February 15, 2025
Clara S. Lewis, Ph.D.

Committee on Children
Testimony in Opposition to Bill No. 1310

I am here to oppose Connecticut's Raised Bill No. 1310. I wish to further amplify a concern shared by numerous other medical and mental health professionals and adoptee rights advocates: namely, that while the legislation being discussed here today represents a commendable interest in saving the lives of our society's most vulnerable babies, in practice infant abandonment boxes do not, and cannot, work.

I am a professor at Dartmouth College with expertise in infant homicide in the United States. As an infant homicide expert, I have served on two national working groups, one with the National Safe Haven Alliance, and now with Yale University's Interdisciplinary Center for Bioethics. I also serve as an expert witness for neonaticide cases, which are tragic infant deaths that occur in the first 24-hours of life, often immediately after a young woman has attempted to deliver her baby in solitude with no medical assistance.

Infant homicide, in general, and neonaticide, in particular, are both misrepresented and thus widely misunderstood tragedies. I am here today, in part, to answer any questions you may have about these tragic crimes and to share one key insight from the well-established research literature in forensic psychiatry.

Advocates for these devices hope that babies can be saved by installing these boxes. Unfortunately, research reveals that this is wishful thinking as opposed to evidence-based fact. Research in forensic psychiatry and maternal mental health demonstrates that women who are at risk of neonaticide are not in a psychodynamic situation conducive to taking advantage of infant abandonment boxes because they are not consciously aware that they are pregnant and thus are unable to make a plan to utilize this option of last resort.

This means that when boxes are used, they would not reduce inevitable infanticides. They would only be used by women who would otherwise surrender in-person within a hospital setting. This means that boxes would essentially take away the in-person option from some women and then they therefore would not receive in-person counseling, medical care, and information about resources available to support family preservation.

It is important to be very pragmatic in these considerations. Please consider the bare medical reality of a young women in this position, who has either concealed her pregnancy or not accurately perceived that she is pregnant. Now consider her laboring alone. Offering her a drop box, assumes that in this post-partum state she will be able to deliver her baby and placenta successfully, then render emergency medical care to her newborn infant, clearing the baby's airways, cutting and clamping the cord hygienically.

Please understand that it only takes two minutes to die of asphyxiation, which is why trained medical professionals are often needed to render emergency care to newborns immediately at birth.

Then, in the face of her own medical injuries, utilizing the box now requires her to transport herself to a box location, and—without the benefit of a conversation with a trained counselor—walk away from her newborn with no hope of future reconciliation or arrangement for an open adoption. This is an unrealistic and even cruel expectation. Research further demonstrates that when these young women receive emergency medical care to support their labor, they and their families opt to keep and raise their babies.

These young women and their families deserve more than a drop box.

In light of this research, the state of Connecticut could prevent more infant deaths by instead investing in evidence-based public health policies that work to prevent infant abandonment through family preservation and confidential birth measures.

Sincerely,

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Working Group for National Standards for
Infant Abandonment Boxes
The Interdisciplinary Center for Bioethics
Yale University.

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