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Mariticide in Milan between 1990 and 2017: A criminological and medico-legal analysis

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Abstract

Most murder victims in a romantic relationship are women but sometimes they will kill their husbands or partners (mariticide). This paper focuses on these rarer cases using a sample taken from the autopsy reports of the Department of Legal Medicine of the University of Milan whose territory includes the municipality of Milan and part of the province of Milan and Monza – approximately four million inhabitants.

Keywords

Italy, murder of spouses and partners, women as perpetrators, motives, separation fear, untreated psychiatric illness, prevention

Relevant data

In the last decades, homicides in Italy have gradually decreased from 1916 cases in 1991 to 357 cases in 2017 – a decrease from 3.4 to 0.65 per 100,000 inhabitants (www.istat.it).[1] This trend applies in Milan where the homicide rate between 1989 and 1991 was 2.21 per 100,000 inhabitants and decreased to 1.00 between 2013 and 2016.[2] Further, Italy is seeing a shift in the genders of the perpetrators and victims; although men remain the most common perpetrators, the rate of murders committed by women has risen from 3.9% in 1992 to 9.1% in 2016[1] reducing the statistical gap between the sexes.

There were 1268 homicide cases between 1990 and 2017: 364 of these involved a female victim (29%) in which 172 victims were killed by their current or former male partner, 13% of total homicides and 47% of those cases involved a female victim. By contrast, there were 20 mariticides, where a woman murdered her partner, in the same area over the same period of time.

The Milanese sample

Between 1990 and 2017, there were 20 mariticides i.e. less than one per year (Figure 1). They occurred throughout the week with no seasonal or weekend prevalence when partners tend to spend more time together. This is notable as our results diverge from previous studies that found increased incidence at weekends and summer which suggested that homicide is a leisure-related activity closely associated with periods of recreation and free time.[3]

On the other hand, our sample aligns with Mann in 1988; nine cases occurred during the night or evening hours which fit Mann's classification of mariticide as a 'night crime' (Goetting, 1988).[3,4]

In our sample, a higher number of cases occurred during the last six years with seven cases from 2011 to 2017.

The most common link between the perpetrators and their victims was marriage (eight cases), followed by relationships with cohabitation (six cases) or without (one case), and five cases of former relationships but in their sample of male victims, Bourget and Gagné[5] found a higher percentage of cohabitating partners than husbands. Along with these findings, Shackelford[6] suggests that there was a greater association with relationships without cohabitation. Despite these seemingly contradictory findings, all authors agree

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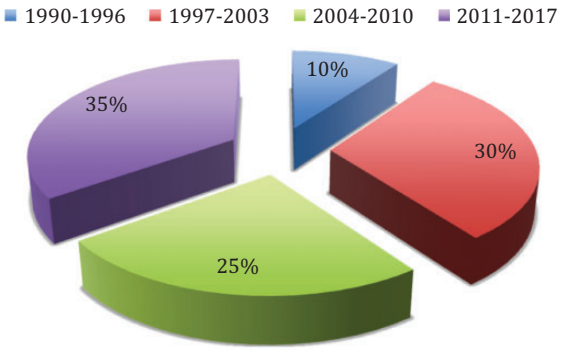

Figure 1. Graph showing mariticides by women in Milan, 1990–2017.

that separation – whether threatened or actual – is the common factor that creates the risk of a wife being murdered. This is explained by male dependency also known as possessiveness. Separation is not a significant risk factor in cases of mariticide by the wife.[7] In the five separation cases we analysed, money was the prime motive, in two, fear of abandonment or jealousy; the fifth case was a woman who had been continuously harassed by a former partner who did not accept their separation.

The victims' ages ranged from 25 to 71 years – (mean age of 46) with most victims in their 50s and 35% between 41 and 48 years old. The female perpetrators were aged between 26 and 61 with a lower mean age of 39 years: the age group most represented in our sample were women in their 60s while 30% were between 51 and 58. In most cases, the perpetrator and victim were either the same age or the victim was older.

In one case, the victim was 14 years older than his partner while in another case there was an age difference of 41 years between the two. Our sample was in line with the cultural norms with women being younger than their male partners – though in four of our cases the women were older than their men. Nonetheless, our sample diverges from others that indicate a major mariticide risk in younger age groups[8] but does align with previous samples that demonstrated age disparity in the relationship as a risk factor for mariticide.[6,9]

Another aspect of our analysis focused on whether children were involved. Of the 20 cases, there were only 8 where the couple had children. In one case, the daughter was an accomplice to the murder while in two other cases the children were victims killed as part of a family massacre.

Since these homicides involve spouses or partners, it is not surprising that they took place in the couples' homes or the immediate surroundings. In 15 cases, the murders were committed in their home, on the terrace or adjoining yard. In the remaining three cases, where the perpetrator was a former partner, the killings were in the street.

No information was available about the location of the homicides in two cases.

Eighteen of the 20 homicides were in areas associated with low to medium socio-economic backgrounds – while two cases involved successful businessmen (one of whom was internationally recognised). In two instances, the victims were known to have criminal records. Two victims had a history of drug use, five others displayed alcohol abuse, even during the crime itself. In two cases, the perpetrators were under the effect of alcohol when committing the crime. There was evidence of psychiatric illness in two of the victims (one had schizophrenia and another unspecified psychological problems), and organic illnesses in three of the older victims (two had cancer and another diabetic heart disease).

With more foreigners in Italy, non-Italians may be victims or perpetrators.[10,11] In our sample, six victims (30%) and eight perpetrators (40%) were of non-Italian origin. In six cases, both the perpetrator and the victim were foreigners – but the couples had the same ethnicity only in four. In two other cases, an Italian woman killed her foreign husband. There were smaller percentages of foreign victims and perpetrators reported in the Canadian sample used by Bourget and Gagné.[5]

In 12 of our sample cases the knife was the most common weapon (60%) which was consistent with Bourget and Gagné's sample.[5] A firearm was used in four cases; a blunt object in two, there was one case of asphyxiation and one where the killer set her husband on fire. Setting fire to the husband was recorded also by Pretorius and Botha.[12] In our case, the perpetrator gave her husband sleeping pills with the intent of rendering him harmless before setting him ablaze. In Adinkrah's[13] sample, 3 of 12 husbands were murdered while they slept but we found only one in our sample. According to Rasko[14] and Walker,[15] the murder of a violent husband while asleep is not unusual as the woman may fear being overpowered if she attacked him while he was awake (as in our own sample).

Four of 'our' homicides involved an accomplice. In two, the wife was the instigator while the accomplice did the killing. One wife was assisted by her daughter in carrying out the act while the other case involved the perpetrator's lover. Complex investigations and legal battles took place in our sample where there was an accomplice.

In seven cases, after committing the crime the perpetrator immediately confessed. One perpetrator then committed suicide and in two other cases there were suicide attempts. These findings align with criminological literature where post-crime suicides after mariticides and uxoricides are unusual.[5,16,17]

A psychiatric evaluation was performed in eight cases to ascertain the perpetrator's mental capacity.

In three cases the perpetrator was found incapable, and in another four cases had diminished liability. The remaining cases found the perpetrator had full capacity. Of the eight women assessed, four were deemed a danger to society.

Motive

What were the motives here? There were fewer incidents where criminal behaviour could be ascribed to battered woman syndrome – i.e. the murder is a response to conditions of unbearable frustration towards the male figure responsible for humiliation, oppression and abuse of the female partner.[13] According to many authors, mariticide would therefore only be the final option the woman believes would end the abuse, especially after continuous attempts to seek help.[18,19] These observations originated the spread, in the United States, of *battered woman self-defence*, a legitimate legal defence identified in cases where a woman suffers violence at the hands of the victim, even in the absence of legal conditions necessary to constitute lawful self-defence.[15] Nonetheless, times are changing: in 1989, Goetting, in his sample, found that in 95% of mariticides committed by women there were several episodes of domestic violence. This percentage decreased to less than one-quarter 20 years later in Bourget and Gagnè's[5] study. In 1988, Mann[4] had already asserted that women who killed their partners differed in motive when compared to the *battered women* of previous years. *Battered women syndrome* as the cause of the homicide in our sample occurred in four cases (20%); generally, motives for mariticide are as shown in Figure 2.

Psychiatric illness as a contributing factor is the most frequent cause in 7 of 20 cases; two additional cases should be added to this count given that continuous abuse and threats of violence were reported as motives in addition to a diagnosis of mental illness. A psychiatric examination was mandated in five cases. Psychosis was diagnosed in two cases – one alongside a personality disorder – while severe depression was diagnosed in four cases. In the cases of severe depression, two were associated with a family tragedy.

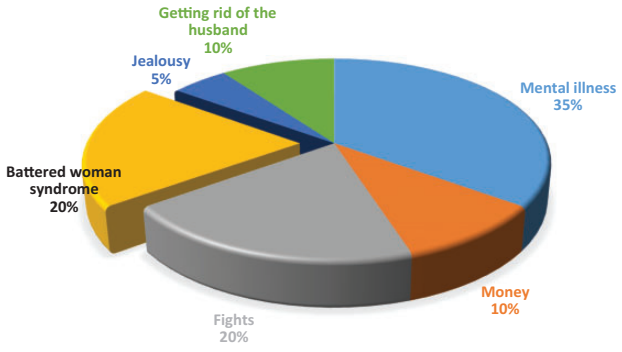

Figure 2. Graph showing motives.

There were four cases of *battered woman syndrome* (where husbands are killed years even decades later as a consequence of their violence). Three of these involved foreign subjects, probably on the grounds that gender discrimination, ranging up to violence, is more widespread among other cultures, or because foreign women find it more difficult to turn to the authorities or help centres before 'solving' the problem on their own. Isolation of female killers who were previously victims of violence is a criminal risk factor also described by Pretorius and Botha.[12]

While we do not have complete data on the verdicts, we believe that in these cases there were relatively limited punishments: six years and three months of imprisonment in one case, six years and eight months in another and two years and eight months in the third case analysed; much lower than the sentences received in the two cases where the perpetrator was motivated by money; in these cases, the killers were sentenced to 26 and 30 years of imprisonment respectively.

It is not surprising that the judicial system shows more leniency towards female defendants but this will depend on the nature of the homicide: leniency is more understandable and justifiable where evidence shows the perpetrator had been abused and beaten by the partner over many years. Walker[15] reports that legal defence teams in the US resort to the *insanity defence*, or change the classification from first degree murder to less severe forms of crime to show mercy towards women who have killed their abusive partners. Our cases of *battered woman syndrome* are similar to the ones described in criminological literature, and a psychiatric examination was requested in two incidents to assess mental capacity to act, which was deemed diminished in one and totally lacking in the other.

In two cases, the killer wanted to get rid of the husband; in the first case because he was mentally ill, and in the second because the woman had taken a lover.

Our Milanese sample contained only one case where a woman killed her husband out of jealousy. This contrasts with Adinkrah's[13] sample of mariticide in Ghana where the motive in a quarter of the reported cases was jealousy – specifically by the husband's desire to take a second wife. Ghana is a country where polygamy is culturally and legally accepted, but often triggers jealousy which manifested itself in lethal violence against the husband.

Conclusion

There remains a big disparity between homicides committed by men and women and also when comparing

uxoricide with mariticide. In Milan, between 1990 and 2017, there were 172 women killed by their current or former partners whereas in the same period only 20 men were killed by their partners. There has been a slight increase in mariticide during the final six years of our sample and the situation should be monitored to understand why, notwithstanding an overall decrease in the Italian murder rate, there has been an increase in mariticide.

Our data show few partner killings in response to abuse or physical aggression during the relationship: the criminogenesis of *battered woman syndrome* only applies to four cases (20%). Instead of *battered woman syndrome*, the most frequent motive occurring in our sample of female perpetrators was mental illness – which was present in 7 out of 20 cases.

Mental illness rarely comes out of the blue which prompts consideration of whether these homicides should have been prevented. In one of the seven cases, the future victim did not realise how serious his wife's condition really was and during an argument said 'I will leave you if you don't pull yourself together'. She killed him for fear he would abandon her. In another case, the perpetrator was affected by severe depression – after killing her husband, her son and the family dog, she took her own life. There was no agreement among witness statements as to whether or not she received therapy from a psychiatrist. Her family practitioner excluded this possibility and toxicology examinations during the autopsy detected no traces of psychopharmacological drugs in her system.

The third case was a family tragedy where two young children (aged 8 and 10) were killed as well. Friends of the family who were interviewed described the woman as 'crazy' but there was no evidence of psychiatric therapy in her medical history. In another case, there was the same under-estimation of the perpetrator's psychiatric condition and, despite this psychiatric history, she had no access to therapy which ultimately resulted in homicide. There was no evidence of psychotherapy seen even in the fifth and sixth cases where both perpetrators showed clear signs of mental illness.

In six of the seven cases where the crimes can be ascribed to mental illness, there were grounds for intervention. In the final case involving a diagnosis of psychosis, a neighbour who happened to be a prison police officer had filed a complaint to the public prosecutor over arguments he had heard in the apartment building. The public minister had requested an inspection which was not conducted. This was similar to one of the previous cases mentioned, where complaints about arguments led to officers contacting the future victim – but not the future killer.

In our four cases of *battered woman syndrome*, the women had not sought help from anyone. In one case of mariticide, the future perpetrator went to an abused women's protection centre. When she was asked to provide her full name, she became scared and left the building immediately. She did not feel comfortable or safe enough to get the support she needed and felt forced to take her husband/partner's life.

While the mentally ill do not commit more crimes than other people, if an individual is experiencing psychological suffering, he or she needs help. The importance of this cannot be stressed enough as some of these homicides could have been prevented had there been such an intervention.

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Nigerian laws on informed consent before a surgical procedure

Mabel Ijeoma Ezeuko

Abstract
Informed consent is a process of communication between a clinician and a patient, which results in the patient's agreement to undergo a medical procedure. Rule 19 Part A: Code of Medical Ethics of Nigeria and Section 23 of the National Health Act 2004 prescribe the process of obtaining consent before a medical intervention. The equitable law of torts and/or criminal liabilities that deal with medical negligence should be invoked more often by patients whose right to informed consent is denied by medical practitioners.

Keywords
Informed consent, surgical procedures, medical negligence

Introduction

Informed consent is a process of communication between a clinician and a patient that results in the patient's authorisation or agreement to undergo a specific medical intervention.

It spells out the procedure that the clinician plans to achieve that specific medical intervention. In addition, it clearly states the benefits and risks associated with the procedure.

A patient is given the informed consent form to read and to append his/her signature to show that he/she understands what the medical intervention is for and consents to it.

This is a mandatory part of medical practice which when found wanting can result in litigation. Informed consent is part of the preoperative routine as a matter of hospital policy, legal requirement and ethical obligation. In surgical practice, the principle behind consent for surgery is essentially the same everywhere, but the emphasis placed on it and the process of obtaining it vary from place to place.[1]

Informed consent is an established ethical and legal requirement for surgical treatment. It has important roots in Anglo-American political theory and has been articulated in the law in a series of judicial decisions.[2]

There is a marked disparity between patients and their medical practitioners with regard to enlightenment and education in Nigeria.

There are scant studies on informed consent before a surgical procedure. Medico-legal issues rarely make it to the courts, and the few that eventually do are on

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