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Case Report

Matricide: An Integrated Medico-Legal and Forensic Psychiatric Analysis—A Case Report Series

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Abstract

Background and Clinical Significance: Matricide represents a rare and particularly complex form of intrafamilial homicide, situated at the intersection of forensic pathology, psychiatry, and criminology. Despite its major medico-legal implications, matricide remains insufficiently portrayed in the literature, especially regarding the correlation between injury patterns, mechanisms of death, and psychiatric profiles of perpetrators. This study presents four matricide cases investigated at the Institute of Forensic Medicine in Cluj-Napoca, Romania, highlighting their forensic and psychiatric heterogeneity. Case Presentation: A retrospective analysis of four matricide cases was performed using autopsy reports, histopathological examinations, toxicological findings, crime scene data, and forensic psychiatric evaluations. All victims were adult women killed by their sons in domestic settings. Fatal mechanisms included sharp-force cranio-cervical trauma with complete C2–C3 spinal transection, complex blunt cranio-maxillofacial trauma with cerebral destruction, mixed-mechanism mechanical asphyxia by manual strangulation and thoraco-abdominal compression, and acute respiratory failure caused by tracheo-broncho-pulmonary blood aspiration following facial trauma. Cranio-facial targeting predominated across all cases, while financial conflict represented the most frequent documented contextual factor (3 of 4 cases). Psychiatric findings ranged from dissocial personality disorder with preserved discernment to paranoid schizophrenia with absent discernment following treatment discontinuation. Simulation or deceptive behaviors were identified in two perpetrators. Conclusions: The presented cases illustrate the marked forensic and psychiatric heterogeneity of matricide, even within a limited regional series. The integration of detailed autopsy findings with forensic psychiatric evaluation provided a useful framework for reconstructing the mechanism of death, evaluating criminal responsibility, and interpreting post-offense behavior. These findings contribute additional empirical data to the limited literature on matricide and underline the importance of interdisciplinary medico-legal evaluation in intrafamilial homicide cases.

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1. Introduction and Clinical Significance

Homicides within the family (particularly matricide, the killing of one's mother) represent one of the most extreme and rare forms of intrafamilial violence, posing complex challenges to both forensic pathology and psychiatric evaluation [1]. Although filicide and parricide are more commonly addressed in the literature, matricide is markedly understudied, often hidden within broader categories of violent deaths or familial homicide case series [2]. Understanding these events requires an integrated medico-legal, psychological, and sociological approach.

From a psychiatric and psychosocial perspective, violence risk assessment integrates individual predispositions and situational stressors. Substance abuse, personality disorders, psychotic decompensation, and familial conflict have all been described among the clinical and psychosocial factors associated with severe interpersonal violence [1,3–5]. Parricidal and matricidal acts, much like filicide, often correlate with psychosocial stress factors, unstable finances, substance misuse, and histories of abuse or family discord [1,3]. A broader view of violence in the mental health domain highlights that comorbidity with alcohol and drug abuse amplifies the risk of violent acts, particularly in psychotic or personality disorder populations [4]. In the Romanian forensic context specifically, associations between personality-related dimensions and violent behavior have also been reported in forensic populations, including studies examining psychoticism, addiction, criminality, and personality disorders in relation to violent crime and domestic violence [5,6].

Among psychiatric conditions associated with matricide, schizophrenia occupies a particularly prominent place in the literature. The psychodynamic conflict between schizophrenic individuals and their mothers, combined with psychotic decompensation, impaired insight, and disrupted reality testing, has been repeatedly identified as a precipitating factor in matricidal acts [7]. At the same time, matricide is not exclusively a psychotic phenomenon—perpetrators with personality disorders, substance dependence, and preserved discernment (i.e., the capacity to understand and appreciate the nature and consequences of one's actions) represent an equally important and forensically distinct subgroup, highlighting the psychiatric heterogeneity that characterizes these cases [1].

Despite the wealth of forensic and behavioral research on homicide, matricide specifically remains rare. Many reports focus on parental homicide broadly or emphasize female perpetrators (mother killing child) rather than matricide per se [1,2]. Retrospective forensic autopsy studies of intrafamilial homicide underscore the need for more empirical case-based forensic scholarship in these contexts, given that parricides (predominantly matricides) represent a distinct subgroup with specific criminological and psychiatric risk profiles [8]. Williams (2021) offered a descriptive synthesis of forensic behavioral science in serial and mass murder, which, though broader in scope, provides theoretical underpinnings relevant to understanding extreme violence dynamics, including familial homicide [9].

The rarity and heterogeneity of matricide cases require carefully documented series to refine understanding [1,10,11]. Each case can illuminate nuances in mechanism (sharp vs. blunt force, asphyxia, cervical trauma), timing (escalation, planning vs. spontaneous act), and psychopathology (discernment present/absent, simulation, comorbidity) [12]. In particular, combining pathological findings with psychiatric assessments offers deeper insight into motive, culpability, and preventive strategies.

Given the rarity and forensic complexity of matricide, the present study aimed to provide an integrated medico-legal and psychiatric analysis of four matricide cases investigated at the Institute of Forensic Medicine in Cluj-Napoca, Romania. Through a retrospective case-series approach, we sought to characterize the injury patterns, mechanisms of death, scene findings, and histopathological features associated with these cases, while simultaneously exploring the psychiatric profiles and discernment status of the perpetrators. Furthermore, the study aimed to identify common forensic and behavioral patterns across cases, to evaluate the relationship between psychopathology and homicidal violence in an intrafamilial context, and to discuss the medico-legal and criminological implications of these findings within the framework of the existing literature on matricide and forensic psychiatry.

2. Materials and Methods

This retrospective descriptive case series included all matricide cases identified among the medico-legal autopsies performed at the Institute of Forensic Medicine Cluj-Napoca, Romania, between 1 January 2021 and 31 December 2024. Cases were identified through a retrospective review of the Institute's medico-legal autopsy records for the study period. A total of 3466 medico-legal autopsies were performed at the Institute during this four-year interval. All four cases meeting the eligibility criteria were included, corresponding to approximately 0.12% of all medico-legal autopsies. No eligible matricide cases identified during this interval were excluded.

Cases were eligible for inclusion when (1) the deceased victim was the biological mother of the alleged perpetrator; (2) death was classified as homicide following medico-legal investigation; and (3) a complete medico-legal autopsy had been performed at the Institute of Forensic Medicine Cluj-Napoca. Cases involving the killing of other family members without the mother being the homicide victim were excluded.

Data were retrospectively extracted from the available medico-legal records, including autopsy reports, crime-scene and investigative information available in the case files, histopathological examinations, toxicological analyses, and forensic psychiatric and psychological evaluation records. The variables collected included victim and perpetrator characteristics, relevant circumstances of the offense, anatomical distribution and characteristics of injuries, mechanism and cause of death, histopathological and toxicological findings, documented psychiatric diagnoses and psychopathological features, and the conclusions of the forensic psychiatric evaluation regarding criminal responsibility and applicable security measures. No additional investigations or psychological assessments were performed specifically for the purposes of the present study.

The forensic pathological assessment, including autopsy and subsequent histopathological and toxicological investigations where indicated, was performed following the death and as part of the routine medico-legal investigation. Toxicological analyses were performed as part of the routine medico-legal investigation when requested by the competent judicial authorities according to the circumstances and investigative requirements of each individual case. Consequently, the extent of toxicological testing was not uniform across all victims or perpetrators. Forensic psychiatric evaluations of the perpetrators were subsequently requested by the competent judicial authorities and conducted at the Institute of Forensic Medicine Cluj-Napoca by the Forensic Psychiatric Commission, comprising one forensic medicine specialist and two psychiatrists, with psychological assessment performed by a clinical psychologist as part of the multidisciplinary evaluation.

Psychiatric diagnoses were established during the original forensic psychiatric evaluations according to the International Classification of Diseases, 10th Revision (ICD-10).

The diagnostic terminology reported in the present study was derived from the original forensic psychiatric documentation and was not retrospectively reassigned by the authors.

Given the retrospective nature of the study, psychiatric and psychological assessments reflected those originally performed during the medico-legal proceedings and were not standardized across the four cases. Similarly, psychometric instruments were not uniformly administered in all cases. The Millon Clinical Multiaxial Inventory–III (MCMI-III) was used only in those cases in which it had formed part of the original forensic psychological assessment. No retrospective reassessment or additional psychometric testing was undertaken for the purposes of this study.

Data were extracted using a standardized case-based framework and subsequently reviewed across the four cases to ensure consistency in the reporting of demographic, circumstantial, pathological, toxicological, and forensic psychiatric variables. Because all eligible cases from the defined study period were included and the study was intended as a descriptive case series, no inferential statistical analyses were performed.

3. Case Presentation

3.1. Case 1—Sharp-Force Matricide with Cervical Spinal Transection

The victim was a woman in her 50s, found deceased at home in spring. The perpetrator, her son, in his 30s, was identified as the assailant. The incident followed an intrafamilial conflict concerning financial and property-related matters. Investigative records documented longstanding intrafamilial conflicts dating back to the perpetrator's childhood, along with a history of psychoactive substance use. No previous psychiatric hospital admissions were recorded.

External examination revealed multiple traumatic injuries. The face showed numerous contusions and widespread scalp trauma, including a frontal hematoma. The parieto-occipital scalp presented with several sharp, chop-like incised wounds with tissue bridges, exposing a skull fracture and extrusion of brain tissue through the bony defect. A large anterior cervical incised wound showed relatively regular, undulating, hemorrhagically infiltrated margins, with an acute right angle, an obtuse left angle, and three residual tissue bridges. The wound completely transected the underlying soft tissues and major cervical neurovascular structures, as well as the cervical spine at C2–C3, leaving only a posterior skin flap intact. Extensive defense-type injuries were present on both hands, consisting of complex trauma with comminuted and multifragmentary fractures, crushing of soft tissues, and multiple excoriations and bruises across the upper limbs. Additional bruises were noted on the left lateral thigh and both knees.

Internal examination confirmed severe cranio-cervical destruction (Figure 1A–D). A fracture line extended across the posterior cranial base to the right lateral clival wall (Figure 1A). The calvarium showed a multifragmentary defect with extensive hemorrhagic extravasation and exposed bone fragments (Figure 1B). Subarachnoid hemorrhage was distributed interhemispherically, over bilateral parieto-occipital convexities, cerebellum, and brainstem, with associated intraventricular hemorrhage, basal frontotemporal contusions, occipital meningo-cerebral laceration, and corpus callosum involvement. Severe cerebral edema and dural lacerations were present (Figure 1C). Both carotid arteries were completely transected above the carotid bifurcation. The cervical spine showed a fracture at C2–C3, with hematomyelia and complete cord transection directly corresponding to the external incised wound (Figure 1D). Pulmonary blood aspiration was also noted. Background pathology included cardiovascular disease (pericardial lipomatosis, cardiomyosclerosis, coronary sclerosis, cardiac hypertrophy), hepatic steatosis with hepatomegaly, splenomegaly, renal nephrosclerosis, and generalized visceral anemia. Notably, the basilar artery showed in-

traluminal atherosclerotic deposits causing varying degrees of obstruction, representing a potential contributing factor to cerebrovascular fragility.

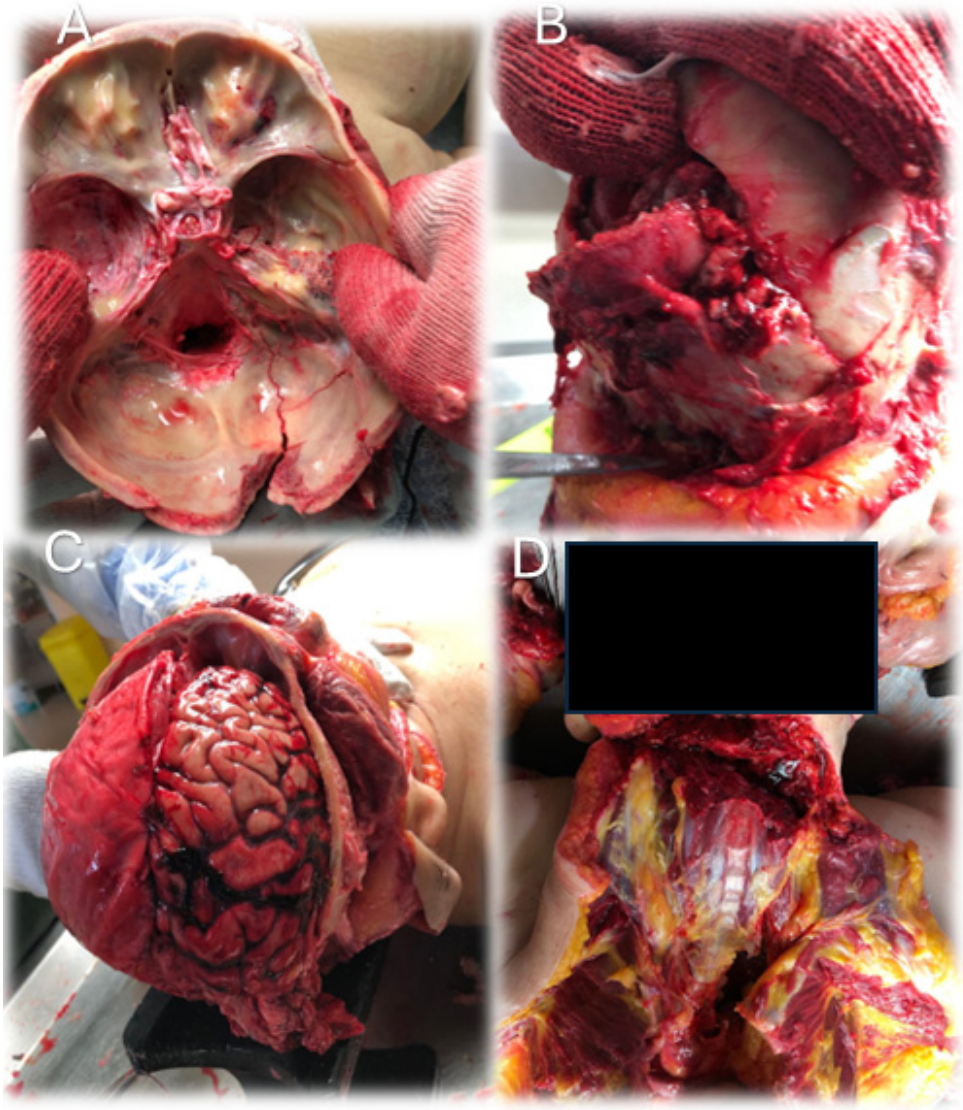


Figure 1. Internal traumatic findings in Case 1 (sharp-force matricide with catastrophic cranio-cervical injury). (**A**) Posterior cranial base fracture extending to the right clival wall. (**B**) Multisplintered calvarial defect with extensive hemorrhagic extravasation and exposure of intracranial contents. (**C**) Subarachnoid hemorrhage associated with right occipital meningo-cerebral contusions and lacerations. (**D**) Cervical injury showing a C2–C3 vertebral fracture, hematomyelia, and complete spinal cord transection.

Histopathological examination confirmed cerebral congestion and edema with intraparenchymal hemorrhagic foci and areas of cerebral laceration, leptomeningeal hemorrhage, spinal cord edema with meningeal hemorrhages, bronchioloalveolar blood aspiration, myocardial fibrosis with coronary atherosclerosis, hepatic steatosis, and tubular necrosis. Vascular sections of the cervical neurovascular bundle showed venous wall discontinuity with periadventitial hemorrhagic infiltration, a lesion-specific finding supporting antemortem vascular injury at the cervical wound site.

Toxicological testing of the victim was limited to blood ethanol determination, which yielded a negative result. No expanded toxicological screening for other substances was performed. The forensic cause of death was certified as violent death due to external hemorrhage and catastrophic cranio-cervical trauma, including multiple incised–chopped

cranio-cerebral wounds with skull fractures and meningo-cerebral lacerations, a deep anterior cervical incised wound with complete C2–C3 spinal transection and sectioning of major neck vessels, and complex bilateral defensive hand injuries. The fatal mechanism combined exsanguination with neurogenic and respiratory failure secondary to sharp force assault and cervical spinal cord transection. The manner of death was classified as homicide (matricide).

The perpetrator denied any psychiatric history and had no prior hospitalizations. Psychological evaluation using the MCMI-III identified elevated antisocial and aggressive personality scales, consistent with dissocial personality disorder as defined by ICD-10 criteria. The forensic psychiatric evaluation was performed by the Forensic Psychiatric Commission within the Institute of Forensic Medicine Cluj-Napoca, which concluded that discernment was present at the time of the offense and at the time of evaluation, and therefore, no medical safety measures were recommended.

3.2. Case 2—Complex Open Cranio-Maxillofacial Trauma with Brain Exposure

The body was found lying in a pool of blood on the hallway floor, with cerebral matter extruded through the nasal passages and extensive craniofacial disfigurement. The victim was a woman in her 60s, found deceased at home in summer. The perpetrator was her son, in his 30s, with concurrent homicide of another family member during the same episode. The assault followed a spontaneous conflict with financial motivation. The perpetrator had a documented history of antisocial acts and recurrent episodes of aggression and claimed that the homicide had occurred in self-defense, an account that was inconsistent with the available crime-scene and autopsy findings.

External examination showed severe combined craniofacial trauma. Multiple excoriations and ecchymoses were noted across the face, with bilateral periorbital hematomas. Additional findings included othematoma and fracture of the right auricular cartilage with otorrhagia, as well as epistaxis. Cerebral tissue extrusion was present, associated with a complex skull fracture radiating to the skull base. The viscerocranium exhibited multiple comminuted fractures of the nasal pyramid, zygoma, maxilla, and mandible. A linear stab-incised wound was observed on the left frontal region. Diffuse, massive epicranial hemorrhagic infiltration was also present. Multiple bruises and excoriations on the forearms, particularly a 14 $\times$ 2 cm linear excoriated placard on the left posterior forearm, were consistent with active defensive movements against the assault.

Internal examination revealed extensive neurocranial and viscerocranial injuries (Figure 2A–E). Fracture lines involved the anterior cranial fossa, extending through the sphenoid bone and the sella turcica, with an additional linear fracture extending through the occipital bone to the petrous portion of the right temporal bone (Figure 2A). Layer-by-layer dissection confirmed widespread soft tissue hemorrhages and a descending frontal fracture reaching the right orbital roof. Comminuted fractures affected the nasal bones, malars, left zygomatic arch, maxilla, and mandible (Figure 2B). A left fronto-parietal linear bony discontinuity with multiple comminuted radiations was identified (Figure 2C,D). Intracranially, subarachnoid hemorrhage was distributed over the convexities, with basal frontal contusions and lacerations—predominantly in the right anterior frontal region—and panventricular hemorrhagic flooding (Figure 2E). Aspiration of blood was noticeable in the tracheo-broncho-pulmonary tree, with focal pulmonary emphysema.

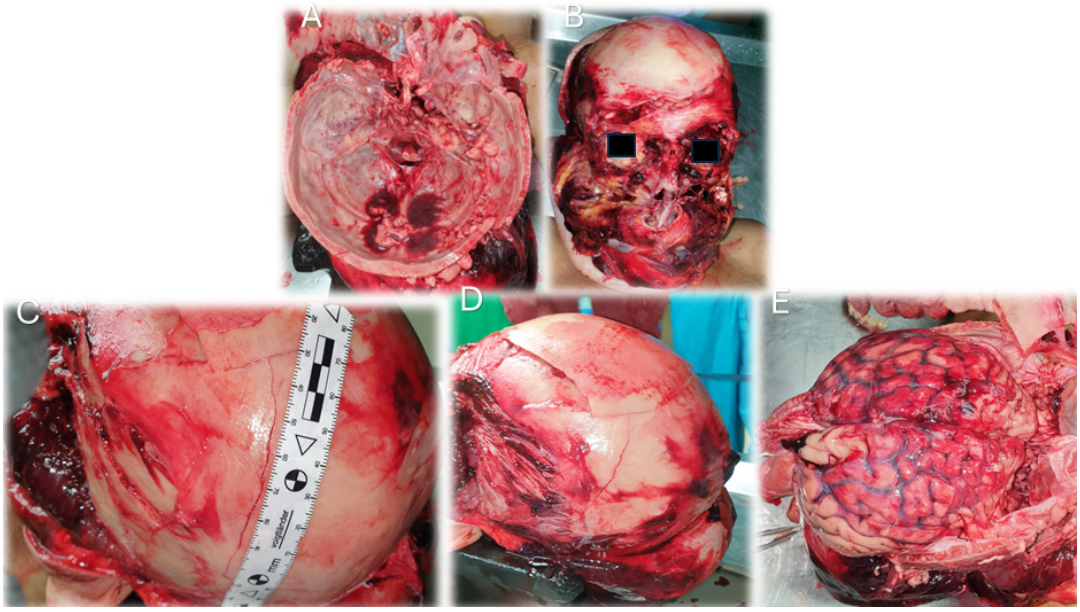


Figure 2. Internal traumatic findings in Case 2 (complex open cranio-maxillofacial trauma with brain exposure). (**A**) Fractures of the anterior cranial fossa extending through the sphenoid region and sella turcica. (**B**) Extensive comminuted fractures of the facial skeleton involving the nasal bones, zygomatic bones, maxilla, and mandible. (**C**) Left fronto-parietal fracture with multiple radiating fracture lines. (**D**) Comminuted left fronto-parietal cranial fractures associated with extensive hemorrhagic infiltration of adjacent soft tissues. (**E**) Diffuse subarachnoid hemorrhage.

Histopathological examination confirmed cerebral edema with significant perivascular and intraparenchymal hemorrhagic infiltrates and architectural disorganization of nervous tissue, brainstem edema with hemorrhages, pulmonary edema with focal emphysema and moderate bronchioloalveolar blood aspiration, myocardial fibrolipomatosis with coronary atherosclerosis, hepatic dystrophy with cholestasis, and renal tubular necrosis.

Toxicological screening was performed on blood and urine samples. No ethanol was detected in the blood. Blood screening was negative for benzodiazepines, barbiturates, phenothiazines, and fentanyl, while urine screening was negative for benzodiazepines, barbiturates, tramadol, paracetamol, ketamine, methadone, mephedrone, AB-PINACA, morphine, and other opiate derivatives. In the context of the perpetrator's documented history of polysubstance abuse, toxicological testing was also performed on the perpetrator. Blood and urine samples were collected on the same day as the offense; however, the available records did not permit reliable determination of the exact interval between the offense and sample collection. Blood screening by thin-layer chromatography was negative for amphetamines, cathinones (mephedrone), cocaine, methadone, morphine, and other opiate derivatives. Urine screening using rapid immunochemical tests was negative for amphetamine, methamphetamine, MDMA, tetrahydrocannabinol (THC), AB-PINACA, cocaine, mephedrone, ketamine, methadone, barbiturates, benzodiazepines, tricyclic antidepressants, fentanyl, tramadol, paracetamol, morphine, and other opiate derivatives. Owing to the limited urine volume available, the urine sample was screened only by immunoassay and was not additionally analyzed by thin-layer chromatography. The certified forensic cause of death was violent death due to brain contusion–laceration and hemorrhage, secondary to open complex cranio-maxillofacial trauma with comminuted depressed fractures involving both neurocranium and viscerocranium. The instrumental mechanisms inferred included repeated blows with a hard-edged object, compression between two hard planes, and a sharp-stabbing action consistent with a knife, findings

that correlated with investigative data. The manner of death was classified as homicide (intra-familial).

Forensic psychiatric evaluation indicated severe psychopathology. Psychological testing documented primary/severe psychopathy and a history of substance addiction, although the specific substances involved were not identified in the available records. The board concluded that the perpetrator suffered from a dissocial personality disorder with severe psychopathy and a history of polysubstance abuse. Discernment was present at the time of the offense and examination. A medical safety measure was recommended under Article 109(1) of the Romanian Penal Code, obliging the perpetrator to undergo psychiatric treatment.

3.3. Case 3—Mixed-Mechanism Asphyxia (Strangulation and Thoraco-Abdominal Compression) After Polytrauma

The victim was a woman in her 70s, found deceased at home in summer. The perpetrator was her son, in his 50s, known to suffer from chronic psychiatric illness (paranoid schizophrenia). Investigative data revealed that shortly before the fatal event, he discontinued antipsychotic treatment and developed insomnia with persecutory delusional themes, including beliefs that his mother had been replaced and property-related concerns. A previous suicide attempt was documented in his psychiatric history.

Emergency prehospital records documented that, upon arrival of the medical crew, the victim was found supine on the floor in cardiorespiratory arrest, with clear signs of death. The perpetrator, present at the scene, stated he had moved the victim from the bed to the floor and had attempted external cardiac massage, although he could not specify when she had lost consciousness. He appeared confused and disorganized, consistent with his known diagnosis of paranoid schizophrenia. No resuscitation was initiated by the emergency medical team, as the cardiorespiratory arrest was considered irreversible.

External examination documented widespread traumatic injuries. The face showed multiple bilateral ecchymoses involving the genian and masseteric regions, as well as frontal bruising and bilateral periorbital hematomas. A circular depressed area approximately 1 cm in diameter and 0.2 cm deep was identified on the left frontal scalp at the hairline, on a pale violaceous ecchymotic background, without palpable bony crepitation. Two superficial linear skin discontinuities with infiltrated margins were present in the left submental area. Oval to ellipsoid, partly confluent ecchymoses were observed across the anterior thorax over the manubrium and upper third extending to both supraclavicular regions and across the entire anterior and bilateral lateral cervical regions in the upper half—a distribution pattern consistent with manual strangulation combined with thoraco-abdominal compression. Multiple variably colored, partly confluent ecchymoses were also noted in the peri-umbilical abdominal region. Extensive ecchymoses were noted across both upper limbs, including the arms, forearms, and dorsal surfaces of both hands over metacarpals I–IV, as well as on both thighs and the left knee, reflecting a multipolar distribution of blunt force impacts. Right acromioclavicular disjunction was identified on passive mobilization of the right upper limb.

Internal examination revealed severe cranio-cervical and thoraco-abdominal trauma (Figure 3A–D). Hemorrhagic infiltration was present in scalp flaps anteriorly and posteriorly, as well as in the left temporalis muscle (Figure 3A,B). A basal subdural hematoma and diffuse subarachnoid hemorrhage were identified, associated with leptomeningeal stasis, cerebral and cerebellar congestion, cerebral edema, and diffuse brain atrophy (Figure 3C). The tongue showed hemorrhagic infiltrates on its left margin and basal surface, with multiple hemorrhagic foci on cross-section. Bilateral latero-cervical hemorrhages infiltrated soft tissues around vascular and neural structures, with associated thyroid cartilage fracture, hemorrhagic infiltration of the larynx, and perilaryngeal tissues (Figure 3D). No scleral or

visceral petechiae were documented at autopsy. The esophageal lumen contained liquid and coagulated blood in moderate quantity. A transverse sternal discontinuity corresponding to the III–IV intercostal space was identified with hemorrhagic infiltration. Multiple costal fractures were documented: right ribs I–III at the midclavicular line, right ribs I–II paravertebral, right ribs IV–VI at the anterior axillary line, left ribs II–VIII at the midclavicular line, and left rib I paravertebral, all with hemorrhagic infiltration. Given the reported attempt at external cardiac massage before the arrival of the medical crew, a possible resuscitation-related contribution to some of the anterior thoracic skeletal injuries cannot be entirely excluded. However, the overall distribution of the traumatic findings, including posterior/paravertebral and upper rib fractures and associated thoraco-abdominal injuries, was considered in the interpretation of the broader traumatic pattern. Pleuro-pulmonary discontinuity was identified, with associated pulmonary contusions, congestion, edema, and interscissural adhesions. Hemoperitoneum was quantified at approximately 700 mL of liquid blood and clots, accompanied by retroperitoneal and perirenal hematomas, diffuse mesenteric hemorrhage, and a pelvic hematoma. No single discrete source of the hemoperitoneum was identified in the available autopsy documentation. Hepatic congestion with subcapsular hematoma, renal congestion, bilateral pyelocaliceal hemorrhages, nephroangiosclerosis, and left renal cysts were also identified. Background pathology included hypertrophic cardiomyopathy and coronary sclerosis.

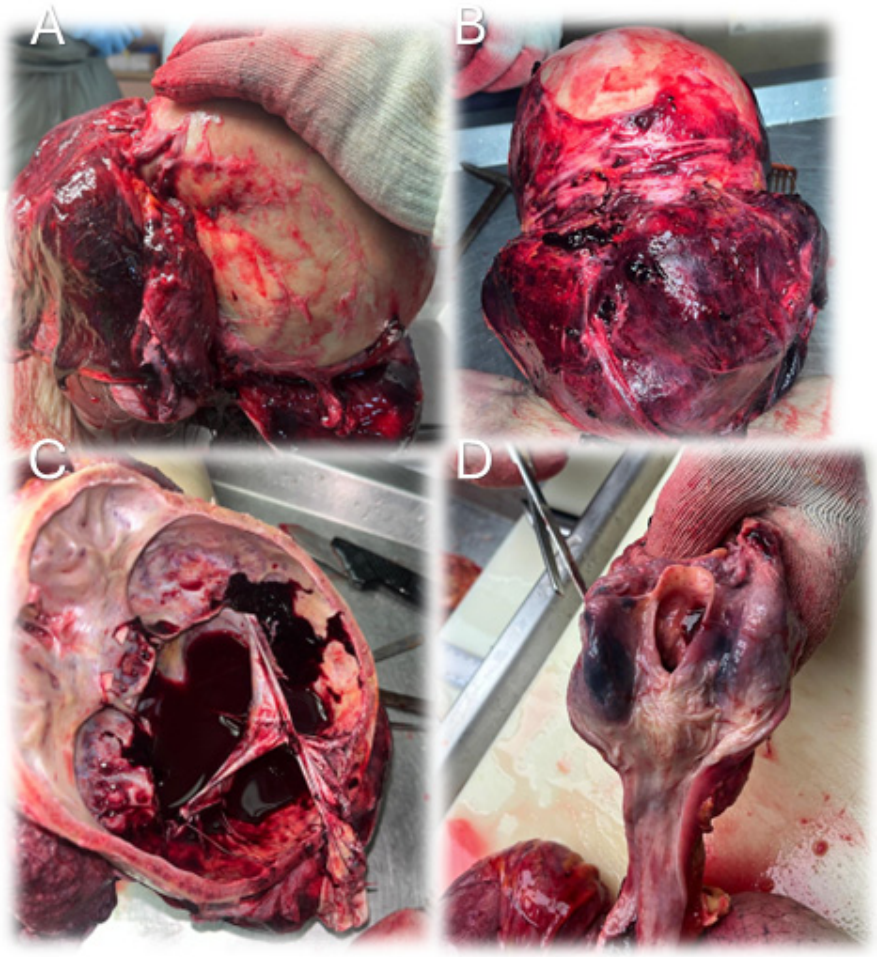


Figure 3. Internal traumatic findings in Case 3 (mixed-mechanism mechanical asphyxia associated with polytrauma). (**A**) Hemorrhagic infiltration of the left temporalis muscle. (**B**) Hemorrhagic infiltration of the anterior skin flap. (**C**) Basal subdural hematoma. (**D**) Extensive hemorrhagic infiltration of the laryngeal, pharyngeal, and perilaryngeal soft tissues, associated with thyroid cartilage fracture and cervical soft-tissue hemorrhages.

Histopathological examination confirmed cerebral congestion and edema with acute perivascular hemorrhagic infiltrates extending intraparenchymally with cortical-subcortical architectural disorganization, leptomeningeal hemorrhage, pulmonary congestion and edema with diffuse emphysema and focal pleuro-pulmonary discontinuity with adjacent hemorrhagic infiltrate, myocardial fibrolipomatosis with hypertrophy and coronary atherosclerosis, hepatic steatosis and dystrophy, acute tubular necrosis with pyelocaliceal hemorrhages, and diffuse hemorrhagic infiltrates of laryngeal, perilaryngeal, perithyroid, and mesenteric tissues, with these lesion-specific hemorrhagic infiltrates supporting the vitality of the corresponding traumatic injuries.

Toxicological screening was performed on blood and yielded negative results for benzodiazepines, barbiturates, phenothiazines, tricyclic antidepressants, and illicit substances including methamphetamine, THC, methadone, MDMA, opioids, and codeine. No ethanol was detected in the blood. Serological and DNA analysis of perivaginal, anal, and buccal secretions tested negative for seminal fluid by immunographic test. Y-chromosome DNA was amplified at very low concentrations (perivaginal ~2.06 pg, anal ~2.7 pg, buccal ~1 pg), insufficient to exclude external contamination, and therefore no definitive biological attribution was established. The certified forensic cause of death was violent death due to mechanical asphyxia by a mixed mechanism, namely manual strangulation combined with thoraco-abdominal compression, occurring in the context of assault-related polytrauma, in a victim with significant pre-existing organic pathology. The inferred instrumental mechanisms included repeated blows with hard objects, compression between hard planes, and manual compression with hands and fingers, consistent with the investigative findings. The manner of death was classified as homicide (matricide).

Forensic psychiatric evaluation revealed chronic psychosis. The psychological assessment confirmed schizophrenia spectrum disorder, with marked impairment in cognitive, social, behavioral, and affective domains, though adaptive participation in clinical interview and testing was achieved. The board diagnosed paranoid schizophrenia and concluded that discernment was absent at the time of the offense. The board further noted that discontinuation of antipsychotic treatment shortly before the offense, combined with the emergence of persecutory delusions (including the belief that his mother had been replaced) and insomnia, represented the acute decompensation context in which the act occurred, directly bearing on the assessment of absent discernment. A medical safety measure was mandated in accordance with Article 110 of the Romanian Penal Code.

3.4. Case 4—Fatal Tracheo-Broncho-Pulmonary Blood Aspiration After Blunt Cranio-Facial Trauma

The victim was a woman in her 50s, found deceased at home in autumn. The perpetrator was her son, in his 20s. Investigative findings described a spontaneous conflict with financial motivation. His antecedents included a previously diagnosed schizotypal disorder, exaggerated attachment to his mother, interpersonal difficulties, episodes of verbal interpersonal aggression, and voluntary school dropout. At psychiatric admission following the offense, he was diagnosed with acute psychotic disorder with schizophrenic symptoms; at discharge, malingering and factitious presentation were considered, with elaborated delusional-like narratives with mystical and cosmogonic themes and lacunar amnesia regarding the violent episode. Scene investigation documented concealment of the body and evidence suggestive of attempted crime-scene cleaning. A blunt object identified at the scene showed biological traces consistent with its potential involvement in the assault.

External examination revealed multiple craniofacial traumatic lesions. The face and scalp displayed numerous excoriations, ecchymoses, and contused lacerations, along with bilateral bipalpebral hematomas and a right subconjunctival hemorrhage. A contused

laceration of the right parietal scalp was observed overlying a pale violaceous ecchymosis. A contused laceration of the upper lip was associated with underlying suffusion and avulsion of teeth 1.1 and 1.2. The right auricle was partially torn in its superior portion, showing a contused laceration with irregular hemorrhagically infiltrated margins affecting the cartilaginous tissue, extending into the retroauricular region. Composite traumatic lesions were visible across the face. Ecchymoses and excoriations were distributed across both upper limbs, including the arms, forearms, and dorsal and palmar surfaces of both hands, with contused lacerations on the right palm and left-hand fingers. Additional ecchymoses and excoriations were noted on both thighs, knees, and lower legs, reflecting multipolar blunt force impacts. Notably, the forensic examiner determined that selected traumatic lesions (including excoriations on the right forearm, right lower leg, and left lateral foot) predated the fatal assault by an estimated 4–7 days, suggesting a prior episode of violence.

Internal examination confirmed severe blunt craniofacial trauma (Figure 4A–C). Calvarial and skull base fractures included a fracture line of the left temporal squama extending into the anterior cranial fossa through the small wings of the sphenoid (Figure 4A,B). Subarachnoid hemorrhage was distributed over both parietal lobes and in the interhemispheric region (Figure 4C). Blood was found within the trachea, with pulmonary parenchymal evidence of aspiration in the left lower lobe (Figure 4D,E). Hemorrhagic infiltrate was present in the left posterior thoracic wall musculature. Complex viscerocranial fractures comprised comminuted fractures of the nasal bones, maxilla, and palatine bone, with adjacent hemorrhagic infiltration and a midline maxillary discontinuity at the intermaxillary suture. A fracture of the left second rib at the paravertebral line with associated hemorrhagic infiltration was also documented. Background pathology included myocardial fibrosis, coronary atherosclerosis, aortic atheromatosis, hepatic steatosis, renal stasis, and nephroangiosclerosis. The stomach contained a moderate quantity of blood-tinged content.

Histopathological examination confirmed cerebral and meningeal congestion and edema, brainstem congestion and edema, pulmonary congestion and edema with diffuse emphysema and bronchioloalveolar hemorrhagic aspirate, myocardial fibrosis with coronary atherosclerosis, hepatic congestion and dystrophy, pancreatic autolysis, renal tubular necrosis, and minimal splenic congestion.

Toxicological testing of the victim was limited to blood ethanol determination, which yielded a negative result. No expanded toxicological screening for other substances was performed. Serological pretesting of vaginal and anal secretions was negative for seminal fluid. Y-chromosome DNA amplification yielded no male DNA, confirming the absence of male biological material from both vaginal and anal samples. The certified forensic cause of death was violent death due to acute respiratory failure caused by tracheo-bronchopulmonary blood aspiration, secondary to blunt cranio-maxillofacial trauma with complex fractures of the maxilla, palatine, and nasal bones. The instrumental mechanism was inferred as repeated blows with a hard object; investigative data suggested a hard blunt object as the likely implement. The manner of death was classified as homicide (matricide).

Forensic psychiatric evaluation described a mixed personality disorder with schizotypal and dissocial traits, complicated by simulation. The board determined that discernment was present at the time of the offense. The board noted that the perpetrator's post-offense psychiatric presentation, characterized by elaborated pseudo-delusional narratives with mystical and cosmogonic themes, lacunar amnesia regarding the violent episode, and inconsistencies between claimed symptoms and observed behavior, was consistent with simulation and factitious disorder rather than genuine psychotic decompensation.



Figure 4. Internal traumatic findings in Case 4 (fatal tracheo-broncho-pulmonary blood aspiration following blunt cranio-facial trauma). (**A**) Fracture line on the left temporal squama. (**B**) Fracture line extending from the left temporal squama to the anterior cranial fossa through the lesser wings of the sphenoid bone. (**C**) Interhemispheric and bilateral parietal subarachnoid hemorrhage. (**D**) Presence of blood within the tracheal lumen. (**E**) Pulmonary parenchymal foci of blood aspiration, predominantly involving the left lower lobe.

To facilitate cross-case comparison, Table 1 summarizes the key forensic, toxicological, histopathological, and psychiatric variables across all four cases. While all victims were adult women killed by their sons in domestic settings, the cases differ substantially in injury mechanism, cause of death, psychiatric profile of the perpetrator, scene findings, and legal outcome—reflecting the heterogeneity that characterizes matricide even within a small forensic series.

Table 1. Comparative overview of the four matricide cases.

Variable	Case 1	Case 2	Case 3	Case 4
Victim	Woman in her 50s	Woman in her 60s	Woman in her 70s	Woman in her 50s
Perpetrator (age)	Son in his 30s	Son in his 30s	Son in his 50s	Son in his 20s
Contextual/clinical features	Financial dispute	Financial conflict; history of antisocial behavior	Acute psychotic relapse (schizophrenia, treatment stopped)	Financial conflict; schizotypal traits, malingering
Main injury pattern	Sharp-force trauma; cranio-cerebral chop wounds; C2–C3 transection; defense wounds on hands	Complex open cranio-maxillofacial trauma; brain exposure; blunt + sharp elements	Mixed-mechanism asphyxia (manual strangulation + thoraco-abdominal compression); multiple trauma	Blunt cranio-maxillofacial trauma; blood aspiration; fractures of max-illa/palate/nasal bones

Table 1. *Cont.*

Variable	Case 1	Case 2	Case 3	Case 4
Cause of death	Exsanguination + catastrophic cranio-cervical trauma	Contusion–laceration and cerebral hemorrhage from open cranio-facial fractures	Mechanical asphyxia + polytrauma	Acute respiratory failure by tracheo-broncho-pulmonary blood aspiration
Defensive injuries	Present (complex bilateral hand trauma)	Ecchymoses and excoriations on the forearms, especially on the left posterior forearm	Multiple ecchymoses on the arms, forearms, and dorsal surfaces of both hands; some upper-limb injuries may also be compatible with gripping or restraint	Ecchymoses and excoriation on arms, forearms and dorsal and palmar surfaces of both hands; contused lacerations on the right palm and left-hand fingers
Psychiatric findings (perpetrator)	Dissocial personality disorder; discernment present	Severe psychopathy + substance abuse; discernment present; safety measures required	Paranoid schizophrenia; discernment absent; safety measure	Mixed personality disorder (schizotypal + dissocial); malingering; discernment present
Manner of death	Homicide (matricide)	Homicide (matricide) in the context of a double familial homicide	Homicide (matricide)	Homicide (matricide)
Scene findings	Indoor, at home; body found at the scene; no concealment documented	Indoor, at home; body found on the hallway floor in a pool of blood; no concealment documented	Indoor, at home; body found supine on the floor in cardiorespiratory arrest; perpetrator present at the scene	Indoor, at home; body concealed within the residence; evidence of attempted crime-scene cleaning
Victim toxicology	No ethanol detected	Negative for ethanol and screened psychoactive substances	Negative for ethanol and all screened substances	No ethanol detected
Weapon/instrument	Sharp and/or sharp-chopping instrument; hands	Hard-edged blunt object; sharp instrument consistent with knife; compression between hard planes	Hands and fingers (manual strangulation + thoraco-abdominal compression); hard blunt objects	Hard blunt object; hands
Histopathology summary	Cerebral congestion/edema, leptomeningeal hemorrhage, spinal cord edema, pulmonary blood aspiration, periadventitial hemorrhagic infiltration supporting antemortem cervical vascular injury	Cerebral edema with hemorrhagic infiltrates, brainstem edema, pulmonary edema with aspiration, hepatic dystrophy, renal tubular necrosis	Cerebral congestion, cortical-subcortical disorganization, leptomeningeal hemorrhage, pulmonary emphysema, laryngeal/perilaryngeal hemorrhage supporting vital neck compression	Cerebral and meningeal congestion/edema, pulmonary emphysema with bronchioloalveolar hemorrhagic aspirate, pancreatic autolysis, renal tubular necrosis

Table 1. *Cont.*

Variable	Case 1	Case 2	Case 3	Case 4
Chronological sequence	Intrafamilial conflict → fatal assault → forensic investigation → psychiatric evaluation	Behavioral disturbances → intrafamilial conflict → fatal assault → forensic investigation → psychiatric evaluation	Treatment discontinuation and psychotic relapse documented before the offense → fatal assault → forensic investigation → psychiatric evaluation	Behavioral disturbances → intrafamilial conflict → fatal assault → forensic investigation → psychiatric evaluation

4. Discussion

Across the four cases presented, cranio-facial targeting emerged as the dominant anatomical pattern of lethal injury, consistent with findings in the broader intrafamilial homicide literature [13]. Despite this shared topography, the mechanisms of injury and resulting causes of death were markedly heterogeneous. In Case 1, a sharp-force assault with a chopping instrument produced catastrophic cranio-cervical destruction, culminating in complete spinal cord transection at C2–C3, a mechanism combining exsanguination with neurogenic and respiratory failure that represents one of the most severe injury complexes documentable at forensic autopsy. The co-occurrence of chopped cranio-cerebral wounds and deep cervical transection reflects a pattern consistent with escalating assault dynamics, in which blunt and sharp force are applied sequentially or simultaneously, as described in retrospective sharp-force homicide series [14]. In Cases 2 and 4, repeated blunt impacts with hard objects produced complex cranio-maxillofacial fracture patterns with viscerocranial involvement and subarachnoid hemorrhage, with blood aspiration documented in both cases but constituting the direct fatal mechanism only in Case 4. In Case 3, the fatal mechanism shifted entirely to asphyxia by manual strangulation combined with thoraco-abdominal compression, with thyroid cartilage fracture, bilateral latero-cervical hemorrhages, and hemoperitoneum, reflecting the extraordinary physical force applied across multiple body regions. Across the four cases, the traumatic findings were characterized by multiple, extensive, and, in several instances, multi-regional injuries. The anatomical distribution and severity of these injuries differed between cases, reflecting the heterogeneity of the mechanisms involved. Although such extensive injury patterns have sometimes been discussed in the forensic literature using the concept of 'overkill' [15–17], definitions and operational criteria for this term vary across studies. Therefore, given the descriptive nature and limited size of the present case series, we considered it more appropriate to characterize the observed injuries descriptively rather than classify them as overkill or infer specific emotional or behavioral states from the injury patterns alone. Upper-limb injuries potentially compatible with defensive activity were documented across the cases; such injury patterns have been described in the forensic literature in association with defensive activity [14], although their precise mechanism cannot always be established from anatomical distribution alone. No ethanol was detected in any of the four victims. Toxicological testing of the perpetrators was not systematically performed across all cases. In Case 2, toxicological screening of the perpetrator was performed on blood and urine samples and yielded negative results for the substances included in the respective analytical panels. As comparable toxicological data were not available for all four perpetrators, no general inference regarding their toxicological status at the time of the offenses can be made.

The four causes of death identified in this series—exsanguination with neurogenic failure (Case 1), cerebral contusion-hemorrhage (Case 2), mechanical asphyxia by mixed

mechanism (Case 3), and acute respiratory failure from tracheo-broncho-pulmonary blood aspiration (Case 4)—illustrate the mechanistic diversity that can characterize matricide even within a small case series. In Case 1, the combination of massive external hemorrhage from transected major cervical vessels and complete spinal cord disruption at C2–C3 represents a dual lethal pathway, with venous wall discontinuity and periadventitial hemorrhagic infiltration providing lesion-specific histopathological support for the vitality of the cervical injury, underscoring the forensic value of vascular histopathology in sharp-force deaths. In Case 2, moderate blood aspiration represented an associated finding rather than the primary fatal mechanism, which was cerebral contusion–laceration and hemorrhage secondary to open complex cranio-maxillofacial trauma. By contrast, in Case 4, acute respiratory failure caused by tracheo-broncho-pulmonary blood aspiration constituted the direct cause of death. In Case 3, the mixed asphyxial mechanism was supported by the overall pattern of findings, including thyroid cartilage fracture, bilateral latero-cervical hemorrhagic infiltration, tongue hemorrhages, sternal and costal fractures, and hemoperitoneum. The reported attempt at external cardiac massage was also considered when interpreting the thoracic skeletal injuries. Although a resuscitation-related contribution to some anterior sternal or costal injuries cannot be entirely excluded, the broader distribution of fractures and associated thoraco-abdominal traumatic findings was not considered attributable to chest compressions alone. Thyroid cartilage fracture, documented in approximately half of homicidal throttling cases, represents one of the most reliable internal indicators of lethal neck compression, particularly in older victims [18]. Histopathological examination documented both non-specific systemic findings, including cerebral and pulmonary congestion, edema, emphysema, and hypoxic changes, and more lesion-specific traumatic findings. In particular, hemorrhagic tissue infiltration at injured sites provided histopathological support for the vitality of selected traumatic lesions. Scene evidence was especially decisive in Case 4, where body concealment, evidence associated with a suspected blunt instrument, and attempted crime-scene cleaning documented post-offense behavior and directly informed forensic reconstruction [12].

The psychiatric heterogeneity across the four perpetrators in this series reflects the broad spectrum of mental disorders associated with parricide in the literature. Three perpetrators (Cases 1, 2, and 4) were diagnosed with personality disorders (dissocial personality disorder in Cases 1 and 2 and a mixed schizotypal–dissocial personality disorder in Case 4), all with preserved discernment at the time of the offense. Previous studies of forensic populations have reported associations between antisocial or dissocial personality pathology and violent behavior, particularly in the presence of additional contextual and clinical factors [5,19]. However, such associations should not be interpreted as indicating that personality disorder alone is predictive of violence. Similar evaluations in forensic cohorts emphasize the complex distinction between major psychotic disorders and severe personality pathology in determining criminal responsibility [20]. In the Romanian forensic context specifically, personality dimensions including psychoticism, addiction, and criminality have been identified as significant predictors of violent crime [6], while the co-occurrence of alcohol abuse and personality disorders has been documented as a particularly potent catalyst for homicidal behavior in forensic psychiatric samples [21]. Financial conflict was documented as a contextual feature in three of the four cases, consistent with previous reports describing financial and broader intrafamilial conflicts in parricide and matricide [1,3]. Given the descriptive nature of the present series, however, its causal or precipitating role cannot be established.

Case 3 stands apart as the only case involving psychotic illness, paranoid schizophrenia with absent discernment, where treatment discontinuation preceded a period of psychotic decompensation characterized by persecutory delusions, in the context of which the fatal

assault occurred. This clinical sequence is consistent with the literature describing treatment adherence and continuity of psychiatric follow-up as relevant considerations in the management of schizophrenia, particularly in the presence of active psychotic symptoms and family conflict [7,19]. Recent evidence suggests that delusional misidentification syndromes, particularly Capgras syndrome, have been repeatedly described in association with severe interpersonal violence, often involving close family members. Although uncommon, these syndromes may contribute to violent behavior through impaired affective recognition and persecutory interpretations of familiar individuals, providing additional context for understanding the psychopathological mechanisms underlying intrafamilial homicide [22]. Beyond psychotic symptoms, recent evidence indicates that cognitive dysfunction may also contribute to violent behavior in schizophrenia spectrum disorders. Impairments in executive functioning, social cognition, emotional processing, and impulse control have been associated with an increased risk of interpersonal violence, particularly when combined with active psychotic symptoms and poor treatment adherence. Although cognitive functioning was not formally assessed in the present case, these findings provide an additional neuropsychiatric framework for understanding the behavioral dysregulation observed during acute psychotic decompensation [23]. Together, these findings reinforce the view that severe interpersonal violence in schizophrenia arises from the interaction of psychopathology, cognitive dysfunction, impaired insight, and treatment discontinuation rather than from psychotic illness alone. This multifactorial interpretation is further supported by neurobiological evidence demonstrating structural abnormalities within corticolimbic networks involved in emotional regulation, impulse control, threat perception, and social cognition among violent individuals with schizophrenia. Although neuroimaging data were unavailable in the present case, these findings provide a plausible neuroanatomical framework for understanding the behavioral dysregulation observed during acute psychotic decompensation [24]. Extreme presentations of matricide, including cases complicated by post-mortem mutilation or pathological cannibalism, further illustrate the heterogeneity of psychopathological mechanisms underlying this rare crime [25].

Where employed, MCMI-III psychological testing provided structured personality profiling that contributed to the broader forensic psychiatric assessment of personality functioning and criminal responsibility, alongside clinical interview and other available clinical information. This approach is consistent with contemporary forensic psychiatric practice, which recommends integrating standardized psychometric instruments with comprehensive clinical interviews, collateral information, and behavioral analysis when evaluating criminal responsibility and discernment in complex homicide cases. Such a multidisciplinary approach enhances the reliability of forensic psychiatric opinions and contributes to a more comprehensive medico-legal reconstruction of the offense [26,27].

Case 3 represents the only instance in this series involving psychotic illness and absent discernment, a distinction with profound legal consequences under Romanian criminal law. The perpetrator's paranoid schizophrenia, together with the documented psychotic decompensation and persecutory delusional symptoms surrounding the offense, formed the clinical context considered in the forensic psychiatric assessment that concluded that discernment was absent at the time of the offense. Previous reports have described treatment discontinuation and subsequent psychotic decompensation among the clinical circumstances observed in some matricide cases involving schizophrenia [7]. Under Romanian criminal law, the absence of discernment due to a mental disorder may exclude criminal responsibility, whereas preserved discernment entails retained criminal responsibility. Medical security measures are legally distinct from the determination of criminal responsibility and may also be imposed on individuals with preserved discernment when the applicable statutory conditions are met. Article 109 of the Romanian Penal Code provides

for compulsory medical treatment, whereas Article 110 provides for compulsory medical hospitalization. In the present series, Case 3, characterized by absent discernment, was subject to a medical security measure under Article 110. By contrast, discernment was preserved in Cases 1, 2, and 4; notably, in Case 2, compulsory psychiatric treatment under Article 109(1) was recommended despite preserved discernment. This contrast within a single case series underscores the critical importance of rigorous forensic psychiatric evaluation in matricide cases, where the boundary between absent and preserved discernment directly determines legal outcome [1,10]. This observation is consistent with contemporary forensic psychiatric practice, which emphasizes that assessments of criminal responsibility should integrate clinical evaluation, structured psychometric testing, collateral information, and behavioral reconstruction to ensure robust medico-legal decision-making in complex homicide cases [26].

Response distortion and malingering represented important considerations in the forensic psychiatric assessment of the presented cases. In Case 2, the perpetrator claimed self-defense despite crime scene and autopsy evidence to the contrary, while in Case 4, an elaborate post-offense psychiatric presentation was ultimately classified as factitious disorder rather than genuine psychosis. These findings highlight the complexity of interpreting self-reported accounts and psychiatric symptom presentation in forensic settings. Where employed, the MCMI-III provided structured psychometric information regarding personality functioning and response validity, complementing the broader forensic psychiatric assessment, while acknowledging its known limitations in detecting deliberate response distortion in forensic populations. Criminal defendants may distort their symptom presentation in either direction, minimizing or exaggerating psychopathology, depending on the anticipated forensic consequences, making structured psychometric assessment alongside clinical interview valuable in forensic psychiatric evaluation. The MCMI-III has specifically been examined for its capacity to detect such response distortion, including dissimulation, in forensic populations [28].

The findings of this series align with and extend the existing literature on matricide and other forms of intrafamilial homicide. A similarly integrated approach has recently been advocated in the investigation of other forms of intrafamilial homicide, including paternal filicide, where the combination of forensic pathology, forensic psychiatric evaluation, behavioral reconstruction, and medico-legal analysis provided a more comprehensive understanding of offender psychopathology, criminal responsibility, and the contextual factors underlying lethal family violence. Our findings are consistent with this multidisciplinary model, suggesting that the interpretation of matricide benefits from the integration of autopsy findings with psychiatric assessment and behavioral evidence rather than reliance on isolated forensic or psychiatric observations [27]. The characteristics observed in our four cases share several features with those reported in international studies of matricide, particularly the predominance of adult male perpetrators and the frequent presence of psychiatric disorders or other psychopathological features. Similar patterns have been described across different countries and socio-legal contexts, suggesting that the characteristics observed in our cases should be interpreted within a broader cross-national framework rather than solely within the Romanian context [1,2,8]. The predominance of cranio-facial trauma across our cases further mirrors patterns documented in retrospective intrafamilial homicide studies, where parricides (predominantly matricides) represent a forensically distinct subgroup with specific criminological risk profiles [8,13].

From a broader clinical and forensic perspective, the four cases illustrate several contextual and psychiatric features: psychiatric illness and treatment discontinuation (Case 3), persistent financial conflict within cohabiting family units (Cases 1, 2, 4), and personality traits accompanied by histories of interpersonal aggression (Cases 2, 4). The observation

that ambivalent and conflictive mother–son relationships co-occurred with psychotic decompensation or personality pathology in some of the presented cases is consistent with factors previously discussed in the literature on intrafamilial violence [5,7]. However, personality disorder alone should not be regarded as inherently predictive of violent behavior, and the present cases do not permit causal attribution of homicidal violence to personality pathology. Recent systematic reviews further support the integration of structured violence risk assessment into routine forensic psychiatric practice, emphasizing that standardized assessment instruments should complement comprehensive clinical judgment and collateral information when identifying individuals at risk of serious interpersonal violence. Such approaches may improve early recognition of high-risk patients and facilitate timely preventive interventions before lethal family violence occurs [29,30]. Although early identification and multidisciplinary assessment of relevant clinical, familial, and social factors may have a role in violence risk assessment, the predictive or preventive relevance of the features observed in the present cases cannot be established from this small descriptive series and requires evaluation in larger populations [31].

A major strength of this study is the integrated analysis of forensic pathological, crime-scene, toxicological, histopathological, and forensic psychiatric findings across four matricide cases, allowing the circumstances, mechanisms of death, and psychiatric characteristics of the perpetrators to be examined within a unified medico-legal framework. The principal limitation is the small number of cases, reflecting the rarity of matricide. In addition, certain case-specific circumstantial information was intentionally generalized or omitted to ensure adequate anonymization and minimize the possibility of identification, thereby limiting the level of detail that could be reported. Consequently, the findings should be interpreted as descriptive observations rather than generalizable epidemiological conclusions.

5. Conclusions

Although all four cases involved adult males killing their mothers in domestic settings, the forensic and psychiatric profiles were markedly heterogeneous. Fatal mechanisms ranged from sharp-force cranio-cervical destruction with complete C2–C3 transection to complex blunt cranio-maxillofacial trauma with cerebral contusion–laceration and hemorrhage, mixed-mechanism mechanical asphyxia by manual strangulation and thoraco-abdominal compression, and acute respiratory failure caused by tracheo-bronchopulmonary blood aspiration. Cranio-facial targeting predominated across all cases, while financial conflict represented the most frequently documented contextual factor. From a psychiatric perspective, three perpetrators presented personality disorders with preserved discernment, whereas one case involved paranoid schizophrenia with acute psychotic decompensation after treatment discontinuation and absent discernment. Simulation or deceptive behaviors were documented in two perpetrators, emphasizing the importance of comprehensive forensic psychiatric evaluation. Collectively, these cases illustrate the substantial medico-legal heterogeneity of matricide and highlight the need for integrated forensic pathology and psychiatric assessment in determining mechanism of death, criminal responsibility, and post-offense behavioral interpretation. Given the limited number of cases, these observations should be interpreted descriptively and should not be considered evidence of causal or predictive relationships.

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Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and the Romanian legal framework governing medico-legal activities, specifically Government Ordinance No. 1/2000 on the organization and functioning of forensic medicine institutions, approved by Law No. 459/2001. Ethical approval was obtained from the Ethics Committee of the "Iuliu Haţieganu" University of Medicine and Pharmacy, Cluj-Napoca, Romania (Approval No. AVZ379/19.12.2025; approved on 19 December 2025). This retrospective study was based on forensic case records, autopsy reports, histopathological examinations, toxicological analyses, and forensic psychiatric evaluations. All direct personal identifiers were removed, and potentially identifying case-specific information was generalized or omitted to minimize the risk of identification.

Informed Consent Statement: Informed consent was waived due to the retrospective nature of the study, which analyzed anonymized medico-legal records from fatal cases. The study involved no direct contact with participants for research purposes, and all data were processed in accordance with the approval of the Ethics Committee and applicable legal and ethical requirements.

Data Availability Statement: The data presented in this study are not publicly available due to legal, ethical, and privacy restrictions governing forensic medico-legal records. De-identified data may be made available by the corresponding author upon reasonable request, subject to approval by the Institute of Forensic Medicine Cluj-Napoca and compliance with applicable legal and ethical requirements.

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