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Mothers in the courtroom III: criminalising the irresponsible mother

> […] your chaotic lifestyle choices, including alcohol abuse and promiscuity at the time of your pregnancies was such as to put the good health of any unborn child at risk. (Sally, judge sentencing).

One of the key changes that can be seen to have occurred over the twentieth century is the nature of the conceptualisation of pregnancy, including how the foetus and pregnant women are perceived in terms of the roles they play in the process of pregnancy. The latter half of the twentieth century and the twenty-first century can be characterised as a period in which the foetus is recognised and perceived as a subject—a being that is independent of the pregnant woman. Foetal subjectivity is reflected and seen very clearly in cultural practices: think, for example, of the cover story of *Life Magazine* in 1965, 'Drama of Life Before Birth', featuring images of the foetus, represented as being outside the body of a pregnant woman (portrayed as if floating in space). Such a depiction suggests foetuses and pregnant women are separate entities, independent, and thus subjects in their own right. The independence of the foetus can also be seen in medicine, with, for example, developments in foetal medicine, where the foetus is the patient.

Similarly, in some legal jurisdictions, such as most states in the United States, the foetus has become a legal subject with varying levels of legal protection (Milne, 2020; Murphy, 2014; National Conference of State Legislatures, 2018). As outlined

in Chapter 1 and explored in detail in Chapters 5 and 6, in England and Wales, the foetus is not a legal subject and has limited legal protection, including as a victim of crime, due to the born alive rule. While abortion[1] continues to be illegal, the only offence that can be committed against the foetus is child destruction: the destruction of a child capable of being born alive through a wilful act.[2] The role of criminal law in protecting foetuses will be explored later in this book.

In this chapter, the focus is upon examining the expectations of pregnant women in relation to their foetus which fall outside of the law, and how these expectations are discussed and communicated in the criminal hearings of women who have been convicted of offences related to a suspicious perinatal death. Such expectations are very closely connected to the myths of motherhood and expectations of 'good' mothering and motherly behaviour. As outlined in Chapter 3, such expectations are pervasive in the hearings, woven throughout the discussion of the women and their actions, and used to construct their character and the narrative around what they did or did not do. As will be illustrated in this chapter, motherhood ideologies, and belief of the 'naturalness' of mothering, stem from the existence of a pregnancy. Such expectations are deeply enmeshed with the perception of the 'responsible' pregnant woman—the woman who manages any risk towards the foetus. These expectations can be encapsulated in the general belief that the women will prioritise the needs of the foetus – which I term the 'foetus-first mentality' (Milne, 2020). An example of such expectations can be seen in Sally's case, in the quote at the top of this chapter. While her conviction for concealment of birth has nothing to do with her behaviour

[1] Offences Against the Person Act 1861, s58, offence of procuring a miscarriage.
[2] Infant Life (Preservation) Act 1929, s1.

while pregnant, the judge deemed it important to comment on the perceived increased risk experienced by her ‘unborn child’ due to her actions and inactions.

Much feminist scholarship has been critical of the changing conceptualisation of the foetus, and subsequent behaviour towards pregnant women, focussing on the substantial impact of foetal subjectivity on the rights of the women in all areas of life. Risk mentality and risk prevention are key areas of theorisation; as Rachelle Joy Chadwick and Don Foster (2014) argue, nowhere is the pervasiveness of risk as apparent as it is in pregnancy and childbirth (Smith et al., 2012). Therefore, the court transcripts will be analysed through the lens of this academic work. In so doing, it will become apparent that in the process of the criminal hearing, the women are framed not only as the failed mother, as explored in Chapter 3, but also as failing in their role as the ‘responsible pregnant woman’ and failing to put the foetus first. Finally, I will consider how narratives of risk could be adapted to take into consideration women’s experiences of crisis pregnancy. Rather than always seeing the pregnant woman as the risk, I consider how perceptions of criminality change if we see a pregnancy as a risk to a woman.

Foetus-first mentality

The changing conceptualisation of pregnancy, the pregnant woman, and the foetus is embedded in the process of the medicalisation of pregnancy. Pregnancy, labour, and delivery have developed from being, generally, a private experience that centres around the woman who is pregnant (Gowing, 1997), to becoming a medicalised, public activity that centres around the foetus which requires medical management and intervention to ensure its safety and well-being. The notion that the foetus

should be put before the pregnant woman, in terms of both health and welfare, is one that can only exist if the foetus is conceptualised as a specific entity in need of protection and care. Historically, understanding and knowledge of the mechanics of pregnancy were limited. Awareness of pregnancy might be indicated by ‘quickening’ (the point at which a woman first feels the foetus move: typically, 15-17 gestational weeks), but otherwise unconfirmable until the final stages of labour. Similarly, the health of the foetus was unknowable until after delivery. As Ann Oakley (1984) argued in her study of the history of the obstetric care of women, no body of knowledge or set of techniques to manage pregnancy existed; consequently, there was no rationale for medical supervision. In the lead up to, and during the twentieth century, the conceptualisation of pregnancy changed. Medical knowledge developed and pregnancy was pathologised – becoming an occasion for medical surveillance and treatment (Oakley, 1993). Tests to ‘diagnose’ pregnancy were developed; for example, the hormonal pregnancy test became available for use by doctors in the 1930s (Oakley, 1984). Pregnancy and childbirth moved from being female-led and community-based, to an institution-based medical ‘condition’, managed predominantly by professionals who were mostly male (see Ehrenreich & English, 2010; Leavitt, 1986; Wertz & Wertz, 1989).

Medicalisation has led to two key consequences in the conceptualisation of pregnancy. Firstly, a change in how pregnancy, labour, and delivery are understood and approached as a medical condition requiring treatment. Ann Oakley (1984) argues that medicalisation resulted in childbearing being divided between the ‘normal’ and ‘abnormal’, rather than simply a state of being that is experienced by women. When antenatal care first operated, the task was to screen the population in

search of the few women who were at risk of disease or death. By the 1980s, screening is conducted in the ‘population suffering from the pathology of pregnancy for the few women who are normal enough to give birth with the minimum of midwifery attention’ (1984, p. 213). The change in perception happened rapidly – 70% of childbirths were thought ‘normal’-enough to be delivered at home by a midwife in the 1930s. However, by the 1950s, 70% of all births were considered sufficiently ‘abnormal’ to be delivered in hospital (Oakley, 1984, p. 142). Today, just 1 in 50 women give birth at home (National Health Service, 2018d).

Risk now defines women’s experiences of pregnancy and childbirth (Helén, 2004), as they are seen as requiring expert management by medical professionals, drawing on evidence-based knowledge, prediction, and control (Lupton, 1999a). As Lealle Ruhl (1999) argues, medical professionals’ involvement in pregnancy has had a dual impact: the creation of risk through testing, monitoring, and research, as well as the alleviation of that risk through treatment and medical management. To minimise risk, childbirth and pregnancy must be ‘managed by experts, constantly monitored and [be] subject to a series of investigations in order to probe dysfunction and abnormality’ (Chadwick & Foster, 2014, p. 70).

Second, and as a direct result of the medicalisation, the development and solidification of the idea that pregnancy involves two patients—the pregnant woman and the foetus—both of whom need medical surveillance and potentially treatment. Lorna Weir (2006) notes that the construction of the perinatal threshold was a key element in the development of current responses to pregnancy. She argues that the birth threshold, the point at which the foetus becomes a living subject and enters the

social world, was disrupted in the early twentieth century. In attempts to lower rates of infant mortality and to optimise infant health, medical intervention moved into the new perinatal threshold. Deaths around birth—before, during, and after—were perceived as bearing similarities, and the foetus in later gestation in the womb was considered to be, in essence, the same as the newborn baby: different only by geography—inside or outside the woman. Consequently, physicians developed new targets and measures to prevent foetal and neonatal mortality—perinatal death. Weir concludes that this development reduced both the significance of birth and the nature of the treatment of pregnancy. As a consequence, the perception that 'mother' and 'baby' are distinct subjects moved from the end of labour (after the baby was born) to during pregnancy. This shift in perception assisted in the construction of the foetus as a subject. Rather than pregnancy being understood as a situation whereby one person (the pregnant woman) needs care to produce a new human life, pregnancy has been constructed as a situation where two distinct humans need care. Weir argues that the changing concept of the life/birth threshold, developed in the 1950s, signifies the start of the application of risk techniques towards pregnancy.

The medicalisation of pregnancy and, in relation to this, the construction of the foetus as a patient has received substantial criticism from feminists and feminist midwifery groups. Arguments have been made that the treatment of pregnancy as a medical condition has resulted in male control over women's reproduction, requiring women to consult medical experts for what is 'naturally' a woman's domain; thus disempowering women and pathologising the experience (Davis-Floyd, 1992; Ehrenreich & English, 2010; Leavitt, 1986; Lupton, 2012a; Martin, 1987; Oakley, 1984; Rothman, 1989, 1993). The aim of this critique is not to argue that all medical

intervention and knowledge is inherently negative. Medical advancements have many benefits for women; for example, medical understanding of pre-eclampsia has resulted in the development of successful treatments for what was previously a fatal condition for women and their foetuses. Instead, the critique lies in the harmful consequences of the technocratic model promoted by medical professionals (Davis-Floyd, 2001). However, as Sarah Jane Brubaker and Heather E. Dillaway (2009) argue, there is no clear definition of the concept of medicalisation within sociological literature, nor is the concept of a 'natural' birth fixed or determined, particularly in the minds of many women or medical professionals. Instead, they argue, hospital births have become so common place that they may seem 'natural'. Furthermore, as Bonnie Fox and Diana Worts (1999) have argued, medicalisation developed with the endorsement and encouragement of communities of women, many of whom take great comfort in the support provided by medical institutions during pregnancy, and labour and delivery. Nevertheless, critique of over-technical medical intervention remains strong as can be seen by campaigns in the United States, where most births are obstetrician-led, such as *Our Bodies, Ourselves*, and the movement advocating midwifery-led care in the United Kingdom (Boston Women's Health Book Collective, 2008, 2011; National Institute for Health and Care Excellence, 2014; Wagner, 2006; Strong, 2000).

Feminist critiques of medical care have also focussed on the impact of the construction of the foetus as a patient. Feminists argue that it is now the foetus who is the focus as the patient, while the pregnant woman has been defined as no more than the foetal carrier or container and gestational environment (Bordo, 2003; Chavkin, 1992; Halliday, 2016; Longhurst, 2001; Lupton, 1999b; Martin, 1987;

Phelan, 1991; Young, 1990). Further development of foetal imaging techniques (Petchesky, 1987) and foetal surgery to directly treat the foetus (Knopoff, 1991; Williams, 2006; Fletcher, 1981) have reinforced this critique. Feminists argue that such technologies and medical developments have framed the foetus as an independent entity, marginalising the woman (MacKinnon, 1991).

Medicalisation and the foetus as a subject have changed how the behaviour of pregnant women is perceived. Risk management and prevention are centred around protecting the unborn as the vulnerable subject, susceptible to danger. As the foetus exists within the pregnant woman, foetal protection requires management of her behaviour: protection of the subject through the maternal abdominal wall, as Phelan (1991) puts it. Consequently, the predominant focus is not upon averting maternal risk, but reducing possible risk to the foetus that may be caused by maternal behaviour (Helén, 2004; Lupton, 2012b; Ruhl, 1999; Weir, 1996). These risk management techniques operate beyond women's interactions with medical professionals and are now a normal element of public discourses and advice surrounding pregnancy, for example, advice and guidance provided to women regarding:

- consumption of certain foods (Foodsafety.gov, 2019; National Health Service, 2020c, 2020b),
- drinking alcohol (Centers for Disease Control and Prevention, 2020a; National Health Service, 2020a),
- smoking cigarettes (Centers for Disease Control and Prevention, 2020f; National Health Service, 2019b),

- using controlled substances (Centers for Disease Control and Prevention, 2020g; National Health Service, 2019a),
- rates of obesity (National Health Service, 2020d; Office on Women's Health, 2018b),
- levels of stress (Burns et al., 2015; Public Health England, 2019),
- certain pre-existing medical conditions (Centers for Disease Control and Prevention, 2020d, 2020e, 2020c; National Health Service, 2018c, 2018b, 2018a; Office on Women's Health, 2018a; National Institute of Diabetes and Digestive and Kidney Diseases, 2018),
- how they wear a seat belt (Ford, 2018; Children's Hospital of Philadelphia, n.d.), and
- the level of pollution in the air they breathe (Carrington, 2019).

The advice and guidance given are focussed on women adapting and changing their behaviour for the benefit of the unborn, rather than for their own health.

The majority of these regulations of risk are achieved through, what Lealle Ruhl (1999) defines as, the 'liberal governance of pregnancy', which enlists the co-operation of the 'responsible' pregnant woman. This theorisation falls within the broad area of governmentality, which concerns itself with analysis of how the state attempts to direct the conduct of the population to remedy or improve perceived problems.[3] Rather than using force and coercion, the state manages the population through guidance that is regulated by experts. The ideal neoliberal subject embodies

[3] For discussion of the broader theories of governmentality and how they impact on wider areas of life, see Rose (1993; 1996a; 1996b; 2000), O'Malley (1992; 2000; 2004) and Simon (1988), who developed Foucault's (1991 [1977]; 1992 [1985]) principles of governmentality.
For discussions of how governmentality, risk, and gender interact, see Hannah-Moffat & O'Malley (2007).

principles of prudence and self-regulation, managing risk and absorbing the cost of risk, as opposed to burdening society by requiring social support. Risk comprises language, practice, and modes of knowledge (Beck, 1992). The more attempts that are made to categorise risk, the more risks will be found. Hence, it is an unfulfilled process: no one can escape the fear of risk or its impact. Furthermore, while risk is often seen as value-free, with the use of scientific knowledge that is presented as objective, it is value-laden, and, specifically for this research, is gendered (Chan & Rigakos, 2002; Hannah-Moffat & O'Malley, 2007; Stanko, 1997; Walklate, 1997).

The liberal governance of pregnancy is an individualised risk model, rather than a collective risk model, meaning the pregnant woman absorbs the burden of the risk. It is her behaviour and the context of her life that is perceived to have the most impact on the health and well-being of the foetus, rather than wider societal factors (Ruhl, 1999; see also Bordo, 2003; Chavkin, 1992; Lane, 2008; Lazarus, 1994). For example, public health messages now advise that women should be a 'healthy' weight prior to becoming pregnant, and that 'if you are overweight, the best way to protect your health and your baby's wellbeing is to lose weight before you become pregnant' (National Health Service, 2020d). The message is individualised—the problem identified is the weight of the woman and her body. As such, the focus is on her food choices and exercise levels, rather than, for example, upon the structural pressures placed on individual's lives as a consequence of white, patriarchal, capitalist society. A woman may struggle to afford fresh fruit and vegetables, and a gym membership, and/or she may have limited time to cook from scratch, or exercise due to the need to work two jobs to afford to pay her rent. Nevertheless, the messaging is around her 'choices' to not exercise and to eat 'junk' food.

Furthermore, wider social ‘problems’ that have an impact on the health of a foetus, but that are beyond the control of women, such as pollution in the air, and chemicals in water and food, are excluded from the lists of potential risks to the foetus. It is the risks that attract social commentary that are borne by the foetus, such as ‘fat’ mothers, and the responsibility for these risks falls to the pregnant woman, regardless of the fact that many are beyond her control (Ruhl, 1999).

The concept of upholding health as an act of responsible citizenship within neoliberal society is not solely experienced by pregnant women. However, as Deborah Lupton (1999b) argues, greater pressure is exerted on pregnant women as they are expected to uphold not only their own health but also the health of their foetus. Consequently, the individualised risk model constructs the pregnant woman as her foetus’ most ardent protector but also its greatest threat (Ruhl, 1999). This construction of the pregnant woman as a potential threat opens up the role of foetal protectors to professionals who may intercede on the foetus’ behalf to ensure its wellbeing and security. In medical settings, it is healthcare professionals who ‘safeguard’ the health of the foetus (Halliday; Phelan, 1991). For example, they ‘protect’ the foetus by applying for a court order to conduct a caesarean section against the will and consent of the pregnant woman, as it is in the best interest of the ‘baby’ (Kingma & Porter, 2020; Michalowski, 1999; Rhoden, 1986; Wells, 1998). However, other professionals such as social workers[4] can and do take such action,

[4] However, in England and Wales it is not possible to make a foetus a ward of the court as the foetus has no independent existence from the pregnant woman and so the court could not exercise the rights, powers and duties of a parent over the foetus without controlling the mother's actions, *In Re F (In Utero)* [1988] Fam. 122. However, in states in the United States it is possible to detain pregnant women on the basis that they may do harm to the foetus, see the National Advocates for Pregnant Women (2018) campaign against Wisconsin’s ‘Unborn Child Protection Act’.

and, as explored in this book, criminal law and criminal justice are able to do the same.

One of the key critiques of the individual risk model of pregnancy is that it is inappropriate, as women do not ‘control’ their pregnancies as the risk model suggests, and the definition of ‘responsibility’ in pregnancy is often moral and scientific (Ruhl, 1999; see also Weir, 1996, 2006). Furthermore, the demands on pregnant women to adapt their behaviour are extensive and rarely acknowledged. The model of risk concludes that a woman is complicit in any birth defects regardless of whether she could have prevented them. Such a perception overlooks women’s lack of control over their foetus’ development. The ‘prudential model of pregnancy’ makes demands on women that are simply unrealistic, requiring ‘that pregnant women be on their guard, every second of their pregnancy, for something, anything, which might prove to be the slightest bit harmful to their foetus’ (Ruhl, 1999, p. 110).

Risk discourses are now also targeting women who are trying to conceive a pregnancy (Centers for Disease Control and Prevention, 2020b; National Health Service, 2020e) and even women who may unintentionally become pregnant. The Centers for Disease Control and Prevention (2016) released a public health campaign arguing that, as approximately half of all pregnancies in the United States are unplanned, women not using a long-active reversible contraceptive should refrain from drinking alcohol as the damage to the foetus caused by alcohol could occur before the woman even knows she is pregnant. Similarly, in the United Kingdom, the National Health Service of Greater Glasgow and Clyde, Scotland, published guidance to support medical professionals working with women of

childbearing age to increase foetal health (Sher, 2016). The report advocates that, at any time said group of women come into contact with medical professionals, the professional should ask if there is a reasonable chance the woman will start a pregnancy that year—note, not if she wants to become pregnant, but if there is a *chance* she will. The guidance advised that in instances where women answered 'yes', health professionals should encourage women to abstain from harmful substances, such as alcohol, smoking, and drugs; lose weight; leave violent and abusive partners; and avoid exposure to radiation and illnesses such as HIV, diabetes, rubella, and the Zika virus. This health advice is targeted at making women 'healthy' not for themselves, but for the 'child' who is yet to be conceived. The implication of such a message is that women who are having sex need to adapt their lives significantly, just in case they become pregnant. Considering the rate at which women are raped,[5] and that even long-active reversible contraception cannot guarantee a pregnancy will not be started, this advice can be interpreted to apply to all women of reproductive age: approximately 13-50.

The perniciousness of the liberal governance of pregnancy lies in how it is connected to motherhood ideals and so to the notion of the 'good' mother, informed by the myths of motherhood, as outlined in Chapter 3. Lealle Ruhl (1999) argues that responsibility for risk management by pregnant women is equated with rationality and the principle of adopting behaviour that will ensure the greatest benefit with the least risk. Thus, this risk discourse is moralistic, as it is premised on the idea that any 'rational' woman would take these steps to protect her unborn 'child'. As outlined in

[5] Official estimates are that one in five women will experience some type of sexual assault at least once in her life-time (Office for National Statistics, 2018).

the previous chapter, the myths of motherhood conflate mother and child, assuming they are one entity with the same needs and desires. The same conflation is exhibited with pregnant women and foetuses: the ‘responsible’ pregnant woman, who manages risk appropriately, is expected to put the needs of her foetus before her own, while the pregnant woman who puts her own needs and desires first is deemed ‘irresponsible’ (Ruhl, 1999). Such judgements of pregnant women’s behaviour go beyond perceptions of responsibility, connecting specifically with the myths of motherhood. The responsible pregnant woman is the ‘good’ mother, while the pregnant woman who does not put the needs of the foetus before her own needs and desires is the ‘bad’ mother (Lupton, 2011; Gregg, 1995).

Studies focussed on women’s experiences of pregnancy report that women feel pressured to conform to the messages of risk discourse, monitoring and disciplining themselves, and surveilling and being surveilled by others (Harper & Rail, 2012; Lupton, 2011; van Mulken et al., 2016). The myths of motherhood, as they operate on pregnant women, promote and legitimise the foetus-first mentality. The myths construct expectations of what it means to be a responsible pregnant woman who places the foetus’ welfare before the welfare and needs of herself. Furthermore, women’s self-regulation and sacrifice are deemed symbols of love and her role as a ‘good’ mother (Brooks-Gardner, 2003). In line with the myths of motherhood, few questions are raised as to whether a woman should sacrifice herself for her child, and by extension her foetus. The construction of this expected maternal sacrifice legitimises and normalises the hierarchy of foetal and maternal health and well-being and, thus, the idea that the pregnant woman will act as the foetus’ most ardent protector (Bessett, 2010). By extension, if she does not, then she is constructed as

the ‘bad’ mother, as the ‘good’ mother would never be in conflict with her foetus (Roth, 2000). Thus, mother-blaming now starts at conception, rather than birth (van Mulken et al., 2016). If conflict does exist, then others can and must intervene to protect the foetus from its ‘irresponsible’, ‘bad’ mother. Consequently, pregnant women have become public figures; their bodies have become a display for others to monitor, touch, and comment upon in ways that would not be considered appropriate for other adult bodies (Lupton, 2012b; Stormer, 2000). As with the control and regulation of mothers, the policing of pregnancy is not conducted equally, with the most vulnerable women, and those situated furthest from the ideology of the ‘good’ mother—the white, middle-class, married, able-bodied, heterosexual woman—being most heavily monitored and most likely to experience intervention from state agencies (Flavin, 2009; Lupton, 2011; Ruhl, 1999).

Failure to put the foetus first

As detailed above, there is now substantial evidence that, as ‘good’ mothers, women are expected to put the needs of the foetus before their own needs, welfare, and desires—the foetus-first mentality, and so this is an accepted part of the day-to-day reality of women. What becomes clear from reading the court transcripts in cases of suspicious perinatal death is that such expectations are also reflected in the criminal hearings of suspected women. These expectations are presented despite the limited scope of the law, to compel women to prioritise the needs of the foetus, as discussed in Chapters 5 and 6.

In a number of the cases, the idea is presented that as a consequence of being pregnant the women should have acted to prioritise the needs of their foetus,

regardless of the circumstances of the pregnancy. This can be seen clearly in Hannah's case, as the prosecution argued:

> The Crown's case is that she had made it plain she didn't want the child and that she could not have a child out of wedlock. She told no one for those reasons. She sought no assistance with the birth as she sought to keep it a secret. She sought no assistance for the newborn child and it died without any attempt, it would appear, by the defendant to give it the care the child required. The child remained unwashed and died without expert or experienced assistance which may have prevented its early death. (Hannah, prosecution opening).

The suggestion being made here is that Hannah acted in her own best interests—keeping the pregnancy a secret and delivering alone, rather than doing what would be best for the 'baby' by telling people she was pregnant. The prosecution is directly connecting her behaviour prior to the birth of the child, and the outcome that occurred following the birth, with Hannah's role as risk manager for her foetus/child. While not directly spelt out, the conclusion of this position is clear: if Hannah had been a responsible pregnant woman, and so a 'good' mother, then she would have taken steps to ensure the protection and safeguarding of the foetus/child through antenatal treatment and ensuring she delivered in a location to facilitate medical care for the child following birth. Hannah maintains that she passed out after the birth and the baby had died upon her regaining consciousness; not an unlikely occurrence, as collapsing from exhaustion post-birth is documented in the neonaticide literature (Oberman, 1996).

In presenting Hannah's behaviour in this manner, the prosecution is directly linking her conduct in pregnancy to her culpability for the death of the child. The focus is upon her decision to place her need to not be pregnant, because she believes she could not have a child in her situation, above the needs of her 'child'. The consequence is that, Hannah's actions look purposeful, and she appears culpable for the death of the child after birth precisely due to her behaviour while pregnant—for allowing herself to end up in a position whereby others were not there to monitor and prevent risk to her 'baby' during and after the birth. As already noted in Chapter 2, Hannah's response to her pregnancy needs to be understood as a response to a crisis pregnancy, a point that is negated by the court, and arguably by wider criminal justice, in their assessments of her actions. More than this, the assumption that underpins the prosecution's narrative that Hannah is an irresponsible pregnant woman is that to be pregnant is to be a woman who puts the needs of the foetus first, regardless of the personal consequences or sacrifices of that situation. Hannah's apparent fears of how her family would react if they discovered her pregnancy are not factored into expectations of her conduct following her own discovery of her pregnancy. The foetus-first mentality is considered to be a far greater influence on women's behaviour and thought processes, so much so that it will supersede any concerns a woman may have about herself, and the impact of her pregnancy on her life and well-being.

In her defence, Hannah's barrister does not challenge the idea that she should have put the needs of her foetus first. Instead, the barrister argues that Hannah was mistaken in both her conduct and her beliefs about her pregnancy:

> There were other options. The defendant didn't avail herself of them. The defendant didn't avail herself of them. She ought to have done … And so I suppose it begs the question as to why it was that this young woman made such a bad and a wrong decision that she did in the circumstances that she did in the early hours and thereafter of [date], why she failed to seek the prompt medical attention really being the gravamen [*sic*.] of the offence to which she has pleaded guilty. (Hannah, defence mitigation).

The suggestion from the words of the defence is that it was not just her behaviour post-birth when Hannah's neglect of the infant became a matter for criminal law that was 'bad and wrong', but that it was also her actions leading her to birth in these circumstances. The defence also describes the loss of the child's life as 'needless', stating that Hannah was wrong to not trust her family, who declared after the death of the child that they would have stood by and supported Hannah if she had told them about the pregnancy. Hence, her actions in relation to the pregnancy are presented as misguided; that she should have put the foetus first, and that she failed to do this due to her mistaken belief that she could not tell her family about the pregnancy.

Similar arguments can be seen in Hayley's case. Central to the discussion is the belief that she should have put the foetus first, regardless of her needs or desires, or the consequences she perceives for herself or her family of being pregnant:

> Despite marrying your long-term partner in [date], it seems, on your own say so, that you conducted an on-off seven year affair with a work colleague before becoming pregnant. You clearly decided, or you clearly thought, I should say, that the child was his because you told him, but not your

> husband, of the pregnancy in [date]. He offered to leave his wife to start a family with you, but you declined. You broke off the relationship with him … saying that there was no child and it was none of his business. You told the Probation Officer, however, that it was not until [date] that you decided you wanted to remain with your husband and to have an abortion. (Hayley, judge sentencing).

Again, we can see here the idea that Hayley is perceived to be putting her relationships with her husband and lover before the needs and well-being of the foetus, which is presented as unacceptable behaviour for a pregnant woman. A similar position is presented in Nicole's case, where the prosecution noted that the only person who knew about the pregnancy was the 'father of the baby'; that she did not know why she strangled the baby, and 'she had decided to stay with [her partner] and not leave to be with the baby's father' (Nicole, prosecution opening, presenting evidence from Nicole's assessment by a psychiatrist). Without directly stating it, the implication here is that her actions were those of a woman thinking of her own needs and not those of the 'baby'. Similarly, in Imogen's case, the narrative is constructed as her not wanting a child due to being career-minded, the pregnancy being an 'inconvenience' to her, and so she did not act to put the needs of the foetus first.

It is cases where the prosecution attempt to prove murder that the implications of the foetus-first mentality are most clearly outlined and are actively connected to motive and culpability. As already argued in Chapters 2 and 3, by not contextualising the pregnancies as crisis pregnancies, and by constructing the women as unmotherly, women such as Bethany and Jessica are easily presented as cold-blooded killers

who intentionally kept the pregnancy a secret as they wanted to kill the child. The foetus-first mentality provides further fuel for such a fire:

> The defendant, says the prosecution, is somebody who is profoundly self-centred.
>
> …
>
> It was suggested to [Jessica when on the stand] that she had no concern for her baby's welfare. She took no steps to ensure that it was well, to see a doctor or a midwife, or to make any arrangements. And she said she was burying her head in the sand or she didn't know what she was thinking. It wasn't because she had no concern for the baby's welfare and it wasn't the case that her focus was on ensuring how the baby would not survive. She didn't know why she said nothing to the family when her waters broke. She wished she had. She didn't know why she didn't seek help. She nearly died she said. Why was it so important to justify this risk? She didn't know. (Jessica, judge summing up).

An implication of such lines of argument is that it is ‘natural’ to put the welfare and needs of a foetus first: to be pregnant is to be a mother, and to be a mother is to put the foetus first. In Jessica’s case, the prosecution construct the narrative that as she did not have the foetus’ wellbeing at the centre of her thoughts and actions, she must have intended and planned to murder the baby after birth. Lack of understanding of a crisis pregnancy, accompanied by the widely accepted foetus-first mentality, allows for women in cases of suspected perinatal killing to easily be constructed as intentional killers who reject their ‘natural’ role as mothers and foetal protectors.

Putting the foetus/child at risk

Connected to expectations expressed in court of women putting the foetus first, the idea of risk management of the foetus/child's health, and the role the women play in that process, also features heavily in the cases. Three key areas of risk management are identifiable. First, that the woman's behaviour towards the foetus/baby was inherently risky; this was mostly expressed in relation to the women who abandoned their babies ending with the survival of the children – Alice and Gwen. This sentiment was also expressed in relation to Imogen, as her behaviour in the final stages of her pregnancy was deemed to put not only the foetus at risk but also herself and people around her. Such a position reflects the notion that pregnancy is inherently risky and that risks need to be managed:

> This defendant kept a pregnancy a secret throughout the term of said pregnancy, placing herself in a perilous position, and precarious position throughout. She did not seek medical assistance following an attempt to abort the pregnancy, and I will return to that in a moment if I may, but almost incredulously she took a flight with her now husband to Turkey and landed probably whilst in labour, and your Honour made the observations that not only was she placing herself and the child in a precarious and dangerous position, but also passengers on that flight and the crew. Her actions at the very best could have been described as reckless. (Imogen, prosecution opening).

A second identified key element is that the women should have averted the risk they posed to their foetus/child by asking for help while they were pregnant, so allowing others to manage the foetus' risk. The notion that the women should have

safeguarded their foetuses by telling someone about the pregnancy is reflected in a number of cases. For example, in Sophie's sentencing hearing the judge stated:

> It is an aggravating factor of this offence that you took time to plan and prepare for it in the form of the internet researches and purchase as I have mentioned. To the extent that you were suffering from personal and psychiatric problems at the time, you could and should have turned for professional help. (Sophie, judge sentencing).

The defence relied heavily on psychiatric reports to mitigate her behaviour of illegally terminating her pregnancy, describing Sophie as 'clearly a young woman who is troubled.' (Sophie, defence mitigation). The suggestion intimated by the defence and, seemingly accepted by the judge, is that Sophie would not have acted to illegally end her pregnancy if she had not been experiencing psychiatric 'problems… I fully accept that you were suffering from mild depression, anxiety and panic symptoms whilst pregnant on this occasion' (Sophie, judge sentencing). However, the judge then indicates that Sophie should have acted to mitigate the risk she posed to the foetus by obtaining professional 'help'.

A similar position is expressed by the judge in Tanya's case:

> It is quite clear that by the time the baby was due, you were in complete denial and so in the early hours of that morning you delivered the baby yourself in your bedroom at home, alone. You didn't cry out. You asked for no help. You were at home in your household. Right next door to you were members of your family who could have and would have helped you but you couldn't see that. You were not rational.
>
> …

> I accept that you hadn't planned to kill him and at some stages during the pregnancy, you checked on whether certain things might harm a developing foetus. At those times you were obviously rational and you will live with the knowledge that, had you been able to confide in someone during your pregnancy, all of this could have been avoided. (Tanya, judge sentencing).

Again, the suggestion being presented is that Tanya, like Sophie, should have alerted someone to the existence of her pregnancy in order to allow others to safeguard the wellbeing of the foetus. The expression of such sentiments during the women's criminal hearings suggests that the foetus-first mentality is both prolific and widely accepted. The expectation is that the women will put the needs of their foetus first, and if they cannot, then they should make room for people who can, by informing third parties about their pregnancy—other professionals who will safeguard the wellbeing of the foetus through the maternal abdominal wall. Such suggestions are made in spite of evidence that the women were not in a position to do this, due to their ability to accept the pregnancy, and/or their perception of the pregnancy as a threat to their wellbeing.

In Hayley's case, there is evidence that medical and child protection services attempted to manage the risk of the foetus:

> My Lord, as a result of the scans in mid-March, the health authorities were made aware of her pregnancy, and they awaited contact from [Hayley] with regard to antenatal care, and no such contact was made by her, and so it was that in mid-May the midwifery department at… Hospital initiated some contact by telephone, and during a conversation on the 17th May the defendant indicated that she had attended at the Marie Stopes Clinic… and

> had a termination on the 15th March, and this was an account that she was to maintain to those in authority for some considerable time.
>
> …
>
> …on the 11th June a General Practitioner from the practice that she was registered at attended at her home address and she again gave this same account as to having had a termination at the Marie Stopes Clinic.
>
> On the 14th June, she had a telephone conversation with the designated nurse from the Safeguarding Children's Services and again gave the same account. (Hayley, defence mitigation).

Hayley's actions of ordering the misoprostol via the internet only came to the awareness of criminal justice authorities after professionals alerted the police that Hayley would not have been able to access a legal abortion, and that no baby had been registered following her due date. In England and Wales, duties to promote the welfare of children, and so safeguard them from harm, are given to specific organisations, agencies, and individuals under section 11 of the Children's Act 2004. These include members of Local Authorities, including children's social care; National Health Service organisations, including general practitioners as primary healthcare providers; and the police. Thus, a missing child that is expected to have been born but has not been presented to professionals would raise safeguarding concerns, which professionals have a duty to investigate under statutory guidance in *Working Together to Safeguard Children* (Department for Education, 2019; this is the most recent iteration of the policy).

However, as per the born alive rule, safeguarding requirements are not in place for a foetus and only come into practice after the child is born. Thus, the concerns raised by professionals must, officially at least, have related to the absence of a born child, not to the welfare of a foetus. In Hayley's case, the first recorded call occurred around the time when Hayley was expected to have reached full term; so arguably, the call by medical professionals in May related to the risk management of the child following birth, thus falling under statutory duty of child protection. However, a 'qualified person' has 42 days after the birth of a child to register the birth or stillbirth.[6] Thus, the concern for the wellbeing of the child could not be due to the realisation that a 'child' was missing, as the 42 days would not have passed until approximately the end of June or early July. Consequently, the safeguarding checks must have related to concerns that Hayley had not engaged with prenatal care, and so was perceived to be putting her foetus at risk by not allowing the medical community to manage her pregnancy.[7] As Hayley's case highlights, and as will be discussed later in this book, the 'invisible line of birth' that changes the nature of the law and child protection policies is complex and appears to no longer be fixed and resolute.

Finally, concerns were raised during the court hearings of the risk that the women were considered to pose to other children in light of their conviction. Most of the

[6] Births and Deaths Registration Act 1953, ss1-2. Qualified people include the mother and father of the child; the occupier of the house in which the child was, to the knowledge of that occupier, born; any person present at the birth; any person having charge of the child; in the case of a stillborn child found exposed, the person who found the child.
[7] Similar concerns have been expressed by health professionals and child protection services in relation to women who have chosen to not engage with antenatal services, often referred to as 'freebirthers'. There is currently very little research into this, see McKenzie et al. (2020). Those interested in women's experiences of freebirthing, including attempts to regulate and control women's behaviour by health and child protection professionals, should look out for work by Gemma McKenzie, who is currently completing a PhD on the topic.

women are automatically barred from working with children and vulnerable adults under the government Disclosure and Barring Service (n.d.). However, concerns are also raised in a number of cases about the women's ability to care for their own living children in light of their convictions. For example, both Alice and Gwen had their children removed from their care following their arrest. However, the indication given during the hearing is that the removal of custody was due to wider personal circumstances of the women's lives, suggesting there were other child protection concerns. The abandonment of the newly born infants occurred in these contexts, and it is expressed during both women's hearings that they concealed their pregnancies as they feared knowledge of the pregnancy by third parties would result in the removal of all their children from their care. In Alice's case, it is indicated that she is able to spend time with her children and that, at the time of the hearing, attempts were being made to reunite the family. Hope for a similar outcome was expressed during Gwen's hearing.

Child protection services were also involved in Elizabeth's and Hayley's cases at the time of the sentencing hearing. In Elizabeth's case, following her acquittal for murder and conviction of manslaughter by reason of diminished responsibility, but prior to the sentencing hearing, children's social services were in touch with Elizabeth's sister to indicate their concern for the welfare of that sister's children if Elizabeth were to return to live with the family. Elizabeth's barrister explained during the sentencing hearing:

> But as My Lord knows, [Elizabeth's sister] has children who live with her, including two particularly young children and [an] infant… And we understand that Social Services, as they're described in the [sentencing]

> report, would consider taking draconian steps if this Defendant were to be living with her sister, an arrangement both would wish to take place, as I understand it. That is why, as I understand it…
>
> JUDGE: Whose word, whose word is: "Draconian"?
>
> DEFENCE: Mine. What I mean is they would consider taking proceedings if my client, that Elizabeth, were to live with her sister, because of concerns, no doubt, about what they describe as risk. I say that because these circumstances are, are particular to this case, and that which the Jury found took place occurred at a time when this Defendant was labouring under a condition which she no longer labours under. Things have changed, and changed materially, since [the delivery and death of the child]. I don't use that word in a critical sense and I'm not being critical, I make clear, of Social Services. It's not my place to be and I am not being. But draconian means harsh in the circumstances where one has two loving sisters, one of whom has been convicted of the offence of manslaughter but at a time when her responsibility was substantially impaired through no fault of her own, and those circumstances have changed. (Elizabeth, prosecution mitigation).

The situation was resolved through Elizabeth's family paying for her to live in a hotel while permanent accommodation could be sourced. It is noted though, that this is not the best outcome for Elizabeth:

> My Lord, then one would venture to suggest on her behalf that what this woman actually needs is an opportunity to start her life or continue the life in which she had led it before, without criticism or blame or fault, until she fell under that condition which caused her to behave in a way which otherwise she would not have done so. My Lord may well have had in mind what

> [psychiatrist] said in his report, his substantive report prepared at the beginning of March, that she is a vulnerable woman and likely to remain. (Elizabeth, defence mitigation).

The support of her family is considered an essential element of her recovery from this experience of pregnancy and involvement with criminal justice.

A similar discussion about child welfare occurs in Hayley's case:

> DEFENCE: Social Services, as you will be aware, are involved in the sense that because of her appearance before the Court, there are parallel child protection hearings. There have been no issues raised at that.
>
> JUDGE: Well, it seems to have been unnecessarily cautious, if I may say so, in relation to the other two children.
>
> DEFENCE: But understandably.
>
> JUDGE: Absolutely.
>
> DEFENCE: It is not said in any way critically. So they are awaiting the sentence of the Court today. (Hayley, defence mitigation).

Hayley was sentenced to an immediate custodial sentence, so, one assumes, the children remained in the family home with their father. It is unknown whether or not social services became involved with the family following Hayley's release from prison.

At no point in my research have I come across any evidence to suggest that a woman who kills a newborn child or aborts a foetus, legally or illegally, and at any stage of gestation, poses a risk to other living children due to her actions of causing the death of the foetus/newborn baby. The only instance whereby she may pose a

risk to other children is in those such as Alice's and Gwen's cases, where there are wider circumstances of their lives that raise child protection concerns. In cases such as Elizabeth's and Hayley's, where there are no wider concerns about their ability to parent and maintain the wellbeing of their living children, the death of a foetus/child following a crisis pregnancy does not indicate a risk to older children (as noted in Chapter 2, both women have a history of multiple crisis pregnancies). Therefore, I would agree with Elizabeth's barrister, and the judge in Hayley's sentencing hearing, that the intervention of children's services is both 'draconian' and 'unnecessarily cautious'. However, as has been argued by Stephen A. Webb (2009), social work has been reconfigured through forms of governmentality, using risk calculation techniques based on the principles of actuarialism—the ability to calculate the probability of risk and operate accordingly. While the extent to which actuarial calculations play a role in risk decisions is disputed, as Mark Hardy (2017) argues, social workers make decisions about child protection in an environment where the fear of blame if they do not act and a child is harmed, is palpable:[8] the culture of blame undoubtedly has an impact on how child protection professionals assess the possibility of risk.

Further concerns are expressed in terms of the risk that the women may pose to future foetuses. In Sally's case, the judge states, 'In mitigation, you are now a lady [in her fifties] and at your age there is no risk of any future similar activity.' (Sally,

[8] See Rose (1998) for a discussion of the impact of actuarial practice and the role of assessment, prediction, and management of risk as central to the logic of 'community psychiatry'. Rose concludes that the changing approach to understanding the risk of psychiatric patients is that mental health professionals operate to seek strategies to minimise the aggregate levels of risk posed by 'risky' individuals; thus, working in a culture of risk management where the focus is less about averting danger, and more about illustrating that the risk assessment and approach was appropriate. See also Feeley & Simon (1992; 1994), Garland (2000, 2001), O'Malley (1992, 2000, 2004) for their discussions of risk mentality and actuarialism in criminal justice policy and practice.

judge sentencing); thus, indicating that her level of risk to future 'children' is averted due to her no longer being able to conceive. Similarly, in Hayley's case, the judge makes a point while sentencing, that other foetuses will be at risk of her illegally aborting them, justifying the sentence that would later be described by the Court of Appeal as 'manifestly excessive':

> As a matter of public policy, and bearing in mind the need for deterrence, a long determinative sentence is required. There is no reason to believe that you would not act in the same way if the same circumstances arose, but fortunately the chances of that are so small that I do not consider it necessary further to consider the dangerousness provisions of the 2003 Act. (Hayley, judge sentencing).

Here, the judge is referring to Part Twelve, Chapter Five of the Criminal Justice Act 2003. This Chapter of the Act allows for a defendant to be sentenced to life imprisonment if the offence is serious (punishable by either life imprisonment or for a determinate period of 10 years or more [s224(2)(b)]), and if the offender is considered dangerous (if the court considers there to be 'a significant risk to members of the public of serious harm occasioned by the commission by him [*sic*.] of further such offences' [s229(1)(b)]).[9] The judge is implying that the only aspect of the case that means Hayley is not an offender who poses 'a significant risk to members of the public of serious harm occasioned by the commission by him [*sic*.] of further such offences' is that the chance of her becoming pregnant again is small. However, the judge is also implying that he considers her to be a significant danger to any foetus she may carry. The judge's position here is alarming for a number of reasons,

[9] See Crown Prosecution Service (2019) for an overview of sentencing guidance for dangerous offenders under this provision.

but specifically, because he is considering a not-yet-conceived foetus to be a ‘member of the public’. The logical next steps of such a view are that it would be reasonable and acceptable to imprison a woman, presumably to prevent her from becoming pregnant, in order to safeguard a foetus that may be conceived if she is not imprisoned. Such a position not only negates the born alive rule but also poses a significant danger to women’s rights of bodily autonomy and equality under the law, as will be discussed in Chapter 6.

Legitimate risk

As has been presented here, the women’s behaviour is considered and discussed in line with the principles of maternal management of risks towards the foetus. The expectation is that the women will put the needs and welfare of the foetus before their own and so avert risk to the foetus. As outlined in the academic literature, this expectation is directly connected to ideals of motherhood and motherly behaviour: to be the ‘good’ mother is to be the ‘responsible’ pregnant woman (Lupton, 2011; Ruhl, 1999). In Chapter 3, I outlined that, during the criminal hearings, there is an expectation voiced that the women will act as mothers to their foetuses purely due to the existence of the pregnancy. Coupling that conclusion with the findings presented in this chapter, it is clear that the women are expected to do everything to be the ‘good’ mother and so being the ‘responsible’ pregnant woman who will protect her ‘child’. For the women to achieve this status as the ‘good’ mother, they would need to have revealed their pregnancies to third parties, in order to receive medical treatment and then medical assistance in labour and delivery, so allowing professionals to assess and mitigate the risks the women pose to the foetus. In not disclosing the pregnancy, the women are conceptualised as failing as individual

mothers, with suggestions during these hearings that these failings are part of the reason why they require criminalisation and punishment.

However, as outlined in Chapter 2, criminal justice fails to understand the experience of a crisis pregnancy and the impact that this will have on the women's ability to assimilate the 'good' mother and 'responsible' pregnant woman. Consequently, the actions or inactions of the women are easily portrayed and interpreted as intentional and perhaps even as a motive to kill the foetus/child. If we understand a crisis pregnancy in line with the main thrust of the literature on concealed/denied pregnancy and neonaticide as a reproductive dysfunction (Beier et al., 2006), then an argument can be made that the women had little ability to mitigate the risk they posed to the foetus, due to their inability to fully acknowledge and respond to their pregnancy. Such an approach leads to the women's actions being dismissed along the lines of the 'mad', 'bad', 'sad' narratives. As outlined in Chapter 3, these narratives have been opposed by feminist scholars as they remove the concept of women's agency as offenders and so individualises their actions (Ballinger, 2007; Morris & Wilczynski, 1993; Weare, 2016). If, however, we conceptualise a crisis pregnancy as I advocated in Chapter 2, and as argued by others (Oberman, 2003; Vellut et al., 2012), as a product of society and a result of the complex personal situations faced by exceedingly vulnerable women, then there is scope to view the actions and/or inactions of the women in a holistic and socially contextualised manner. Viewing their behaviour during pregnancy, labour and delivery, and following the birth, as relational to wider social structures that both facilitate and result in a crisis pregnancy, gives us the ability to understand what has occurred as more than simply an individual response deserving individualised criminalisation and

punishment. The focus is no longer upon personal failure to act as pregnant women and mothers 'should', as presented in the court hearings, nor on explaining away the women's actions and thus removing any form of agency by the women, as critiqued by feminists.

To allow for this contextualised view of the women's actions/inactions, it is necessary for us to reconstruct the concept of risk in cases of suspicious perinatal death. At the moment, perceptions of risk and risk management strategies flow in one direction—the foetus at risk from its 'mother'. This normalised flow of risk is not just evident in the cases assessed here, but in most pregnancies, as outlined in the literature at the top of this chapter.[10] However, if we conceptualise the woman as at risk from the foetus, this challenges the interpretations of the women's actions/inactions that are presented as the norm in the criminal hearings analysed here. For example, in Hayley's case, the understanding here is that she failed to put her foetus first because she did not want her husband to discover that she was pregnant following an affair. If we reconstruct the narrative of events with Hayley as the subject of risk, then it could look something like this: Hayley, who has a history of experiencing her pregnancies as risks to her sense of self and her wellbeing, became pregnant, which she did not want to be. This pregnancy threatened her living children, her relationship with her husband, and with her lover. If this pregnancy was accepted,

[10] The one exception to this may occur whereby the woman has a medical condition that means a pregnancy would be a risk to her health—for example, cancer requiring chemotherapy or radiotherapy. However, even in this situation, it is most likely that the foetus will not be considered the cause of the risk; instead, it is the cancer that is the risk to the woman's health, with the possibility of the foetus being seen as also at risk due to the woman needing treatment for her cancer. See, for example, *In re AC*, 573 A.2d 1235 (DC 1990): Angela Carder was forced to undergo a life-threatening, court-ordered caesarean section against her wishes (and the wishes of her family and her doctors) in an unsuccessful attempt to save the life of her foetus, due to Angela requiring treatment for cancer and wishing to terminate the pregnancy to facilitate that treatment. Angela and the baby died soon after the caesarean section.

and later if this child was born, it would have potentially caused a breakdown in Hayley's personal relationships, thus destroying her life as she knows it, and so is a fundamental risk to her wellbeing.

Similarly, Hannah's story can be reframed to prioritise her account of her fears about her family's reaction to her pregnancy. Rather than being portrayed as making 'bad and wrong decisions' about her relationship with her partner, we can interpret her decisions about her emotional and sexual relationship in a woman-focussed, sex-positive way: a woman, over the age of consent, choosing to have a relationship with a man she desires. Rather than seeing her decision to keep her pregnancy from her family as being a 'mistaken' belief that her family would not accept the pregnancy, and so would reject her, we can reconceptualise the foetus as a risk to Hannah's sense of safety and acceptance by her family. We can see Hannah's relationship with her family, and her sense of security as a woman who believes she cannot legitimately become pregnant out-of-marriage, as her being at threat from a foetus, and subsequent child. Each of the cases can be reframed in this way, to centralise and prioritise the well-being and safety of the woman over the foetus.

One of the potential challenges to reconstructing these cases, to conceptualise the foetus as a risky entity with the potential to cause harm to the woman, is that this is not how our society (read: heteronormative, white, capitalist patriarchy) conceptualises children. As outlined in the literature presented above, foetuses are now widely considered to be unborn 'children' in public discourses, health approaches, child protection policies and services, and, as presented here, in criminal hearings. Children, including foetuses, are conceptualised as 'innocent',

‘vulnerable’, ‘precious’, and in need of care and protection (Ariès, 1965; Zelizer, 1994). Therefore, how can a category of humans, who are, quite literally helpless, in that they cannot help themselves and so are in need of protection, be conceptualised as a risk to adult women who have the ability to protect themselves. As Robin West (1988, p. 69) argues, ‘the fetus is not one of Hobbes’ “relatively equal” natural men against whom we[women] have a right to protect ourselves’ and thus is not conceptualised as such by men, nor in law, which is created by men to address the harms perceived by men. In order to square this circle, we again need to move away from the individualised model; rather than seeing the foetus/newborn child as an individual threat, we need to conceptualise the threat caused by them to women in a wider social context—as a product of heteronormative, white, capitalist patriarchy. We also need to identify and acknowledge that the threats to women will differ depending on their intersecting characteristics: there is no singular women’s experience (Harris, 1990).

Foetuses and pregnancies, as they are conceptualised and perceived by societies in the Western world, are, regularly, threats to women. The threat of a pregnancy is tied to how sexuality, family, and the importance and value attributed to women as members of society have been constructed and portrayed—today and historically. The historical elements will become clearer in Chapter 5, as the history of criminal offences connected to suspicious perinatal deaths is assessed. So, for now, let us consider the contemporary representation of women, sexuality, and family in the UK.

We have already seen one element of how pregnancy, childbirth, and childrearing can pose inherent threats to women, in our review of feminists’ critiques of

motherhood and mothering in Chapter 3. Feminists are not united in their assessment of motherhood as either being inherently a negative aspect of life for women that needs to be overcome and transcended (Beauvoir, 1997[1949]) or to be reclaimed as inherently positive outside of man's control and patriarchal structures (Rich, 1986). Nevertheless, the social, cultural, and political association of woman with mother, and motherhood as inherent to women's identities and role in society, has had, and continues to have, an impact on women's ability to operate outside of the role of 'mother', beyond the domestic labour of gestating, birthing, and then rearing children (Glenn et al., 1994). Ideologies of motherhood, and the norms that are constructed by and through those ideologies, reach into all areas of social life, shaping how women are able to interact with the world.

But, as outlined in Chapter Three, the myths of motherhood do not operate equally on all women, and are impacted by elements of identity such as race, ethnicity, class, (dis)ability, immigration status, nationality, age, sexuality, marital status, educational level. Controls have always been placed on who should or should not 'breed', replenish/ contribute to the population of the society and/or nation (Foucault, 1998[1976]; Fyfe, 1991; Weeks, 1981). Such controls continue to operate today, although in less punitive forms than in previous centuries, as illustrated in Chapter 5. Examples of regulation of women's procreation can be seen in a policy change in the United Kingdom to limit the child element of child tax credit to the first two children a woman has, excluding all future children, brought in by the Conservative Government in 2017 (HM Revenue & Customs, 2020).[11] Such a policy has a very

[11] With the exceptions of a further pregnancy resulting in a multiple birth or a child born as a result of 'non-consensual conception'.

specific focus on poor women and their families—women who need to claim child tax credit to provide or supplement their income. The message of such measures is clear; if you cannot afford to support more children then you should not have them, as the state will not be supporting them. Such regulations on family size are not placed on women who live with financial security and wealth and so do not rely on state support to survive and live. In this context, a pregnancy could be a threat to a woman's financial security and her ability to provide for herself and her existing and future children.

Similarly, in terms of age, the government guidance, *Teenage pregnancy prevention framework,* sends the message that society is hostile to women under 20 years of age reproducing (Public Health England, 2018). At the other end of the age spectrum is the representations of 'older' or 'geriatric' mums as being at 'risk [of] missing out on motherhood' if she has not had a baby before her mid-thirties (National Health Service, 2009), together with the ominous 'ticking' of a woman's biological clock (Weigel, 2016). Such representations of women's aging bodies and motherhood operate in public discourse and health policy. Despite evidence that men's fertility also declines with age (Sample, 2017), it is women's bodies, age, and lifestyle that bear the brunt of social and cultural scrutiny. Whether too fat or too thin, too employed or too unemployed, too single, too poor or too rich ('too posh to push'; Rustin, 2016), too uneducated, too educated, too drunk, too disabled, too gay, too butch, too black—the list of conditions placed on women to regulate and censure the 'rightness' of her decision to reproduce is endless. These impact most women, falling hardest on the most vulnerable in terms of the involvement of child protection services, economic implications, criminal justice intervention, and public scorn.

In addition to policing who can have a baby, limits are also placed on women's decisions to end a pregnancy. Pressures are placed on a woman's ability to access an abortion, and whether the decision to terminate a pregnancy is considered 'valid' or 'appropriate'. As Sally Sheldon (1993, 1997) and Fran Amery (2020) argue, legal provision of abortion in Great Britain was not granted on the basis of allowing women reproductive freedom and bodily control to allow them to decide whether they continue a pregnancy. Instead, the Abortion Act 1967 was constructed to gatekeep access to abortions, ensuring that only women deemed worthy and who want to terminate a pregnancy for the 'right' reasons can access the medical procedure. Women's desires to control their bodies and prevent an unwanted pregnancy are not considered good-enough reasons for a termination to be legal. Abortion continues to be shrouded by stigma and notions of shame that a woman would end up in such a situation where an unwanted pregnancy needs to be ended (Bommaraju et al., 2016; Hoggart, 2017; Kumar et al., 2009). Society continues to resist seeing abortion as an element of reproductive health, part of a continuum for preventing unintended pregnancy that ranges from methods to prevent ovulation, barrier methods or hormones to create a hostile environment for sperm and so prevent fertilisation, emergency contraception to prevent implantation, and ending with abortion (Sheldon & Wellings, 2020). Such resistance is evident in the uneasiness of accepting the artificial line between 'contraception' and 'abortion': developments of contraception that would work to end the pregnancy after implantation are illegal under the statutory framework for legal abortion in Great Britain (Sheldon, 2015).

Less researched are the stigma and social difficulties faced by women who continue their pregnancy but terminate their role as a mother to that child through adoption. As Marshall (2012) argues, women who decide to give up a child for adoption are often confronted with arguments by state actors that they will regret their choice, or that the choice is not 'natural'; their decision to conceal the pregnancy and relinquish their parental role towards the child is seen as inauthentic and therefore impermissible. In relation to this, state intervention to take children from women following birth, due to their role as a mother being seen as dangerous, unacceptable, and/or too risky towards or for the child, is the latest measure in a long history of what Pamela Cox (2012) terms 'governing intimate citizenship'; preceded and flanked by institutionalisation, sterilisation, and coercion to use long-acting, reversible contraception.

For those women who continue a pregnancy, whether wanted or not; and become mothers to that child, whether wanted or not; or who parent a child that they have not gestated and birthed, the hardships and labour of motherhood are, for many if not most, relentless and all-encompassing. Across societies, the vast majority of childcare responsibilities still fall to women, with a substantial gap between women and men in terms of the amount of unpaid work conducted. As Diva Dhar (2020) argues, women's unpaid care work has been unmeasured and undervalued for too long:

> Women perform 75% of such work globally, dedicating, on average, four hours and 25 minutes daily to it – more than three times men's average of one hour and 23 minutes.

Often not perceived as work, and not valued as equal to paid employment, women bear most of the burden of caring for and raising children. The gap between men's and women's engagement in unpaid care has a dramatic impact on women's paid employment prospects post-birth, as outlined in the key findings of the UK household longitudinal study by Understanding Society (2019):

- Fewer than one-in-five of all new mothers, and 29% of first-time mothers, return to full-time work in the first three years after maternity leave. This falls to 15% after five years.
- 17% of women leave employment completely in the five years following childbirth, compared to 4% of men.
- In the year before birth, the man was the main earner in 54% of couples. This increases to 69% three years after birth.
- Mothers who leave employment completely are three times more likely to return to a lower-paid or lower-responsibility role than those who do not take a break.
- For new mothers – but not fathers – staying with the same employer is associated with a lower risk of downward occupational mobility but also with lower chances of progression.

Similarly, in their study, The Fawcett Society (2016) concluded that 29% of people think men are more committed to their jobs after having a baby, while 46% believe women are less committed to their jobs after having a baby. Also, women are more likely to take time off when the child is ill, rather than the father. Thus, the cost of having a child in terms of both lifestyle and employment prospects is substantial for women, compared to men.

The detrimental experiences of pregnancy and motherhood outlined here, and others I have not discussed, require a structural analysis so as to move away from the notion of individual responsibility. The concept of 'gendered harms' has been deployed by feminist legal scholars to acknowledge harms in society experienced by women due to their gender—not a product of their biological sex *per s*e: 'biology is indeed destiny when we are unaware of the extent to which biology is narrowing out fate, but that *biology is destiny only to the extent of our ignorance*' (West, 1988, p. 71, her emphasis), as women do not need to be led by their biological destiny and would not be, with the destruction of the patriarchal order. As Joanne Conaghan (1996) argues, 'gendered harm' is based on the principle that harm has a gendered content, specifically that 'women suffer particular harm and injuries *as women*: their experiences of pain and injury are distinguishable, to a large extent, from the experiences of men' (Conaghan, 1996, p. 407, her emphasis; see also, also Fineman & Thomadsen, 1991; Graycar & Morgan, 2002; Howe, 1987; West, 1997). Here it is important to reiterate that women's experiences of harm, while distinct from men's, are not universally the same (Harris, 1990). For Conaghan, there are at least two dimensions to gendered harm: first, pregnancy and childbirth, and menstrual and/or ovulation pains; and second, harms that are not exclusive to women in a biological sense but are risks that women are more likely to experience—risk of rape, incest, sexual harassment, intimate partner violence and abuse, and harmful medical intervention. Many feminists would argue we can add raising children and associated unpaid labour of care to this list, as I have noted above.

For feminist legal scholars, gendered harm is a tool of analysis, a prism through which to see how the Rule of Law (not just criminal law) fails to recognise, address,

and protect against the harms experienced by women. In her analysis of legal outcomes of cases of newborn child killing in Ireland during the twentieth century, Karen Brennan (2018) uses the concept of gendered harm to assess the structural dimensions that contribute to women killing their newborn children—lack of reproductive autonomy, including access to contraception and abortion; stigma over pregnancy outside of marriage; and lack of economic, cultural, and social support to raise children. For Brennan (2018, p. 186):

> patriarchal norms and values, which were embedded in various legal provisions and in the Irish state's approach to unmarried mothers, cause harm to women … it is possible to see that the harm caused to the baby by its mother was a consequence of the "gendered harms" caused to her by patriarchy, and the state's adoption of patriarchal values in its laws and policies.

Brennan concludes that the state bears some responsibility for the crime of newborn infanticide homicide by mothers. Furthermore, the state causes more harm to these women, by holding them solely responsible for their actions and thus criminalising their behaviour, rather than contextualising their actions in wider social structures that lead to newborn child killing.

Using this conceptual framework, we can see pregnancy, reproduction, and child-rearing as a potential gendered harm, in that they are experienced exclusively or disproportionately (in regard to child-rearing) by women. As with all social harms, the pains of the harm are experienced most greatly by those who are most vulnerable (Fineman, 2008), thus it is not a universal experience, but one that is deeply entrenched in and shaped by intersections of identity and the disadvantages of life

that are disproportionally experienced by some women due to race, class, and other aspects of identity. In the context of the arguments I make here, the gendered harm is a consequence of the lived experience of reproduction and mothering today, and the conditions under which women are expected to engage in both—in the context of heteronormative, white, capitalist, patriarchy. Accordingly, it is not women's fundamental ability to become pregnant that is the source of gendered harm—the 'invasion' of the body, as pregnancy is conceptualised by some radical feminists[12]—but the conditions under which women are expected to become pregnant, carry a foetus, labour and deliver that foetus, and then mother the child. Reproduction and mothering need to be 'released' from patriarchy: the institution that makes the acts compulsory and so constrains them (West, 1988, p. 47).

Despite considerable harms experienced by women due to pregnancies, foetuses, and children, these 'life experiences' continue to fail to be conceptualised and appreciated as legitimate risks to women's well-being and life, in law and criminal justice, as well as in health and wider society. As outlined by Wendy Chan and George S. Rigakos (2002), risk discourses and theoretical discussions of 'risk society' and governmentality have generally been perceived to be gender neutral, whereby risk theorists have made 'dubious claims about the death of class, gender and race' (2002, p. 745). Risk taking and risk management have been assumed to be generally universal experiences of calculation and effect borne from instrumental science; thus race, gender, and class are perceived as but one more risk variable. However, as Chan and Rigakos argue, risk is not a neutral concept—it is political.

[12] Analysis of pregnancy, as an invasion that women need to be able to protect themselves from, is an argument that certainly could be made here. See West (1988) for her discussion of radical feminists' positions on pregnancy and heterosexual sex as the intrusion of women's bodies and, thus, oppression of her subjectivity.

Women perceive and experience risks very differently to men, shaping their lives accordingly (Stanko, 1997; Walklate, 1997): most women can tell you about the precautions they take when walking home alone at night, to counter the perceived risk of the stranger in the night, an experience either not lived or lived differently by most men.[13] The unpleasantness of this perception of risk, Chan and Rigakos (2002) argue, is that it works as a form of social control of women, pushing them into the private sphere, the home, and the 'protection' of the men they know intimately, who, many, many feminists have concluded, are of most danger to women (Hanmer & Saunders, 1984; Stanko, 1985).

But the gendered nature of risk goes beyond how risk is perceived and experienced. What and who counts as risky, and which situations are seen to not embody risk are also shaped by gender; as Chan and Rigakos (2002, p. 754) argue, risk is determined through 'unabashed male privilege in the formulation of official dangers'. Here they are referring to how patriarchy—the masculinity of the Rule of Law and institutions of social control—respond to the perceived danger posed by some women; for example, the danger perceived, and responded to, through the witch-hunts of the sixteenth and seventeenth centuries. In the context of suspicious perinatal deaths, it is the woman who does not embrace motherhood nor act as the responsible pregnant woman upon conceiving, who is seen as dangerous, and thus a risk that criminal justice and law responds to.

[13] The public discussion and protests following the murder of Sarah Everard in London in March 2021 highlight the risks experienced by women every day.

‘Masculine privilege’ also accounts for the lack of perceived risk in other situations; for example, refusal to acknowledge that men who commit intimate partner violence and abuse against women are a risk to the safety and lives of those women. In a number of instances where a woman kills her violent and/or abusive partner, if she waits for time to pass since he last beat her before she kills him, or kills him while he sleeps or is unconscious, or kills him with a weapon while he is unarmed, she is denied use of legal defences, such as provocation or self-defence to murder charges.[14] In these instances, women’s perception of the risk to themselves (being killed or seriously harmed) and the appropriate and proportional steps they need to take to ameliorate that risk (kill their partner) are understood by law and criminal justice to be either unreasonable levels of fear or a desire for revenge, consequently delegitimising the risks that these women face.

The same logic can be applied to offences relating to suspected newborn child killing. The assumption is that the foetus/newborn child supersedes the woman who is pregnant/has given birth and so she is expected to manage any risks experienced by the foetus. Added to this is the widely held perception that the foetus cannot pose a risk to the woman. The result is that any perception that the foetus/pregnancy is a risk to the woman is considered illegitimate. The concept of there being a risk to the woman is so foreign to discourse and understanding surrounding these cases, it is not even considered or mentioned in the court hearings. Instead, the perception is that the pregnant woman, as a mother, should put the foetus first. Her perception of risk is considered illegitimate, mistaken, foolish, wrong, unjustified, unnatural. This

[14] In England and Wales, changes have been made to the defence of provocation, now known as loss of self-control (Coroners and Justice Act 2009, ss54-56), with the aim of making it easier for women to use the partial defence to murder in such circumstances. However, see Edwards (2016) for her discussion as to how and why the new defence is still likely to preclude women receiving leniency.

perception of her concept of risk delegitimises her choice to not respond to the pregnancy as anticipated, as expected. Thus, her actions are perceived as individual failings—the response of the ‘bad’ mother and ‘irresponsible’ pregnant woman. By individualising the failings, the social cultural factors that lead a woman to conceal/deny a pregnancy, and to give birth alone resulting in the death of the child, continue to be masked: the gendered harm continues to be obscured. It is she, and she alone, who is to blame.

As we will see in Chapters 5 and 6, this perception of the foetus/pregnancy as an illegitimate risk to a woman has significant consequences for how her actions or inactions in pregnancy and following the birth of a baby are perceived. Society sees her as a risk and a danger, and so criminal law and justice are deployed accordingly to manage that risk and to facilitate punishment of her deviant mothering. As part of this, I will explore how criminal law is utilised to facilitate the criminalisation of women in these cases, both historically and today. In theory, the born alive rule prevents a woman from being held criminally liable for being the ‘irresponsible’ pregnant woman. However, as will be explored, in practice, the law is applied in ways that effectively defeat the born alive rule. Consequently, the risk women are perceived to pose to the foetus when they fail as mothers can be, and is, captured as criminal offending. First, in Chapter 5, I will outline how the ‘menu’ of criminal offences came into existence, and the historical context of the adoption of these laws.