>.

77 Centre for Criminal Law and Criminal Justice, above n 76.

78 See also section V.D "Amending s 178" of this article.

79 Centre for Criminal Law and Criminal Justice, above n 76.

80 *R v Moke*, above n 73; *R v Metuatini* HC Auckland TO25795, 18 November 2003; *R v Golovale-Siaosi* HC Dunedin CRI-2006-012-2533, 11 December 2007; *R v RLT*, above n 6; *R v CRS*, above n 73; *R v B* [2020] NZHC 1930; and *R v G* [2024] NZHC 1201.

81 *R v Tauwhare*, above n 73; *R v Wright*, above n 73; *R v Gordon* CA276/04, 16 December 2004; *R v Akau'ola* [2013] NZHC 2007; *R v Paea*, above n 73; *R v JB*, above n 73; and *JB v R*, above n 73.

82 *R v Harrison-Taylor*, above n 73; *R v E* above n 73; *E v R*, above n 73; *R v Ngawhika* above n 73; and *R v Dickason*, above n 4.

83 *R v P* [1991] 2 NZLR 116 at 118.

> mental and physiological stresses, and while she continues to have responsibilities for the newborn child and other children in her care there will be occasions when all are vulnerable.

Between 1993 and 2016, there was a series of infanticide cases where sentencing Judges pointed to similar multifactorial nexuses.[84] However, there are indications that, since Heron J's statement, the approach taken by the New Zealand courts has become more restrictive.

Although the science now indicates that the causes of PPD are multifactorial, recent infanticide cases in New Zealand demonstrate an insistence on the biological/psychosocial dichotomy: if the defendant cannot prove that her action was caused solely by the biological, physiological symptoms of childbirth, the prosecution does not charge the defendant with the offence of infanticide, but with murder or manslaughter. This is despite defendants suffering from mental illnesses and frequently killing their children within time frames much closer to conservative understandings of the postpartum period. Such cases include *R v Akau'ola*, where the defendant, an immigrant like Dickason, pleaded guilty to manslaughter for suffocating her newborn after experiencing not only childbirth but moderate depression, periods of suicidal ideation and the suicide of a cousin.[85] Venning J described the defendant as an "inadequate" mother "unable to cope with the situation she faced".[86] In *R v Ngawhika*, the jury rejected infanticide even though the defendant was suffering from severe depression, psychotic hallucinations and PTSD when she suffocated her six-month-old baby—conditions that must surely have been exacerbated by the effects of motherhood.[87] While Jagose J in *Ngawhika* at least recognised the mitigating factors and sentenced the defendant to 12 months home detention, Venning J sentenced 24-year-old Akau'ola to two-and-a-half years in prison.

There has also been a tendency towards requiring formal diagnoses and minimising the role played by psychosocial stressors. Anderson J, for instance, asserted in 2001 that the "primary purpose" of s 178 was to recognise the "mitigating features of postnatal physiology in cases of the culpable homicide of children".[88] In the 2022 case *R v JB*, a 20-year-old solo-parent of two children—one with a disability—killed her one-month-old baby IB by shaking him.[89] She pleaded guilty to manslaughter, with Venning J sentencing her to three-and-a-half years in prison.[90] This was later reduced to two

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84 *R v Moke*, above n 73, at 4; and *R v RLT*, above n 6, at [14]–[15]; see also the attempted murder case *R v X*, above n 73, at [6] and [14], which Heath J treated as a case of attempted infanticide at sentencing.

85 *R v Akau'ola*, above n 81, at [16]–[17].

86 At [27].

87 *R v Ngawhika*, above n 73, at [13].

88 *R v Wright*, above n 73, at [23] (emphasis added).

89 *R v JB*, above n 73.

90 At [45].

years, 10 months by the Court of Appeal.[91] Venning J stressed that there had been "no *formal* diagnosis of PTSD or anything of that kind",[92] but this overlooked substantial evidence that suggested the defendant was deeply mentally unwell. Despite the lack of formal diagnosis, the Court of Appeal stated that JB had "major depressive disorder", while a psychologist noted "possible diagnoses of complex [PTSD] and borderline personality disorder".[93]

Notably, the Crown appears more willing to charge with infanticide mothers like the defendant in the 2020 case *R v B*, where great emphasis was placed on the fact that the defendant had had no previous history of mental illness or substance abuse.[94] The Crown also charged defendants G and Patricia Golovale-Siaosi with infanticide, who were both described as coming from an "outstanding background".[95] Similarly, though the defendant in *R v Metuatini* came from a difficult background, she was described as "a quiet, law abiding and good person": "You are the sort of person that society wants to welcome and help."[96] This, of course, highlights the issue of what sorts of people society does not want to help, especially in light of Bartels and Eastel's finding that very few infanticidal women have "clean" mental health backgrounds.[97] As in *Dickason*, the prosecution and courts apparently frown upon anger, as they did in the cases of 18-year-old Myra Paea and 20-year-old JB.[98]

The insistence on proof of a uniquely biological, postpartum aetiology for mental illness stands in the way of the infanticide defence protecting those who need it most. There consequently appears to be a trend towards prosecutors first investigating whether a recognised PMI like PPD has been formally diagnosed and only then charging defendants with the offence of infanticide. When it is invoked as a defence, the prosecution, as in *Dickason*, challenges it on a bio-psychiatric basis. Section 178 is therefore operating within a legal and evidentiary framework that is increasingly out of step with contemporary scientific understandings that support a multifactorial model of maternal mental health.

The bio-psychiatric application of infanticide provisions has been subject to critique for some time. The biological/psychosocial dichotomy on display in these New Zealand cases—whether they constitute a trend or not—has favoured the biological to the exclusion of the psychosocial. However,

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91 *JB v R*, above n 73, at [72].

92 *R v JB*, above n 73, at [29] (emphasis added).

93 *JB v R*, above n 73, at [38] (emphasis added).

94 *R v B*, above n 80, at [6], [9], [23] and [25].

95 *R v G*, above n 80, at [11]; and *R v Golovale-Siaosi*, above n 80, at [6].

96 *R v Metuatini*, above n 80, at [17].

97 Bartels and Easteal, above n 7, at 338; see section II.C "The link between PPD and infanticide" of this article.

98 *R v Paea*, above n 73, at [3]; and *R v JB*, above n 73, at [4]–[7].

the other side of the dichotomy has seen scholars placing such an emphasis on the psychosocial causes of infanticide that some of them deny that PPD exists at all. It is to these critiques that I now turn.

B The Feminist Critique: Medicalisation and Biological Denial

A wide range of scholars and legal practitioners have contested the appropriateness and effectiveness of infanticide provisions. There are two main premises underpinning these criticisms:

(1) there is no link between "childbirth" and PMI; and
(2) there is no link between PMI and infanticide.

Moreover, some writers, like Judith Osborne and Katherine O'Donovan, do not merely doubt the link between maternal mental health and infanticide but assert that the English Infanticide Acts created, rather than simply recognised, a causal connection between childbirth and infanticide.[99]

While the position taken by Osborne and O'Donovan may seem extreme, their insistence on this process of "medicalisation" had sociologist-feminist motivations. Moreover, the rise of such arguments reflects the increased focus on psychosocial factors in medical and psychological research from the 1980s.[100] Ignoring the socio-economic factors involved in infanticide, these feminist critics were saying, did not paint the full picture.

Feminist scholars have long critiqued infanticide provisions for casting women as "inherently unstable due to their biology", portraying women as "pitiable, weak, and not responsible for their violent actions".[101] Such provisions reinforce the idea that women who kill are either "mad" or "bad".[102] Patriarchal society finds the idea of such women—especially those who kill their children—difficult to reconcile with the deeply engrained image of the loving, self-sacrificing mother.[103]

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99 Katherine O'Donovan "The Medicalisation of Infanticide" (1984) 1 Crim LR 259 at 261; and Judith Osborne "The Crime of Infanticide: Throwing Out the Baby With the Bathwater" (1987) 6(1) Can J Fam L 47 at 58; see also Maier-Katkin and Ogle, above n 61, at 55.

100 See for example Leonard I Pearlin and others "The Stress Process" (1981) 22(4) Journal of Health and Social Behavior 337; and Michael W O'Hara, Lynn P Rehm and Susan B Campbell "Predicting Depressive Symptomatology: Cognitive-Behavioral Models and Postpartum Depression" (1982) 91(6) Journal of Abnormal Psychology 457, cited in Yim and others, above n 26, at 102.

101 New South Wales Law Reform Commission (NSWLRC) *Partial Defences to Murder: Provocation and Infanticide* (Report 83, 1997) at [3.31]; see also Heath, above n 59, at 36; Maier-Katkin and Ogle, above n 61, at 904; and Osborne, above n 99, at 57.

102 Ania Wilczynski "Images of Women Who Kill Their Infants: The Mad and the Bad" (1991) 2(2) Women & Criminal Justice 71; Josephine Stanton and Alexander Simpson "Filicide: a review" (2002) 25(1) Int'l J L & Psychiatry 1 at 10; Friedman, Cavney and Resnick, above n 24, at 592–593; and Siobhan Weare "'The Mad', 'the Bad', 'the Victim': Gendered Constructions of Women Who Kill within the Criminal Justice System" (2013) 2(3) Laws 337.

103 James Mason "The Myth of Madness: Murderous Mothers and Maternal Infanticide" (2021) 85(6) The Journal of Criminal Law 441 at 441.

Infanticide is such an overwhelming challenge to this idea that it can only be explained through recourse to mental abnormality.[104] But attributing infanticidal offending to bio-psychiatric causes and a singular, mentally unwell offender ignores the socio-economic pressures faced by women and "leaves little room in which to question the manner in which society's structural underpinnings contribute to the persistence of the crime of infanticide".[105] Moreover, it strips women of their agency,[106] a concept often equated with resistance to patriarchy.[107]

Some feminists criticise infanticide provisions for promoting excessive leniency towards women who kill and stemming from a need to "explain away female aggression".[108] Ironically, these critics call for harsher penalties to be imposed on infanticidal women: "if women are equal to men and equally capable, then they should be treated equally, thus punished as harshly as men".[109] The feminist position remains influential, as recent publications demonstrate,[110] including one on *Dickason*.[111] But it oversimplifies the debate about female agency, which:[112]

> is not and should not be seen as a dichotomy. It is not that women either have agency and therefore made a decision to end the life of the foetus/child or that their actions or inactions occurred as a consequence of wider factors and so they had no option and thus lacked agency…

Indeed, as the scientific discussion above demonstrates, the debate is much more complicated than a simple dichotomy between powerlessness and agency, biology and psychosocial factors.

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104 Ania Wilczynski *Child Homicide* (Oxford University Press, London, 1997) at 149; Weare, above n 102, at 343–345.

105 Michelle Oberman "Understanding Infanticide in Context: Mothers Who Kill, 1870–1930 and Today" (2002) 92(3/4) J Crim L & Criminology 707 at 735; see also Ania Wilczynski "Mad or Bad: Child-Killers, Gender and the Courts" (1997) 37(3) Brit J Criminol 419 at 433.

106 Heather Leigh Stangle "Murderous Madonna: Femininity, Violence, and the Myth of Postpartum Mental Disorder in Cases of Maternal Infanticide and Filicide" (2008) 50(2) Wm & Mary L Rev 699 at 705–707.

107 Debra Powell "The Ogress, the Innocent, and the Madman: Narrative and Gender in Child Homicide Trials in New Zealand, 1870–1925" (PhD Thesis, University of Waikato, 2013) at 15–16.

108 Stangle, above n 106, at 701; see also Osborne, above n 99, at 58.

109 Emma Milne *Criminal Justice Responses to Maternal Filicide: Judging the Failed Mother* (Emerald Publishing, Bingley, 2021) at 149.

110 See for example Mason, above n 103.

111 Carrie Leonetti and Kayley Smith "New Zealand's approach to women's 'insanity' is archaic" (3 August 2023) University of Auckland <www.auckland.ac.nz>.

112 Milne, above n 109, at 150.

The feminist critique poses a challenge to biological essentialism and society's difficulties acknowledging female aggression, as exemplified in cases like *R v Paea* and *R v JB*.[113] However, it undermines its own scientific legitimacy by leaning too heavily on the psychosocial side of the dichotomy. Thus, the most common criticism of s 178, writes Jessie Heath, is that "the biological rationale of the law is unfounded".[114] Whether its advocates argue for the abolition or amendment of infanticide provisions, the conviction that PMIs or infanticide have no biological causes has played an influential role in legal reform and discourse. However, the scientific discussion outlined above clearly indicates that this is false. Nevertheless, it has had a tangible impact on law reform and legislative approaches to infanticide.

In 2007, for example, the Law Reform Commission of Western Australia (LRCWA) made the recommendation—which was followed—that Western Australia's infanticide provision be abolished on the basis that the biological rationale underlying infanticide had been discredited.[115] Two of the scholars cited by the LRCWA in its discussion were O'Donovan and Osborne.[116] The LRCWA not only disclaimed any link between childbirth and infanticide, but also declared that there were no biological factors involved in the aetiology of postpartum disorders,[117] describing the "relationship between mental impairment and childbirth required by the offence of infanticide" as "artificial".[118] The LRCWA also gave a reason for abolishing the provision that can be found in many other critiques, namely, that PPD and postpartum psychosis have no uniquely postpartum cause.[119] The implication is that infanticide provisions would only be legitimate if it could be proven that PMIs have an exclusively postpartum, biological aetiology. It is almost inconceivable that, in 2007, the LRCWA was still claiming that there were no biological factors at play in the development of PPD—particularly with the scientific resources at its disposal—but the influence of these views in Aotearoa can still be felt in discussions of infanticide law since *Dickason*.

In her 2023 dissertation, Heath writes, "It is extremely difficult to assess the appropriateness of s 178 when the *biological assumptions* underlying the provision have not been conclusively proved or disproved."[120] Heath continues, “The main contention in infanticide law is whether scientific

113 *R v Paea*, above n 73; and *R v JB*, above n 73.

114 Heath, above n 59, at 35.

115 Law Reform Commission of Western Australia (LRCWA) *Review of the Law of Homicide: Final Report* (Project 97, 2007) at 105–106.

116 At 104, n 5 and 13; at 105 n 14, 21 and 22; and at 108, n 51 and 58.

117 At 107–108.

118 At 106.

119 At 108.

120 Heath, above n 59, at 4 (emphasis added).

studies support a *biological* relationship between postpartum mental illnesses and infanticide."[121] Likewise, in 2023, Warren Brookbanks wrote, without providing any further sources:[122]

> While depression after childbirth is common, and psychoses and dissociation may occur, it is widely thought that the killing of a child is *more likely* the result of social and emotional pressures or personality disorder.

Legal scholarship does not exist in a vacuum, with judges, lawyers and policymakers comprising its readership. In addition to the example of the LRCWA, Brenda Midson sent her dissertation to the Law Commission for consideration,[123] and in the 2001 Court of Appeal Case, *R v Wright*, Anderson J mentioned two articles on infanticide cited in the discussion above.[124] As the following examination will show, this dichotomy appears to be a symptom of a larger failing on the part of legal practitioners and scholars to meaningfully engage with science.

IV LAW AND SCIENCE

As Yvette Tinsley writes, "Despite its long history, the relationship between law and science remains an uneasy one."[125] This section will closely consider some of the citation networks between legal texts to uncover the problems inherent in the law's engagement with "science". This will show that a considerable number of legal texts rely on outdated research. Moreover, an ouroboric tendency can be made out in legal scholarship to produce, and then consume, "scientific" discourse that at some point becomes so far removed from actual findings that a new scientific reality is created. Rather than merely describing them, these works have served to found myths that have since circulated through the legal scholarship in a seemingly endless game of "broken telephone". Though the writers who founded the myths did not have access to the scientific insights available today, it is difficult to understand or defend their continued espousal.

A Outdated Research

One problem in the legal discussion seems to be a fundamental misunderstanding of how science is produced. This could have to do with law's understanding of itself as something ahistorical that

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121 At 22 (emphasis added).

122 Warren Brookbanks "Infanticide—an unusual crime" [2023] (9) NZLJ 292 at 295 (emphasis added).

123 Libby Wilson "Ranking murder: call for new NZ legal approach to categorising killings" *Stuff* (New Zealand, 13 January 2019); and New Zealand Law Society "Degrees of murder" system proposed" (24 January 2019) <www.lawsociety.org.nz>.

124 *R v Wright*, above n 73, at [24], citing Bernadette McSherry "The Return of the Raging Hormones Theory: Premenstrual Syndrome, Postpartum Disorders and Criminal Responsibility" (1993) 15(3) Syd LR 292, and at [25], citing Maier-Katkin and Ogle, above n 61.

125 Yvette Tinsley "Science in the Criminal Courts: Tool in Service, Challenge to Legal Authority or Indispensable Ally?" (2013) 25(4) NZULR 844 at 844.

changes only when new circumstances and situations force it to respond.[126] Western law requires consistency and predictability, meaning that change should occur only when the old position has become functionally untenable. Thus, "[h]istorically, the law has tended to look to science for clear answers with no ambiguity …"[127] This stands in stark contrast to the scientific reality, which is subject to a process of "perpetual revision".[128] Scientific advances are taking place at a rate of knots, with a veritable explosion of PPD literature in the last twenty years. Entering the search term *postpartum depression* or one of its variations into PubMed, one of the most widely used medical research databases, reveals that these keywords appeared in 159 studies published in 2005. In contrast, the database returns 1,364 studies published in 2025 featuring the same keywords.[129]

Admittedly, lawyers are not scientists and perhaps cannot be expected to keep abreast of the latest scientific developments. Scientific journals aim to publish findings as quickly as possible, but publication pathways in law and humanities and social science disciplines can be long, with research often taking years to reach its intended audience. Heath demonstrates the wide gap in understandings of what "recent" means when she references a "recent study"[130]—which was 23 years old at the time she was writing.[131] In an age of rapid scientific discovery,[132] many legal writers seem to be using outdated research, potentially revealing a lack of insight into how to scope, weigh and analyse scientific data.

For instance, Karen Brennan, matter-of-factly declared in a 2007 paper that is still widely cited in infanticide discourse:[133]

> … while some medical evidence supports a biological cause, the general consensus among medical experts appears to be that postnatal mental disturbances, particularly postnatal depression, are not caused by the profound biological changes, such as chemical and hormonal imbalances, which accompany childbirth.

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126 See for example PG McHugh "Aboriginal Societies and the Common Law: A History of Sovereignty, Status, and Self-Determination" (Oxford University Press, London, 2004) at 16.

127 Tinsley, above n 125, at 844.

128 *Daubert v Merrell Dow Pharmaceuticals Inc* 509 US 579 (1993) at 597, cited in Tinsley, above n 125, at 847.

129 PubMed search for "'postpartum depression' OR 'post-partum depression' OR 'post-natal depression' OR 'postnatal depression'" (accessed 21 August 2026) <https://pubmed.ncbi.nlm.nih.gov>.

130 Bloch and others, above n 45.

131 Heath, above n 59, at 43.

132 Tinsley, above n 125, at 845.

133 Karen Brennan "Beyond the Medical Model: A Rationale for Infanticide Legislation" (2007) 58(4) NILQ 505 at 509; also cited in Brenda Midson "Why did they do it? Moral sensibilities, motivating reasons, and degrees of moral blame in culpable homicide" (PhD thesis, University of Waikato, 2018) at 220 and 251; and Heath, above n 59, at 38.

The statement is furnished with a quote: "The results of endocrine research in puerperal mental illness are not encouraging. Despite a profound feeling that hormones 'have something to do with it', there are few positive data."[134] But the volume from which the quote was taken was 19 years old when Brennan's article was published. In contrast, in 2007, Bloch and others' paper on the hormonal aetiology of PPD was already seven years old.[135]

In another example, Heath, writing in 2023, relies heavily on the 2007 report by the LRCWA, which she appears to view as a credible scientific source. The report itself draws on outdated data contesting the existence of PMIs. For example, a claim about the incidence of depression[136] is made on the back of a 1993 law journal article that draws on data from 1984 and 1988.[137] Thus, the scientific studies informing Heath's analysis were already 39 and 35 years old when she indirectly cited them.[138]

B Ouroboric discourse

Another problem in the "scientific" discussion in legal writing is that, in searching for something to grasp, legal writers frequently look to the work of other legal writers. For example, Midson states in her 2018 doctoral thesis that there is now general recognition that:[139]

> Social and psychological stresses play a more significant role in maternal infant-killing than mental disturbance and physiological factors, *there being little evidence that hormonal or chemical imbalances are at play*.

To support her statement, Midson references the 2017 edition of Simon Bronitt and Bernadette McSherry's *Principles of Criminal Law* rather than any kind of scientific study.[140] Bronitt and

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134 A George and M Sandler "Endocrine and Biochemical Studies in Puerperal Mental Disorders" in R Kumar and IF Brockington (eds) *Motherhood and Mental Illness 2: Causes and Consequences* (Wright, London, 1988) 78 at 104, as cited in Brennan "Beyond the Medical Model", above n 133, at 509.

135 Bloch and others, above n 45; see also section II.B "Factors in the aetiology of PPD" of this article.

136 LRCWA, above n 115, at 107.

137 Maier-Katkin and Ogle, above n 61, citing Michael W O'Hara, Danny J Neunaber and Ellen M Zekoski "Prospective Study of Postpartum Depression: Prevalence, Course and Predictive Factors" (1984) 93(2) Journal of Abnormal Psychology 158; and Peter J Cooper and others "Non-Psychotic Psychiatric Disorder After Childbirth: A Prospective Study of Prevalence, Incidence, Course and Nature" (1988) 152(6) British Journal of Psychiatry 799.

138 See Halbreich and Karkun, above n 32.

139 Midson, above n 133, at 219 (emphasis added).

140 At 218, n 1104, citing Simon Bronitt and Bernadette McSherry *Principles of Criminal Law* (4th ed, Thomson Reuters, Sydney, 2017) at 336.

McSherry base their statement on research from 1978,[141] which McSherry also cites extensively in a 1993 paper.[142]

Midson only tentatively accepts the existence of PMI: "there may be some *temporal* association between childbirth and risk of certain types of mental disorder".[143] She grounds her statement in a series of statistics presented in another law publication by Ania Wilczynski from 1997.[144] Midson concludes by stating that though postpartum psychosis might be hormonal, "very few" women who kill their children suffer from it—basing her statement, again, on Wilczynski.[145]

The LRCWA similarly supports its scientific assertions with law papers.[146] "[S]tudies show that the incidence and quality of blues and depression are no more pronounced following childbirth than in the general population," the report's authors opine, supporting their statement with a 1993 *Criminal Law Review* article.[147] "These conditions are usually associated with lack of sleep, adjustment to new circumstances and general stress," they claim, drawing on McSherry's 1993 article.[148]

Finally, in a 2021 issue of the Journal of Criminal Law, James Mason presents a paper that reproduces the full feminist critique of infanticide provisions described above.[149] Mason claims to utilise "the perspectives of contemporary medical science" to scrutinise "the scientific credibility of the medical rationale",[150] but cites only nine medical or psychological/psychiatric sources, which appear in a mere 11 of his 142 footnotes.[151] Moreover, only three of those sources are from the 21st century, with the rest dating to the period 1963–1998. Mason otherwise cites from law and history publications.

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141 M Sandler *Mental Illness in Pregnancy and the Puerperium* (Oxford: Oxford University Press 1978), cited in Bronitt and McSherry, above n 140, at 336.

142 McSherry, above n 124, at 293, n 7 and at 294, n 11.

143 Midson, above n 133, at 219.

144 At 219, n 1107–1112; see also Wilczynski *Child Homicide*, above n 104, at 155. In the 1990s, Ania Wilczynski argued that psychosocial stressors were more significant contributors to infanticide than mental disturbance or other physiological factors. At 156–157; see also Wilczynski "Images of Women Who Kill Their Infants: The Mad and the Bad", above n 102, at 432.

145 Midson, above n 133, at 220.

146 LRCWA, above n 115, at 106–108.

147 At 107, n 41, citing Maier-Katkin and Ogle, above n 61.

148 LRCWA, above n 115, at 107, n 42, citing McSherry, above n 124.

149 Mason, above n 103.

150 At 441.

151 At 444, n 37–41; at 445, n 43; at 446, n 55; and at 447, n 74.

Of course, there are scholars who manage to bridge the gap between law and science. One such is Russ Scott, an Australian psychiatric practitioner. In his 2020 article, Scott draws on literature published between 2000 and 2018, basing most of his scientific discussion on papers that had appeared in the three years prior to publication.[152] He states that the latest research into infanticide:[153]

> … has *clearly* demonstrated the association between childbirth and major mental illness and supports the hypothesis that for a very small cohort of women who develop postpartum depression or psychosis, their mental illness may include cognitive distortions or delusions from which they kill their child or children months, even many months, after the birth of the last child.

Scott is emphatic:[154]

> … those various modern law reform commissions in Australia which have concluded that any association between childbirth and mental illness is "discredited" or "unproven" have been poorly served by very limited and selective advice.

In "an age where science is advancing rapidly, the law must be equipped to assess scientific evidence to maximise its reliability".[155] This ability is clearly lacking in the legal discourse on maternal mental health and infanticide. By relying on both outdated medical research and looking to law journals for "scientific facts", legal scholars have produced an alternate reality that has only a loose connection with ongoing research into the aetiology of PMI and its relationship to infanticide. Thus, if any changes are to be made to New Zealand's infanticide regime, care must be taken to ensure that experts who are abreast of the latest scientific developments are involved in the process.

V WHERE TO FROM HERE?

It can only be hoped that the spotlight that Dickason's case has shone on infanticide might prompt the legislature to re-examine s 178 in light of more contemporary understandings of the multifactorial causes of PMI and infanticide. But in order to figure out where New Zealand's infanticide regime should go from here, it is worthwhile taking a step back to consider where it has come from. The next section will therefore consider the Rome to which all infanticide provisions in common law jurisdictions lead—the English Infanticide Act 1938—before examining more recent attempts on the part of policy and lawmakers to revisit New Zealand's infanticide regime. Finally, the section will consider the issue of juries in trials involving complex scientific issues.

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152 Scott, above n 31.

153 At 1045 (emphasis added).

154 At 1045.

155 Tinsley, above n 125, at 846.

A Legislative history

English moral panic surrounding infanticide peaked in the period 1840–1880,[156] with a noticeable increase in infanticides in the 1860s.[157] Women who killed their babies were frequently young domestic servants or unmarried rural women who had been raped or deserted,[158] and poverty and shame were huge factors in such killings.[159] But as JR Dickinson and JA Sharpe show in relation to 18th-century Chester, sentencing decisions reflected an understanding of the social and economic circumstances driving infanticide.[160]

When the English Infanticide Act 1922 was drafted, it was still neonaticide, rather than infanticide, that it explicitly addressed:[161]

> Where a woman by any wilful act or omission causes the death of her *newly-born* child, but at the time of the act or omission she had not fully recovered from the effect of giving birth to such child, and by reason thereof the balance of her mind was then disturbed, she shall, notwithstanding that the circumstances were such that but for this Act the offence would have amounted to murder, be guilty of felony, to wit of infanticide, and may for such offence be dealt with and punished as if she had been guilty of the offence of manslaughter of such child.

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156 R Sauer "Infanticide and Abortion in Nineteenth-Century Britain" (1978) 32(1) Population Studies 81 at 85 and 92.

157 D Seaborne Davies "Child-Killing in English Law—Part I" (1937) 1(3) MLR 203 at 222. For more on the history of infanticide, see for example Susan J Lagaipa "Suffer the Little Children: The Ancient Practice of Infanticide as a Modern Moral Dilemma" (1990) 13(4) Issues in Comprehensive Pediatric Nursing 241; Spinelli "Maternal Infanticide Associated with Mental Illness: Prevention and the Promise of Saved Lives", above n 24, at 1549; Nigel Walker *Crime and Insanity in England* (Edinburgh University Press, Edinburgh, 1968) vol 1 at 127–137; William L Langer "Infanticide: An Historical Survey" (1974) 1(3) History of Childhood Quarterly 353; Sauer, above n 156; Peter C Hoffer and N E H Hull "*Murdering Mothers: Infanticide in England and New England, "1558–1803* (New York University Press, New York, 1981); O'Donovan, above n 99; Osborne, above n 99; Carol Smart "Disruptive bodies and unruly sex: the regulation of reproduction and sexuality in the nineteenth century" in Carol Smart (ed) *Regulating Womanhood: Historical Essays on Marriage, Motherhood and Sexuality* (Routledge, London, 1992) 7; JR Dickinson and JA Sharpe "Infanticide in Early Modern England: the Court of Great Sessions at Chester, 1650–1800" in Mark Jackson (ed) *Infanticide: Historical Perspectives on Child Murder and Concealment, 1550–2000* (Routledge, London, 2002) at 35; Powell, above n 107; and Joanne Pearman "Bastards, Baby Farmers, and Social Control in Victorian Britain" (PhD Thesis, University of Kent, 2017).

158 Scott, above n 31, at 1017; see also Sauer, above n 156, at 85; and Dickinson and Sharpe, above n 157, at 49.

159 Sauer, above n 156, at 84–85; and Seaborne Davies, above n 157, at 221; see also Shee J before the 1866 Capital Punishment Commission, as cited in Seaborne Davies, above n 157, at 221.

160 Dickinson and Sharpe, above n 157, at 39 and 49.

161 Infanticide Act 1922 (UK) 12 & 13 Geo 5 c 18, s 1(1) (emphasis added); see also LRCWA, above n 115, at 110.

The Infanticide Act 1938 then extended the defence to cover deaths of infants up to 12 months of age.[162] It is likely that the modification reflected changing patterns in early 20th century infanticide,[163] with safer abortions rendering it increasingly unnecessary.[164]

The "new words" regarding the disturbed balance of mind in the 1922 Act were a legislative innovation,[165] drafted to be distinct from insanity and drunken derangement.[166] In the 1980s, O'Donovan and Osborne argued that the use of medical language in the 1922 Act conveniently "medicalised"[167] infanticide to avoid unnecessary death sentences and to conceal the real reason the courts were treating infanticidal mothers leniently—their consideration of socio-economic stressors.[168] But the "new words" did also reflect burgeoning 20th century understandings of PMI, which had been preceded by the first scientific accounts of PMI in the mid-19th century.[169]

Thus, infanticide was not, as O'Donovan claims, simply "medicalised" by the adoption of infanticide provisions, nor were socioeconomic considerations and psychosocial stressors a blind spot in infanticide's early legal history. It is therefore possible that, from their inception, infanticide provisions were the product of an unconscious *multifactorial* understanding of infanticide.

B Causation and flexibility

It therefore seems significant that s 178 does not require that the balance of the defendant's mind be disturbed exclusively by reason of childbirth or a disorder consequent upon childbirth. As the UK Court of Appeal held in *R v Tunstill* in relation to s 1(1) of the English Infanticide Act 1938, drawing on the criminal test of causation:[170]

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162 See Debra Wilson "The Offence/Partial Defence of Infanticide in New Zealand Law: Past, Current and Future Use" (2022) 17(2) Otago LR 335 at 337.

163 McSherry, above n 124, at 302; and Wilson, above n 162, at 338.

164 Sauer, above n 156, at 92; Judith A Allen *Sex and Secrets: Crimes Involving Australian Women Since 1880* (Oxford University Press, Melbourne, 1990) at 109–110; and McSherry, above n 124, at 301–302.

165 (25 May 1922) 50 HL Deb "Child Murder (Trial) Bill", cols 761–762 (25 May 1922), cited in Brookbanks, above n 122, at 292.

166 Brookbanks, above n 122, at 292.

167 O'Donovan, above n 99.

168 Osborne, above n 99, at 58.

169 Étienne Esquirol *Des maladies mentales considérées sous les rapports médical, hygiénique et médico-légal* (JB Baillière, Paris, 1838) vol 1; Louis-Victor Marcé *Traité de la folie des femmes enceintes, des Nouvelles accouchées et des nourrices* (JB Baillière et Fils, Paris, 1858); and Spinelli "Maternal Infanticide Associated with Mental Illness: Prevention and the Promise of Saved Lives", above n 24, at 1550.

170 *R v Tunstill* [2018] EWCA Crim 1969, [2019] 1 WLR at [31] (emphasis added).

> The phrase "by reason of" … does not in our judgment necessarily need to be read as if it said "solely by reason of". It seems to us that as long as a failure to recover from the effects of birth is an *operative or substantial* cause of the disturbance of balance of mind that should be sufficient, even if there are other underlying mental problems … which are part of the overall picture.

In *Tunstill*, the Court rejected the trial Judge's refusal to admit an infanticide defence on the basis that the defendant's pre-existing mental illness had only been exacerbated by childbirth when she killed her newborn.[171] The appellant argued that not admitting the defence for women suffering from pre-existing mental illness would put them in a worse position than those without a history of mental illness.[172] An expert witness for the appellant testified that, in cases of pre-existing depression, it would be difficult to determine which symptoms belonged to the pre-existing condition and which were exacerbated by the birth.[173] The Court agreed:[174]

> It would seem anomalous to us that a person who, prior to childbirth, is in a fragile mental state and whose balance of mind is disturbed as a result of a failure to recover from childbirth should be placed in a different and less favourable position from someone affected solely by the experience of childbirth.

In light of the current state of medical and psychological research into the causes of PPD and infanticide, and considering the criminal test of causation, McLeavey's and Monasterio's statements about Dickason's being ineligible for s 178 due to her history of depression should thus have been deemed irrelevant. Section 178 does not require the mental disturbance to have a uniquely postpartum aetiology. PPD may not be aetiologically distinct from major depression, but that does not mean that it does not exist. Women with pre-existing depression are more likely to commit infanticide than women with a "clean" background;[175] requiring PPD to have a distinct postpartum aetiology would therefore bar the women most in need of the infanticide defence from availing themselves of it. Indeed, and unintentionally drawing attention to the flexibility of infanticide provisions, Wilczynski lamented in 1997 that "virtually any type of mental or social stress or distress can be invoked if required".[176]

In *Tunstill*, the Court said that the "purpose of the Infanticide Act [1938]"—and thus by extension New Zealand's s 178—"was to ameliorate the potential harshness of the law of murder by recognising that in a period after birth a mother's balance of mind may be affected".[177] It was clear, they said,

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171 At [15].

172 At [16]

173 At [28].

174 At [29].

175 Bartels and Easteal, above n 7, at 338; see also section II.C "The link between PPD and infanticide" of this article.

176 Wilczynski *Child Homicide*, above n 104, at 165.

177 *R v Tunstill*, above n 170, at [30].

"that the intention behind the legislation was to be merciful".[178] New Zealand case law contains similar sentiments.[179] Early infanticide legislators seem to have been aware that there was something about the postpartum period that made women more susceptible to killing their children. Their inkling is supported by both homicide statistics and scientific literature. Infanticide is a "distinctive kind of human tragedy" that requires a "distinctive response".[180]

So, how can s 178 be reformed to ensure that it reflects both the historical purpose of infanticide legislation and contemporary understandings of the multifactorial causes of infanticide to ensure that the infanticide defence protects the women who need it most?

C Reform Attempts

Cabinet and the Law Commission have revisited infanticide a handful of times since 1961. The Crimes Bill 1989 proposed a simplification of the language in s 178 that was not enacted.[181] In 2003, Cabinet then suggested abolishing s 178 on the basis that the age limit of 10 years and the restriction to a mother killing "a child of hers" were arbitrary.[182] Interestingly, Cabinet also recognised that the wording did not account for "socio-economic factors associated with raising a young family that might equally trigger or exacerbate mental disorder", listing as examples "tiredness, overcrowding, poverty, lifestyle changes, [and a] lack of support".[183]

The Law Commission briefly considered infanticide in the consultation draft that would later become the *Partial Defence of Provocation* report.[184] Infanticide was included once more in the terms of reference for the project that resulted in *Mental Impairment Decision-Making and the Insanity Defence*.[185] However, infanticide was excluded from both final reports. The consultation draft, which cannot be taken as the final views of the Commission,[186] recommended retaining s 178 without

178 At [30].

179 See for example *R v Moke*, above n 73, at 4; and *R v Metuatini*, above n 80, at [14].

180 Victorian Law Reform Commission *Defences to Homicide: Final Report* (VLRC, 2004) at [6.19]; see also Brennan, above n 133, at 519.

181 Crimes Bill 1989 (152-1) (explanatory note) at xvii; see also cl 124.

182 Cabinet Paper "Criminal Defences Reform: Necessity and Partial Defences (Provocation and Infanticide)" (18 November 2003) POL (03) 367 at [11.2] and [11.3].

183 At [11.1].

184 Law Commission *Partial Defences: Provocation and Infanticide* (unpublished consultation draft of report NZLC R98, April 2007); and Law Commission *The Partial Defence of Provocation* (NZLC R98, April 2007).

185 Law Commission *Mental Impairment Decision-Making and the Insanity Defence* (NZLC R120, 2010).

186 In an email, the Commission stated, "As a draft, any opinions, conclusions or recommendations were tentative and preliminary only, and the chapter on infanticide was removed from the final report to allow the Commission to consider the issue further before drawing any conclusions about the need for reform of the

amendment. The Commission noted the provision's flexibility as both an offence and defence, asserting that there was no "appetite" to repeal it.[187] In 2009, the Minister removed infanticide from the Law Commission's work programme altogether due to the prioritisation of other projects.[188]

In the absence of a diminished responsibility regime,[189] abolishing s 178 outright would be unwise and unjust—even if judges like Mander J in *Dickason* have the power to, and routinely do, ameliorate the harshness of murder or manslaughter convictions at sentencing. In order to propagate the human species, women as a group have no choice but to put themselves at increased risk of developing or exacerbating mental illness during the postpartum period. If infanticide is a symptom of multifactorially induced mental illness, then the law should show compassion when that symptom manifests—or risk burdening women with harsh jail sentences and the stigma of murder and manslaughter convictions. This leaves two viable options: retention or amendment. In light of the prosecutorial trend towards interpreting s 178 on a purely biological basis, I would argue that the section must be amended to more clearly account for the multifactorial causes of PMIs and infanticide.

D Amending s 178

Russ Scott suggests replacing the wording regarding the disturbed balance of the mind with the more modern "mental impairment".[190] However, care must be taken to avoid reinforcing physiological interpretations and narrowing the fact-finder's focus to diagnosed or diagnosable mental impairments. Wording that reflects the multifactorial causes of PMI and infanticide but can still explicitly accommodate women who have not been diagnosed with a PMI:[191]

> … would assist those women who kill their child (or children) who may not be presenting PND [postnatal depression] evidence in their defence because they have fallen through the 'cracks'. These cracks include the failure to [be] properly diagnosed and the lack of appropriate expert witnesses.

It is through precisely these cracks that many of the women in the New Zealand cases described above appear to have fallen.

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law." Email from Law Commission to Lydia J White regarding the unpublished *Partial Defences: Provocation and Infanticide* consultation draft, above n 184 (10 April 2025).

187 Law Commission *Partial Defences: Provocation and Infanticide*, above n 184, at [180] and [182].

188 Law Commission, *Annual report 2009–2010*, at 12 and 52; and letter from Law Commission General Manager to Simon Power (Minister of Justice) regarding the NZLC work programme (30 November 2009), as cited in email to Lydia J White, above n 186.

189 See also Brookbanks, above n 122, at 296.

190 Scott, above n 31, at 1030.

191 Bartels and Easteal, above n 7, at 338.

Any amendment would need to take pre-existing mental illness into account. The wording "the balance of her mind was disturbed" is flexible in this regard, as it can be interpreted to refer to somebody's prepartum mental equilibrium—which could be an ongoing depressive state—being brought out of balance by the physiological impact of the psychosocial stressors of motherhood. For example, the Court of Appeal in *JB v R* remarked that the birth and needs of JB's child "interfered with the fragile balance [JB] had established".[192] However, the time has come to remove the insistence on childbirth, for it is increasingly being interpreted as requiring an exclusively postpartum aetiology for PMIs. Drawing on a recommendation by the NSWLRC,[193] Bartel and Easteal suggest changing the wording to "consequent on or exacerbated by the defendant having given birth".[194]

Given New Zealand's culture of "penal populism",[195] any amendment to s 178 would have to remain conservative. I would therefore adapt Bartel and Easteal's wording and make the following suggestion for the amendment of s 178(1):

> Where a woman causes the death of a child in her care under the age of 10 in circumstances amounting to culpable homicide, and where, at the time of the offence the balance of her mind was disturbed—
>
> (a) by reason of the woman not having fully recovered from the effect of giving birth to that child or any other child; or
>
> (b) by the effects or circumstances consequent upon or exacerbated by giving birth to that child or any other child
>
> to such an extent that she should not be held fully responsible, she is guilty of infanticide, and not of murder or manslaughter, and is liable to imprisonment for a term not exceeding 3 years.

Admittedly, this would retain some arbitrariness in the form of the 10-year victim age limit, but a limit is necessary if an infanticide regime is to be maintained. Keeping the more traditional requirement in (a) allows for cases like *R v Golovale-Siaosi*, which was argued on the purely physiological basis of rapid blood loss.[196] The addition of (b) would accommodate the multifactorial causes of PMIs and infanticide without the defendant having necessarily to adduce evidence of a specific or previous diagnosis. Some might object that all this discussion does is underline New

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192 *JB v R*, above n 73, at [40].

193 NSWLRC *People with cognitive and mental health impairments in the criminal justice system: Criminal responsibility and consequences* (R 138, 2013) at [5.60].

194 Bartels and Easteal, above n 7, at 337.

195 See for example John Pratt and Marie Clark "Penal populism in New Zealand" (2005) 7(3) Punishment & Society 303; John Pratt *Penal Populism* (Routledge, London, 2007); and Luke Oldfield "Penal Populism, Prison and Performance Measures: Autoethnography of a New Zealand Corrections Officer" (2023) 38(2) New Zealand Sociology 35.

196 *Golovale-Siaosi*, above n 80.

Zealand's need for a diminished responsibility regime. However, in some jurisdictions with diminished responsibility regimes, infanticide provisions have been retained precisely because they allow for a lower diagnostic threshold and the consideration of psychosocial stressors.[197]

The proposed amendment to section 178 would ensure that women suffering from PMIs—whether diagnosed or not—are not unjustly excluded from the defence. It would also recognise the complex interplay of biological, psychosocial and epigenetic factors while remaining broad enough to accommodate future scientific findings.

E Jury trials

Before concluding this article, I would like to make a note about the role played by juries in infanticide cases, though the scope of the article does not allow me to consider them in depth. *Dickason* raises important questions about their role in trials involving complex scientific subject matter. Though he was bound by the jury's verdict, Mander J said that he was satisfied that the killings were a "product" of Dickason's mental disorder: "This tragic event would not have occurred *but for* the major depressive episode from which you were suffering."[198] His Honour rejected the Crown's theory of the case and recognised the relationship between environmental stressors and depression:[199]

> I do not discount you experienced anger and frustration at the three little girls acting their age earlier that night, but I consider that was likely to have been a further stressor that added to your sense of hopelessness about the situation you found yourself in as a result of your distorted and impaired cognition that was the product of your depression.

This judicial recognition of the interplay between psychosocial stressors and mental illness stands in contrast to broader trends towards resisting such nuance.

The preceding discussions have revealed that even experts and lawyers grapple with issues like PPD and its relationship to infanticide. It therefore does not seem far-fetched to speculate that twelve laypeople plucked from the streets of Christchurch, for example, might face even more challenges coming to terms with the medical evidence. In addition, it cannot be ruled out that the members of the jury in a case such as *Dickason* are influenced by those patriarchal ideas about motherhood that the feminist critique strives to combat.[200] Indeed, Chris Gallivan has stated specifically that "anybody

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197 See for example Law Commission of England and Wales *Murder, Manslaughter and Infanticide* (LAW COM No 304, 2006) at [8.36]–[8.37]; and NSWLRC *People with cognitive and mental health impairments*, above n 193, at [5.40]–[5.44].

198 *R v Dickason*, above n 4, at [48] (emphasis added).

199 At [46].

200 On the culturally embedded misconceptions influencing juries see Yvette Tinsley, Claire Baylis and Warren Young "'I Think She's Learnt Her Lesson': Juror Use of Cultural Misconceptions in Sexual Violence Trials" (2021) 52(2) VUWLR 463.

who's been following [*Dickason*] would think the criminal justice process of determining the culpability of this person is a fairly crude and fairly blunt way of doing it".[201] Future considerations of New Zealand's infanticide regime should therefore seriously scrutinise whether this is one of those areas where jury trials are no longer appropriate.

VI CONCLUSION

Dickason is a case that urges us to more closely scrutinise New Zealand's current infanticide regime and ask whether it is fit for purpose. The scientific literature on postpartum mental illness has evolved rapidly in recent decades, revealing a complex, multifactorial and epigenetic aetiology that prosecutors and legal discourse have largely failed to acknowledge. This article has shown that both prosecutors and scholars frequently rely on outdated or overly simplistic models of PMI in their considerations of s 178, privileging either biological factors *or* psychosocial stressors. The persistence of this dichotomy stands in stark contrast to contemporary scientific research, which emphasises the interplay of hormonal, neurological, environmental and genetic factors. If the law is to remain credible, it must reflect this scientific reality, rather than perpetuate myths born of disciplinary insularity.

Ultimately, the issue of how New Zealand should approach infanticide cannot be separated from the question of how the criminal law balances compassion and criminal responsibility. If compassion should be shown to mothers who kill children, then why not to postpartum women who commit other crimes?[202] The courts' reluctance to apply inchoate liability to infanticide could reflect a general unwillingness to extend the infanticide defence beyond this narrow context—or to men.[203] But infanticide forces us to confront the deeper implications of what it means to hold someone criminally responsible. In light of recent scientific findings, cases like *Dickason* seriously call into question the idea of the infanticidal mother acting free of the burden of biological, psychosocial and epigenetic influences. However, as O'Donovan wrote in 1984, "To admit that social and economic circumstances, or motherhood, may cause crime is to open a hitherto tightly closed box."[204] More broadly, to admit that mental illness and crime are both multifactorial—and that the seeds are planted as early as in childhood, a period beyond any perpetrator's control—is to completely question the concept of criminal responsibility itself. For if we are going to show compassion to mothers for circumstances that are beyond their control, why not to others?

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201 Chris Gallivan, speaking in Michael Wright "Should Lauren Dickason have been tried by a jury?" *The Press* (online ed, 17 August 2023).

202 See for example Nilo Tayebi and others, above n 56.

203 Cases where inchoate liability was established: *R v L* HC Invercargill CRI-2009-025-329, 24 November 2009; and *R v Milton* [2014] NZHC 778. For a case where inchoate liability was denied: *R v X* [2016] NZHC 840 at [25].

204 O'Donovan, above n 99, at 264.