

FILED
Court of Appeals
Division II
State of Washington
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IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION II

IN RE THE RESTRAINT OF
LEON REYES,

Petitioner.

NO. 52449-0

STATE'S RESPONSE TO PERSONAL
RESTRAINT PETITION

I. ISSUES PERTAINING TO PERSONAL RESTRAINT PETITION:

1. Has petitioner presented newly discovered evidence?

II. STATUS OF PETITIONER:

Petitioner, Leon Reyes, is restrained pursuant to a Judgment and Sentence
(Appendix 1-12) entered in Pierce County Cause No. 06-1-00890-3 on March 30, 2007.¹

III. FACTS

Petitioner was convicted of homicide by abuse. Appendix at 3. Prior to killing [Haydon K.], petitioner “engaged in a pattern or practice of assault or torture of Haydon [Haydon K.]” Jury Instruction 12, Appendix 45. The investigation of this crime began when Tacoma police officers responded to 8833 Yakima Avenue, Tacoma on February 20, 2006 at 9:11² to a report of a “child who was choking.” 9 VRP 660. Petitioner was on the ground over top of Haydon K.,³ “rocking back and forth, saying the child was not

¹ The jury also found defendant guilty of murder in the second degree and homicide by abuse, but defendant was not sentenced on the murder charge because of double jeopardy concerns. 17 VRP 4-5 (State’s recommendation, adopted by the sentencing court in the judgment and sentence).

² 9 VRP 675.

³ Officer Vause refers to Haydon as the child underneath petitioner. 9 VRP 662, 663, 670, 675.

breathing.” *Id.* Officer Vause and her partner, Officer O’Keefe cleared Haydon’s airway of vomit and Haydon “finally took a breath” after not a long time. *Id.* After unsuccessful treatment, Haydon died on February 22, 2006. 7 VRP 321.

A. UNEXPLAINED BRUISING APPEARED ON HAYDON
AFTER HAYDON STARTED LIVING WITH PETITIONER.

Haydon K. was born on September 15, 2003. 7 VRP 385. Patty Richards, Haydon’s surrogate grandmother,⁴ was with Haydon pretty much at least one day every weekend. 7 VRP 386. When Haydon was about a year and a half old (about March, 2005), Haydon’s mother started a relationship with petitioner.⁵ 7 VRP 388. Some time after that, Haydon’s mother moved in with petitioner. 7 VRP 388. After that, Ms. Richards had Haydon at her house for about two weekends a month. 6 VRP 392. Before petitioner moved in with Haydon’s mother, Ms. Richards noticed no bruises or injuries other than what a little year and a half old would normally have. 7 VRP 392. When Haydon was about a year and a half old, Ms. Richards saw a bruise to Haydon’s nose—it was just black and blue, and it just seemed like an odd place to have a bruise. 7 VRP 393.

Haydon’s mother worked. 7 VRP 456-57. She testified that Haydon stopped going to day care in about mid-2005. 7 VRP 456. Haydon’s mother testified that when she was at work petitioner took care of Haydon and the other children in the house. 7 VRP 458.

B. PETITIONER IMPLAUSIBLY EXPLAINED HAYDON’S LIMP.

In April, 2005,⁶ Ms. Richards noticed Haydon’s leg. “It wasn’t a bruise. He had been limping and [Ms. Richards and presumably Haydon’s grandfather] asked what was

⁴ Ms. Richards was Haydon’s grandfather’s girlfriend. 6 VRP 386. She was present at Haydon’s birth. *Id.* Ms. Richards had a strong emotional bond with Haydon. 7 VRP 388-90.

⁵ Haydon’s mother testified that she met petitioner in November 2004 and that they moved in together about a month after that. 7 VRP 454-55. That would be about December 2004. *Id.*

⁶ 7 VRP 394.

wrong.” 7 VRP 393. They were told that petitioner “had been carrying him, and bent over and got his foot stuck in between his leg somehow, and that was because Haydon limped for . . . about a week and a half.”⁷ 7 VRP 394.

Linda Merritt, the owner of Haydon’s day care, testified that she couldn’t recall the exact month (maybe January), but she recorded that Haydon came to her facility limping.

8 VRP 626. Ms. Merritt documented this injury:

Yes, because it was a concern of mine that I've never seen an 18-month-old child, who was very pliable, with a sprained ankle; and I've done this a lot of years, and I've never seen a toddler with a sprained ankle that – it went on for a week or more.

8 VRP 626.

Haydon’s mother testified that she witnessed Haydon’s injury. 8 VRP 565.

However, on the night Haydon was taken to the hospital, Haydon’s mother clearly stated that she was inside the store when Haydon was injured. 9 VRP 663.

C. PETITIONER (THE SOLE WITNESS) ATTRIBUTES
HAYDON’S BRUISES TO A “FALL” INTO THE TOILET.

In January, 2005, Ms. Richards observed that Haydon had a bruise on his back and bruises on the back of his legs. 7 VRP 401. Haydon also had a bruise on his forehead. 7 VRP 402. Ms. Richards was told by Haydon’s mother⁸ that petitioner told her that Haydon had been sitting on the toilet, going to the bathroom, and that petitioner had forgotten about him. *Id.* Ms. Richards was told that when petitioner remembered, he went in and startled Haydon and Haydon woke up and had kind of fallen in the toilet. *Id.* Haydon’s mother testified that petitioner was at home watching Haydon when the “fall asleep on the toilet”

⁷ Petitioner told a consistent story to a CPS worker. 7 VRP 374.

⁸ 7 VRP 402.

incident happened. 7 VRP 471. Petitioner's mother said that Haydon "had hit his head on the back of the seat of the toilet." 7 VRP 472.

D. PETITIONER INFLICTED HARSH POTTY TRAINING UPON HAYDON AND WAS ANGERED BY HAYDON FAILURE TO PERFORM AS PETITIONER EXPECTED.

Boyd Kostelecky, Ms. Richards' boyfriend and Haydon's grandfather, testified about Haydon's potty training. 7 VRP 434-35. Petitioner was involved in Haydon's potty training.⁹ 7 VRP 434. Haydon went from being happy when being potty trained, to becoming afraid of the toilet:

Well, when Patty would try to put him back on the toilet at her house, he would literally start bawling and crying, and I'd have to go up there and say, just, no. He was afraid of it.

7 VRP 435. Haydon's mother testified that Haydon regressed during the course of his potty training and that this made petitioner angry. 7 VRP 466-67. Sarah Birnel was the sister of petitioner's first wife. 8 VRP 531. She testified that she lived next door to petitioner and Haydon's mother. 8 VRP 531-32. Ms. Birnel saw the kids "probably every day." 8 VRP 532. Ms. Birnel saw Haydon's potty training. 8 VRP 533-34. About two or three times, Ms. Birnel saw Haydon having to sit on the toilet for "10 to 20 minutes." 8 VRP 533-34. Ms. Birnel noted that Haydon would try to move on the toilet, but he wouldn't try to get off the toilet. 8 VRP 534. Charlene Birnel, petitioner's ex-wife and Sarah Birnel's sister, also testified that petitioner had Haydon sitting backwards on the toilet for "about 20 minutes or more." Charlene Birnel testified that she told petitioner it was too long, and she didn't understand why he sat backwards. 8 VRP 546. Charlene Birnel testified that petitioner told her it was not her business. 8 VRP 546.

⁹ Petitioner's involvement in Haydon's potty training was corroborated by Haydon's mother. 7 VRP 466.

After Haydon had been taken to the hospital, Haydon's mother told Detective Graham that Haydon was being potty trained. 9 VRP 703. Haydon had regressed in his potty training. *Id.* Haydon's mother said that defendant used to tell Haydon that he had to "grow up" when Haydon had an accident. 9 VRP 704. Petitioner did not like it when Haydon had accidents. *Id.* Haydon had had a lot of accidents during the week prior to his death. *Id.* Haydon's mother noted that Haydon had been experiencing diarrhea. *Id.*

Detective Graham testified:

Well, she explained that she knew it was a natural thing, that it was going to happen because he had been having diarrhea, but that the defendant was upset about it. He didn't like the fact that he was having these accidents and that they were diarrhea.

9 VRP 705. Haydon's mother told Detective Graham that she believed that Haydon was afraid of the defendant. 9 VRP 708. Haydon's mother unambiguously stated that petitioner was never permitted to physically discipline Haydon K. 8 VRP 590-91.

E. PETITIONER MADE INCONSISTENT STATEMENTS
ACCOUNTING FOR HAYDON'S BROKEN ARM.

On June 5, 2005, Haydon was taken to Dr. Victoria Silas by his mother because his elbow was hurting. 6 VRP 267. Dr. Silas determined that Haydon's elbow had been broken. 6 VRP 268.

Sarah Birnel asked petitioner about Haydon's broken arm:

Q [Prosecutor] Just one question I forgot to ask. Did you ever see Haydon in a cast?

A Yes.

Q Did you ever talk to the defendant about what happened to his arm?

A Um, yeah. He said, um, Haydon was choking, and so he picked him up, and somehow his arm got bent. And then the next thing I knew, they said day care did it.

Q Do you remember, like, when it was the defendant made that comment to you? Like, was it a few days before they said day care did it, or was it the day before; any time frame of when you can put that statement?

A Laura found his arm -- he wasn't moving his arm on the porch, and then they went to the hospital, and then they said day care did it. And then later, a couple days later, Leon said he might have did it when Haydon was choking and he bent his arm.

Q And was Laura there when he made that statement to you, the defendant made that statement to you?

A Yes.

8 VRP 542.

A child protective services worker, Julie Johnson, testified that she asked petitioner about the injury. 7 VRP 372. Defendant said:

That they had initially believed that the injury occurred at day care, but were later told that the injury was possibly --or likely to be caused from a fall, so they were less concerned.

Id. Ms. Johnson testified that defendant made no statement “about maybe he may have caused the injury while trying to help Haydon.” *Id.* Ms. Johnson testified that defendant told her that he did not discipline Haydon in the home. 7 VRP 373-74.

Charlene Birnel asked petitioner (her ex-husband) about Haydon’s arm:

He just told me that Haydon was choking and he was trying to help him and he had him bent some way and he either bent down or hit his arm, and that's how it broke because he was just choking, and he was trying to help him.

8 VRP 547.

Haydon’s mother testified that she believed that the broken arm occurred at the day care because Haydon’s “arm was fine when I dropped him off and he was favoring it after I picked him up.” 8 VRP 550. She told the same story to investigating officers on the day Haydon was taken to the hospital. 9 VRP 662-63.

Linda Merritt, Haydon's day care provider testified that it never came to her attention that Haydon may have injured his arm at day care and there was no documentation of any such injury—where the day care people are trained to document such injuries. 8 VRP 627. Ms. Merritt recalled petitioner coming to the day care to get his boys on June 3. 8 VRP 628. Haydon had a cast on his arm. 8 VRP 629. Ms. Merritt expressed the reasons she was very concerned:

We were all very concerned because we had sent him to the doctor that morning after Laura had attempted to bring him in the morning, and we would not accept him -- same thing with the ankle -- until he was seen by a doctor. We didn't see Haydon or get a phone call until really late in the evening, Friday evening.

8 VRP 629. Ms. Merritt testified to the explanation petitioner provided to her about Haydon's broken elbow:

That the doctor said that it could have --it was an accident, I can't say how it happened, and -- but he stood by my desk and showed me how he was roughhousing with him, and that it could have happened when he slipped and he went to reach him and pick him up, because they were wrestling, roughhousing, but that it was an accident, the doctor claimed.

8 VRP 629. Ms. Merritt never saw Haydon after that date. 6 VRP 632.

Sophia Storaasli, the assistant director/office assistant at the day care testified that she remembered Haydon. 8 VRP 635. Ms. Storaasli stated that she closed that day, and was with Haydon at the end of the day and she did not notice anything that indicated that Haydon was not able to use his arm or that Haydon had injured his arm. 8 VRP 635. Haydon was the last child to leave that day. 8 VRP 636. Ms. Storaasli testified that she saw Haydon pull himself up onto a small table. 8 VRP 637. She stated that she "had to go lift him down and remind him, feet stay on the floor, and all that." *Id.* Ms. Storaasli testified that when she was there the next morning she saw Haydon had a cast on his arm.

8 VRP 638. Ms. Storaasli was present when defendant talked to Ms. Merritt. *Id.* She related what she heard petitioner say:

He said it could have happened -- something about last night it could have happened when we were playing, and he slipped, and I had to grab his arm to help him -- he actually had Haydon in his arms, so he was gesturing how it happened, how he grabbed his arm to help him from falling.

Id.

Katherine Miller, another person who worked at the day care, also recalled the morning of June 3:

Laura called the day care, and she asked if she could bring him in. And she asked -- she said that his arm was hurting him. And I explained to her that -- and she asked if anything had happened. [objection interposed and sustained]

She asked if she could bring him in. She did bring him that morning, even though, you know, I told her if he cannot do the day-to-day activities, then he could not participate. Well, she did bring him in.

8 VRP 649. Ms. Miller explained what happened after Haydon's mother brought him in:

He was really clingy, and his arm was just, like, limp. It was, like, laying there. And I just explained to her that I did not feel that he could participate; that she would need to take him to the doctor, and I would need a doctor's note to be able to let him back in.

8 VRP 649. Ms. Miller testified that Haydon's mother had told her that she had not taken Haydon to a doctor. *Id.* When told that she could not let him back in, Haydon's mother was mad. She said that she needed to go to work and that she needed to leave him. *Id.*

F. HAYDON APPEARED UNWELL AROUND NEW YEAR, 2006.

Around Christmas, 2005, Haydon's mother told Ms. Richards that Haydon was complaining that his head hurt and that Haydon had vomited. 7 VRP 405.

In early January, 2006 Ms. Storaasli saw Haydon briefly when Haydon's mother stopped by to visit with her new baby:

Q [Prosecutor] How did he appear to you?

A Kids grow, and he just -- he didn't look right. He looked really pale. His head was, like, really oddly shaped and -- I mean, kids grow into the shape of their head, but I had never seen a kid's head like that. He didn't look well.

Q And how was his behavior, if you can describe?

A He was quiet. His teacher, Gia, when she came in, he, like, seemed to remember her and kind of, you know, smiled and -- just very quiet. Haydon's so outgoing, so it was weird for me to see him so quiet and just kind of...(pause).

8 VRP 640.

G. PETITIONER IMPLAUSIBLY EXPLAINED HAYDON'S
AWFUL SCROTAL BRUISING.

On January 7,¹⁰ Ms. Richards noticed bruises in Haydon's scrotal area when she was giving Haydon a bath before bedtime. 7 VRP 402.

... And I had put him in the bathtub and noticed that his whole scrotum area was black and blue. And I had called Boyd, his grandfather, up to look because I was horrified that --to see this little boy with that black and blue. And we questioned Laura that night, and she said that Leon had told her that he had fallen, getting out of the shower. He had fallen on the track of the tub. So he had hit his scrotum on the door tracks. They had sliding doors on their bathroom.

Q [Prosecutor] Did you ask Laura to explain how Haydon would have fallen on the tracks if he's two years old and has to climb over it?

A We asked why he was getting out of the shower by himself. Because of his short, little legs he would have never been able to reach the floor without hurting himself. And she said, well, he was getting out by himself, so he must have fallen that way.

7 VRPP 403. The bruises were concerning to Ms. Richards: "Very much so. I've never -- I've never seen anybody that could be so black and blue." 7 VRP 404. Boyd Kostelecky also described those injuries:

¹⁰ 7 VRP 403-04. When Haydon's mother was at work, petitioner was responsible for potty training Haydon. 7 VRP 470-71.

Swollen, black and blue; worst I've ever seen. Been kicked there. And I immediately called my daughter and asked what happened.

7 VRP 433. Haydon's mother was not surprised, she knew about the injury. *Id.*

She had told me, every time I asked her a question, she'd reply, and I -- she said he tripped over --he was in a bathtub, and he fell out of the bathtub on the metal rail of the shower door.

Id. Mr. Kostelecky further related the conversation:

It was like he -- he was trying to get out of the bathtub, and he slipped on the rubber mats. You know, he's only so tall, and the tub is taller than his legs and his groin area.

7 VRP 434.

Haydon's mother told Detective Graham that petitioner told her Haydon had vomited and had to be put in the bathtub. 9 VRP 703. Haydon's mother testified that she learned this via a phone call at work where petitioner called her and told her that Haydon had hurt himself. 8 VRP 557. Haydon's mother described Haydon's bruise as "nickel" or "quarter" size. 8 VRP 558. The prosecutor had Haydon's mother describe how she had observed Haydon climb out of the shower previously. 8 VRP 558-560. The explanation is inconsistent with extensive scrotal bruising. *Id.* Haydon's mother didn't recall whether she took Haydon to the doctor following this incident.¹¹ 8 VRP at 560. Dr. Duralde examined Haydon's records. 6 VRP 241-42. Haydon was never taken to a doctor for bruises to his testicles or scrotal area. 6 VRP 242. Dr. Duralde, a pediatrician, testified that just coming into contact with a shower track would not have caused Haydon's bruising, but landing on it would. 6 VRP 243.

¹¹ A finder of fact could readily conclude that Haydon's mother was minimizing the seriousness of Haydon's scrotal injury. See her relation of the conversation between herself and her father. 8 VRP at 561.

H. PETITIONER IS THE SOLE SOURCE OF THE SUPPOSED
“BATHTUB” FALL A WEEK BEFORE HE DIED.

Petitioner told Haydon’s mother that Haydon had fallen in the bathtub the week before Haydon died. 8 VRP 562. Petitioner is the only source for this information.

I. HAYDON WAS UNWELL IN THE LEAD UP TO HIS DEATH
AND HE HAD THE TREAD MARKS OF A SHOE ON HIS
ABDOMEN.

Ms. Richards observed a cut on Haydon’s penis about a week before the incident. 7 VRP 404 (observation); 9 VRP 713 (timing). The cut appeared red, “but it didn’t look like it had been bleeding, and it never did bleed.” *Id.*

Haydon’s mother testified that in the week prior to Haydon’s death, Haydon’s head was hurt and he had thrown up a couple times. 8 VRP 574. Haydon also complained that his stomach was hurting. 8 VRP 575. Haydon was sick off and on in the two weeks before he died. 8 VRP 575. Haydon’s mother noted what she believed were tread patterns of a shoe on Haydon’s stomach, but she testified that couldn’t remember when she saw them. 8 VRP 576. On direct examination, Haydon’s mother testified that she thought it could have been perhaps a week or two before Haydon died. 8 VRP 577. On cross examination, she testified that it was approximately a week. 9 VRP 595. Haydon’s mother testified that she asked petitioner about it and he appeared shocked. 8 VRP 578. Haydon’s mother made a of what those shoe marks looked like. 8 VRP 579-580. It was admitted as Plaintiff’s Exhibit 2. Detective Graham seized the shoes petitioner was wearing at the time of his arrest. 9 VRP 714-15, 721. They were admitted into evidence as Plaintiff’s Exhibit 89. 9 VRP 715. A photograph of those shoes taken by Detective Graham was admitted as Plaintiff’s Exhibit 1. 9 VRP 715-16. The jury got to compare the drawing with the shoes and the picture. 9 VRP 714-17.

On February 19, 2005, Haydon complained to his mother that his stomach hurt and Haydon “was fussy that night.” 7 VRP 406. Ms. Richards went on a shopping trip with Haydon. *Id.* Haydon was “crying and cranky” and didn’t want to be with anyone but his mother (which was unusual).¹² 7 VRP 406. Unusually, Haydon drank very little when he was taken to Dairy Queen for a drink. 7 VRP 406. Haydon stayed at Ms. Richard’s home that night. 7 VRP 407-08. Ms. Richards describes Haydon’s very unusual behavior that evening. 7 VRP 407-410. Ms. Richards also noted that it seemed like Haydon’s stomach seemed a little larger than normal, but she “just thought maybe he was a little bloated.” 7 VRP 411-12. Ms. Richards was concerned and had Haydon sleep with her. 7 VRP 411.

The next morning, at breakfast, Haydon ate something, but less than Ms. Richards expected, and drank less than normal. 7 VRP 413. He had a little bit more energy than the day before, but not a lot. *Id.* Ms. Richards took Haydon home. 7 VRP 414. When she got back to the house Haydon “wanted to know where Daddy [petitioner]¹³ was. As soon as I got him out of the car, it's, Where's Daddy? Where's Daddy?” 7 VRP 414. Ms. Richards observed a faded bruise on Haydon’s forehead that night. 7 VRP 417.

Haydon’s mother told the first responding officers that Haydon had no known medical problems.¹⁴ 9 VRP 662-63. She told them about Haydon’s falling in the shower, that Haydon had thrown up in the shower, that Haydon had recently been vomiting. 9 VRP 677-79. Haydon’s mother later described Haydon’s condition to Det. Graham:

Well, she had said that he had been experiencing a little bit of fever, some diarrhea, some vomiting. Nothing constant, but off and on every day, every

¹² This was corroborated by Haydon’s mother. 7 VRP 460.

¹³ 4 VRP 4.4.

¹⁴ As noted above, Haydon’s mother also informed the investigating officers of Haydon’s prior “bruised or sore ankle” and his prior broken arm. 9 VRP 661-62.

other day. He had been experiencing some things that I recall she put it, he was just not himself.

9 VRP 701. Haydon's mother also told Detective Graham that Haydon had been complaining that his head was hurting "[a]lmost daily, or every other day. It had been going on for a few months." 9 VRP 703. She said that Haydon was also complaining that his stomach was hurting. *Id.*

J. PETITIONER WAS THE ONLY SOURCE OF THE FALL-FROM-THE-BUNK STORY, WHICH PETITIONER DID NOT WITNESS.

On February 20, 2006, at about 9:10 p.m., Tacoma Police Officer Betts responded to 8833 Yakima Avenue, Tacoma. 5 VRP 99. The dispatch to the responding officers in this case "said that a child had fallen from a bunk bed or from a bed." 5 VRP 99.

Officer Betts arrived to see two other officers providing first aid to a young child or infant on the living room floor. 5 VRP 100. The child did not "appear to be breathing or breathing correctly." *Id.* The child "was very distended, kind of swollen looking." 5 VRP 101. Petitioner was the only adult present in the house. 5 VRP 101-02. Officer Betts, trying to get information to aid the medics when they arrived, talked with Petitioner:

Mr. Reyes said that they just had dinner, the family had just had dinner, and that the three boys had been in the bedroom playing while he was in the kitchen doing some dishes, and that he'd heard crying and went to the room from the kitchen, and the boys were saying that Haydon had fallen.

5 VRP 104. Petitioner said that the bedroom was the bedroom with the red bunk bed. *Id.*

Officer Betts related more of petitioner's statements:

Mr. Reyes went to the room, and he stated that Haydon had stood up, and Mr. Reyes said that he's fine, he's fine, and that since the baby had stood up, he thought he was okay; and that Haydon had said, head, head, repeatedly, several times, and pointed at his own head. Leon stated that he reached out and started to pick up Haydon, who went limp all at once.

Q. What did he say he did after that?

A. He said that Haydon started to have muscle spasms, following that, or something to that effect, and that his hand had contorted into a strange position that Mr. Reyes demonstrated to me. And even reading that in the report, I can't remember exactly how he demonstrated to me at the time.

Q. What happened after that?

A. He stated that Haydon seemed to be unconscious, and he took -- and that he shook Haydon several times to try to wake him, but that it didn't work. He stated that he brought him to the bathroom and splashed cold water on his face to try to wake him up, also, but that didn't work either. And that at this point, Mr. Reyes said that he, himself, became scared.

Q. What did he say, if anything, about what Haydon did at this point?

A. He stated after this, that Haydon began to vomit, and that he carried Haydon to the couch in the living room, to try to help him there. He stated that he called 911, and the person on the phone, the 911 caller -- receiver tried to give him directions to help clear the throat, the mouth, of vomit so that he can do CPR.

5 VRP 104-05. Petitioner related information about a prior injury Haydon had had:

Q. Did the defendant give you any information about any prior injuries of Haydon?

A. He did. He said that they had just taken Haydon to the doctor a few days before, four or five days before, and he thought either the Thursday or Friday before that.

Q. Did he say for what particular purpose?

A. Yeah. According to my report, the reason I started asking along those lines, I wanted to get more information for the medical team still there, and I thought this doctor's appointment might somehow give them more info if there was a previous injury. I asked Mr. Reyes about it, and he said that he had fallen, that Haydon had fallen, and they had taken him to the doctor and the doctor said he was fine. I gave the medical team that information that he might have had a previous injury, thinking that might affect it.

5 VRP 106.

Q. What did he say the doctor's appointment was about?

A. It was pink eye, originally, is the reason they had taken him there, but while they were there, I believe the doctor noticed another injury on the baby and asked about it, another injury on Haydon.

Yes. Later on, I went back to him and I asked Mr. Reyes to tell me more about how Haydon had gotten hurt last week, the week prior, and why he had gone to the doctors. Mr. Reyes stated that the appointment had been for Haydon having pink eye, but that Haydon had fallen in the shower and hurt his head.

Leon interrupted himself when he said, "fallen in the shower," and explained, actually, Haydon had been crawling into the shower and had scratched his testicles in the shower. Leon explained he had been working hard getting Haydon potty-trained, "just like my own kids," was his words, and also getting Haydon to shower on his own, but of course, they were having difficulties.

5 VRP 107.

Medical services personnel told the treating doctor at the hospital Haydon "had been said to fall out of bed. 6 VRP 170. In a later interview, petitioner told Detective Devault that he thought that Haydon's injuries were "the result of roughhousing between the boys . . . and that Haydon probably had fallen from the top of the bunk bed." 6 VRP

207. Dr. Paschall, a treating physician, testified about the credibility of that statement:

Q. You testified earlier that you make a determination of whether an injury was accidental or non-accidental. Do you have an opinion, with reasonable medical certainty, whether or not the injury that Haydon suffered was accidental or non-accidental?

A. I do.

Q. What is that opinion?

A. I would believe this child's injury was non-accidental in nature.

Q. And again, what is that opinion based on?

A. Well, it's based on several things. One, the severity of his head injury is not consistent with the history of how he obtained it. Two, the CT scan showed both this acute injury, as well as previous injury. Three, the presence of retinal hemorrhages; and four, there were some abdominal injuries noted as well. So the child had evidence of multiple injuries at multiple differences in time, with the presence of retinal hemorrhage and a story that didn't fit the injury.

Q. The story being that he fell from a bunk bed; is that right?

A. That's what I was told, yes, or was -- yes.

6 VRP 191.

Haydon's mother testified that when she saw petitioner in jail after he was arrested that petitioner told her that he was doing dishes and Haydon fell off the bunk bed. 7 VRP 463. She visited petitioner a second time and he told her the same thing. 7 VRP 464.

Tristan Reyes, petitioner's son, testified that he slept in the room with the bunk bed, that nobody slept on the top bunk, and that the top bunk had no mattress. 8 VRP 522-23. (The height of the bunk bed, as measured by a forensic technician was four foot ten and a half inches. 9 VRP 684.) Ms. Reyes testified that there was no jumping off the bunk beds. 9 VRP 706. Tristan testified that Haydon slept in a room with Pacey (petitioner's other son) and that there was no bunk bed in that room. 8 VRP 523. Tristan provided contradictory testimony about what happened to Haydon at the home before the police arrived. 8 VRP 525-29. Tristan told Officer Vause shortly after police arrived that he did not see what happened. 9 VRP 661.

K. BLUNT HEAD TRAUMA CAUSED HAYDON'S DEATH.
HAYDON ALSO SUFFERED OTHER INJURIES, INCLUDING
INJURIES PROBABLY CAUSED BY SHAKING.

1. Dr. Paschall

Dr. John Paschall, a physician with fourteen years' experience, worked in the pediatric intensive care unit of Mary Bridge Hospital. 6 VRP 162-63. Dr. Paschall treated young Haydon K. 6 VRP 168. He saw Haydon a few minutes after he arrived in the emergency department. 6 VRP 169. Haydon's "color was very poor, his circulation, his profusion looked very poor." *Id.* Haydon's abdomen was quite distended. *Id.* Haydon was not moving on his own, he was not awake, and he was cold. 6 VRP 170.

There was a large collection of blood under Haydon's skull, in the brain area, which was pushing the brain over towards the left. 6 VRP 175. That was a subdural hematoma. 6 VRP 176. No skull fracture was seen.¹⁵ 6 VRP 177. "And you could see – at the time [of surgery], you could see the bulging of the dura, which is, again, one of the coverings of the brain with the blood underneath of it." 6 VRP 181. There was a lot of blood under a lot of pressure which came out once an incision was made in the dura to relieve the pressure on Haydon's brain. 6 VRP 182. In surgery, part of Haydon's brain had to be cut off so that it could be placed back into his skull. 6 VRP 183. A blood flow study relating to Haydon's brain was made the following day. 6 VRP 187. No blood was flowing into Haydon's brain at that time. 6 VRP 187-88. Haydon had no brain function, whatsoever. 6 VRP 189. Haydon's pupils were fixed and dilated, meaning that they were large and not reactive to light. 6 VRP 172. Haydon had retinal hemorrhaging.

Dr. Paschall said that the "trauma to the inside of Haydon's brain, with subdural hematoma, causing the brain so shift to one side when there's no skull fracture ... was probably related to an acceleration/deceleration injury or shaking-type injury most likely." (emphasis added) 6 VRP 177. When asked a similar question he responded "It certainly could be." (emphasis added) 6 VRP 177-78.

Dr. Paschall opined that Haydon's injuries were non-accidental. 6 VRP 191. He expressed the bases for his opinion:

Well, it's based on several things. One, the severity of his head injury is not consistent with the history of how he obtained it. Two, the CT scan showed both this acute injury, as well as previous injury. Three, the presence of retinal hemorrhages; and four, there were some abdominal injuries noted as well. So the child had evidence of multiple injuries at multiple differences in

¹⁵ Dr. Duralde also testified that she observed no skull fracture on Haydon. 6 VRP 234.

time, with the presence of retinal hemorrhage and a story that didn't fit the injury.

Id. Dr. Paschall opined that petitioner's fall from the bunk bed story did not fit the injury.

Id. Haydon, with no brain function whatsoever, was taken off life support on the 22nd. 6 VRP 188-90. The opinion of "non-accidental trauma" is plainly not a shaken baby syndrome opinion (as shaken baby syndrome is defined by Dr. Ophoven) because the presence of previous injuries and abdominal injuries were explicit reasons for Dr. Paschall's diagnosis.¹⁶

2. Dr. Duralde

Dr. Yolanda Duralde, a very experienced pediatrician,¹⁷ testified about the mechanism of injury that occurs with shaking. 6 VRP 227. She used a video to illustrate that mechanism. 6 VRP 226-27. She did not testify that a subdural hematoma could only be caused in the manner related in the video. 6 VRP 226-29.

Dr. Duralde testified generally that there are "sometimes associated" injuries that accompany a child's brain injuries: "A lot of times when you have head-injury patients, that's really the only injury that you see, and more likely to be from some sort of shaking when you have retinal hemorrhage associated with the brain injury." (emphasis added) 6 VRP 231. Dr. Duralde testified about what "usually" happens when the shaking occurs:

and so we think that it's a direct application of forces to the rib cage and part of the shaking, in that it can actually bend the child's rib cage around the spinal column. So you're much more likely to get posterior rib fractures with shaking injuries, than rib fractures in other areas of the rib cage.

(emphasis added) *Id.*

¹⁶ Additionally, Dr. Paschall stated that retinal hemorrhaging is "generally associated" with a shaking-type injury. 6 VRP 165.

¹⁷ 6 VRP 221-24.

Dr. Duralde testified that she had “sometimes,” “seen cases where the skull was not fractured, where there was an “amazing amount of internal [brain] injury,” and where there was a bruise. (emphasis added) 6 VRP 231-32. “So sometimes you can see other injuries, but you don’t always.” 6 VRP 232.

Dr. Duralde also testified that subdural hematomas are occasionally seen in situations which do not involve shaking. 6 VRP 233. She testified how subdural hematomas can occur when skull fractures are present. 6 VRP 233. Dr. Duralde also testified that it would be “unusual” and “quite rare” to see bleeding inside the skull without a skull fracture. 6 VRP 233. When asked what kind of falls would cause bleeding inside the skull without actually seeing a fracture, Dr. Duralde responded: “Again, it would be, you know, like really severe falls where there's, you know, a lot of force to the head.” 6 VRP 233. When asked to clarify the type of fall that she was talking about, Dr. Duralde responded:

Even short falls can cause skull fractures. Even -- usually very minor, less than two percent of falls from under four feet will cause skull fractures. Much more likely to have increasing skull fractures and other extremity fractures once you get over ten feet; and you really start talking about head trauma and issues with head trauma when they are falls of greater than 15 feet.

6 VRP 233-34.

Dr. Duralde testified to a “pretty high medical certainty” that Haydon’s death was non-accidental trauma. 6 VRP 234. Dr. Duralde testified that a fall from a bunk bed was not consistent with Haydon’s injuries. 6 VRP 234. The basis for that opinion was not further explored on direct examination. *Id.* On cross examination, Dr. Duralde did not adopt a shaken baby syndrome diagnosis:

Q . . . Now, first of all, you indicate that this – in your analysis of this, that's essentially shaken baby syndrome; is that correct?

A Well, I think that there are elements of shaking this child, shaking with probable impact.

(emphasis added) 6 VRP 257.

Dr. Duralde testified that “you really don’t see [bilateral retinal hemorrhage] outside of shaking forces. 6 VRP 235. Dr. Duralde testified that bilateral retinal hemorrhage is “really rare” to see outside shaking injuries.

The only other times you really see those particularly bilateral injuries is you might occasionally see it in a [high speed] motor vehicle accident. But even that is less than -- like, three percent of kids who are in motor vehicle accidents have retinal hemorrhage. So it's very rare to see in any of the cases; really takes a high amount of force. And again, it's sort of a direct injury to the eye itself.

6 VRP 235. Dr. Duralde stated on cross-examination that “there haven’t been any reported cases where there’s bilateral retinal hemorrhage in accidental blunt force trauma.” 6 VRP 258-59.

Dr. Duralde discussed Haydon’s past visits to the doctor. 6 VRP 238-243. Dr. Duralde also related that on December 9, 2005 Haydon “came in, and the story was he had intermittent vomiting for a week. ... Anywhere from one to four times a day. ... And that at least per the note [in the medical records], the child was just accompanied by his mom, and the history given was that he had -- he had a fall on the toilet. It says a fall into a toilet, and that he had hit the right side of his face. . . . [and there was] redness and swelling around his right eye.” 6 VRP 264.

Dr. Duralde testified about the fact that Haydon’s stomach was hard to the touch and appeared distended. 6 VRP 243-45. She testified that if those observations were made prior to resuscitation attempts (*see* testimony of Dr. Paschall at 6 VRP 168-69), that would be a concern:

A Yeah, that's a concern. You'd be worried that there was some, you know, undisclosed trauma to the abdomen, with possible irritation that makes it distended; that there's either bleeding or some free air or fluid in the abdomen.

Q Would an abdominal injury, internal abdominal injury, would that cause vomiting, in your opinion?

A Yes.

Q And how would that cause vomiting?

A Well, it's irritation of the abdominal contents, and then it would be difficult to keep anything down.

6 VRP 244. Dr. Duralde testified that an injury to the brain could also cause vomiting. 6

VRP 245. Dr. Duralde also testified that a head injury could also cause a child to have diarrhea. 6 VRP 246-47.

Dr. Duralde used a series of photographs she took to illustrate various bruises over Haydon's body that were in various stages of healing. 3 VRP 249-254. There was bruising on Haydon's forearm and bruising on the upper aspect of Haydon's right arm. 3 VRP 250. There was bruising on Haydon's right leg. 6 VRP 250. This was the product of a "high velocity injury" consistent with an electrical cord or a belt. 6 VRP 251-52. It was a type of bruises not normally expected from a two-year old or two-and-a-half year old. 6 VRP 252.¹⁸ Dr. Duralde testified that the bruise on the left side of Haydon's head did not cause his traumatic brain injury. 6 VRP 254. Dr. Duralde testified that an incident which would have caused the bruise underneath Haydon's scalp would not have caused the type of internal head trauma that was observed in Haydon. 6 VRP 254.

¹⁸ These were also addressed on cross-examination at 6 VRP 255-56. Defense counsel's focus was on the inability to date those injuries or attribute their cause to a specific person. *Id.*

Dr. Duralde did not disagree with any of the findings in Dr. Ramoso's reports. 6 VRP 260. Dr. Ramoso testified that the cause of Haydon's death was "blunt head trauma." 6 VRP 291.

Dr. Duralde testified that Haydon had "a few" hemorrhages in each eye, but they were not "massive." 6 VRP 258.

3. Dr. Ramoso

Dr. Ramoso, the medical examiner, testified that Haydon had a bruise on his forehead a few days to about a week old on February 20, when he was taken to the hospital. 6 VRP 283. Haydon had a bruise on the top of his head that appeared "kind of fresh, very recent." 6 VRP 283-84.

Dr. Ramoso testified that Haydon had "a small redness of the skin, small bruising. Not prominent, very faint, actually. An examination of the inside of the chest, there is a fracture of the 9th rib on the back side, a very fresh fracture, very recent hemorrhage present in the area." 6 VRP 284.

Dr. Ramoso noted evidence of "loose adhesions" (indicating healing) in the stomach, pancreas, small intestine, stomach, transverse colon, pancreas, duodenal wall, and the liver. 6 VRP 287. Dr. Ramoso testified that Haydon's liver showed areas of "fibroblastic response, suggestive of healing from some implementary [sic] process going on in the area." 6 VRP 288. Dr. Ramoso observed microscopic evidence of a spleen laceration ("fibroblastic response and new vessel formation). 6 VRP 288. Dr. Ramoso testified that Haydon's abdominal organs showed "significant substantial injuries" in the spleen, the duodenum, the transverse colon, and the bowel. 6 VRP 286. The injuries, to the liver, spleen, and stomach occurred in the range of "several days or maybe a week or

between a week or two weeks” prior to the events which brought Haydon to the hospital for the last time. 6 VRP 289.

Haydon had bruises on his extremities.

The left thigh of the decedent shows a fairly big bruise, about 3, 4 centimeter of the left thigh, and that seems to be a fairly recent bruise. The thighs also show small bruises, but they are brown, very small, half-centimeter, maybe 3/4 of an inch -- 1/2 an inch, or about 3/4 of an inch, and they seem to be an older bruise, brownish in color.

6 VRP 290. Each of Haydon’s eyes showed hemorrhages in the optic nerve and in the retina. 6 VRP 291.

Dr. Ramoso, the only witness in this case to testify to the cause of Haydon’s death, testified that the cause of Haydon’s death was blunt head trauma. 6 VRP 291. Defense counsel, clarified the point:

Q When you say blunt trauma, is that the subject of a blow resulting in hematoma?

...

Q A blow, a physical blow, resulting in a hematoma?

A It could be due to that, yes.

6 VRP 298. Dr. Ramoso, on cross-examination, acknowledged that the time (January 29, 2007¹⁹) that the shaken baby syndrome diagnosis was “controversial” and that Haydon’s injury was consistent with blunt trauma injury and shaken baby syndrome.

Q Right. But it is not a factor that contributed to Haydon's death?

A No. The head injury is the --

Q Okay. The head injury is the sole factor in Haydon's death; is that right?

A Yes.

¹⁹ 6 VRP 1.

Q Now, you indicate that in examining the eyes, microscopically, that there was retinal hemorrhaging; is that correct?

A That's correct.

Q Could you determine the degree of retinal hemorrhaging at this time?

A Degree in what way -- oh, how much?

Q How much, right?

A I said focal, but it's present. And if I remember it vaguely, substantial focal hemorrhage.

Q It was substantial?

A Yes.

Q And that's also consistent with blunt trauma injury; isn't that correct?

A It has been observed in blunt trauma injury, and it's been observed in many condition, primarily the shaken impact baby syndrome is the most common cause of it.

Q Is blunt trauma injury and shaken baby syndrome separate diagnoses?

A Well, it's controversial.

Q For you?

A Some people believe -- I think the shaken -- in this case, especially -- specifically, if you -- if I have to make an opinion with what we have, it's consistent with the shaken baby, with an impact to the head, because there's bruising of the head.

Q So, both, in this case; is that right?

A That's most consistent with that, yes.

6 VRP 302-03. In this cross-examination exchange, Dr. Ramoso did not adopt the shaken baby diagnosis. *Id.*

IV. ARGUMENT:

A. THE PETITION IS TIME BARRED BECAUSE IT DOES NOT PRESENT NEWLY DISCOVERED EVIDENCE.

Personal restraint procedure derives from habeas corpus, guaranteed by the State Constitution. *In re Hagler*, 97 Wn.2d 818, 823, 650 P.2d 1103 (1982). Collateral attack is

not a substitute for direct appeal. *Hagler*, 97 Wn.2d at 824. “Collateral relief undermines the principles of finality of litigation, degrades the prominence of the trial, and sometimes costs society the right to punish admitted offenders.” *Id.* These costs are significant and require that collateral relief be limited. *Hagler*, 97 Wn.2d at 824.

RCW 10.73.090(1) fixes a one year time limit in which to file a collateral attack. In addition to the exceptions listed within that statute, RCW 10.73.100(1) provides an exception for “[n]ewly discovered evidence, if the defendant acted with reasonable diligence in discovering the evidence and filing the petition or motion.” *Id.* In this case, petitioner relies solely upon the newly discovered evidence exception. Petitioner’s newly discovered evidence claim must demonstrate five things:

- (1) The evidence must be such that the results will probably change if a new trial were granted;
- (2) The evidence must have been discovered since the trial;
- (3) The evidence could not have been discovered before the trial by exercising due diligence;
- (4) The evidence must be material and admissible; and
- (5) The evidence cannot be merely cumulative or impeaching.

State v. Williams, 96 Wn.2d 215, 223, 634 P.2d 868 (1981). The petition should be dismissed because petitioner cannot demonstrate that the evidence is such that the results will probably change if a new trial were granted and petitioner cannot demonstrate that the evidence could not have been discovered before the trial by exercising due diligence.

B. DR. OPHOVEN’S OPINIONS ARE THE ONLY EVIDENCE PRESENTED IN THIS PERSONAL RESTRAINT PETITION.

Newly discovered evidence is “evidence which could not have been discovered since the trial by exercising due diligence.” *State v. Williams*, 96 Wn.2d at 223. Only one item of “evidence” admissible for the truth of the matter asserted is presented in this

personal restraint petition—the declaration of Dr. Ophoven (hereinafter “Ophoven”).²⁰ The remaining materials are all hearsay, admissible for only two purposes: (1) determining the preliminary question of admissibility of Dr. Ophoven’s testimony (the ER 103 inquiry); and (2) offered to explain the basis of Dr. Ophoven’s opinion. *See State v. Mohamed*, 186 Wn.2d 235, 242-46, 375 P.3d 1068, 1072 (2016); *In re Marshall*, 156 Wn.2d 150, 162, 125 P.3d 111, 117 (2005). The threshold question presented in this restraint petition is whether the opinion of Dr. Ophoven is newly discovered evidence. If Dr. Ophoven’s opinion testimony is not newly discovered evidence, then the other materials presented in this personal restraint petition are inadmissible hearsay evidence.²¹ *In re Rice, supra.*

²⁰ “As for the evidentiary prerequisite, we view it as enabling courts to avoid the time and expense of a reference hearing when the petition, though facially adequate, has no apparent basis in provable fact. In other words, the purpose of a reference hearing is to resolve genuine factual disputes, not to determine whether the petitioner actually has evidence to support his allegations. Thus, a mere statement of evidence that the petitioner believes will prove his factual allegations is not sufficient. If the petitioner's allegations are based on matters outside the existing record, the petitioner must demonstrate that he has competent, admissible evidence to establish the facts that entitle him to relief. If the petitioner's evidence is based on knowledge in the possession of others, he may not simply state what he thinks those others would say, but must present their affidavits or other corroborative evidence. The affidavits, in turn, must contain matters to which the affiants may competently testify. In short, the petitioner must present evidence showing that his factual allegations are based on more than speculation, conjecture, or inadmissible hearsay.” (internal citations omitted) *In re Personal Restraint of Rice*, 118 Wn.2d 876, 885–86, 828 P.2d 1086, *cert. denied*, 506 U.S. 958, 113 S. Ct. 421, 121 L. Ed. 2d 344 (1992).

²¹ Petitioner has not sought to demonstrate or lay an evidentiary foundation for the hearsay related in any of petitioner’s other supporting documents.

C. PETITIONER HAS NOT PROVEN THAT THE RESULTS OF TRIAL WILL CHANGE IF A NEW TRIAL IS GRANTED.

When this case went to trial in 2007, competent trial counsel²² presented an unassailable trial strategy²³ in an indisputably fair trial.²⁴ Any challenge to the adequacy of petitioner's representation or the adequacy of petitioner's trial is time-barred by RCW 10.73.090 (and would render the petition a mixed petition). Petitioner's trial strategy presented no challenge to the causation of Haydon's death. 12 VRP 953-966. Trial counsel asked the jury to find petitioner guilty only of manslaughter. 12 VRP 965-66.

This case is similar to *State v. Faircloth*, 177 Wn. App. 161, 311 P.3d 47 (2013). In *Faircloth*, a defendant claimed that his recently recovered memories of childhood abuse warranted a new trial. *State v. Faircloth*, 177 Wn. App. at 163. This Court, acknowledging the newness of petitioner's recently recovered memory, concluded:

We also note that Marvin admits that he could have presented a battered child syndrome defense at his original trial, even without the recovered memory, but chose not to do so. Marvin cannot use the newly discovered evidence exception as a guise to present a time barred ineffective assistance of counsel claim or to get a second opportunity to pursue a trial strategy which the defendant originally abandoned or chose not to pursue. Evidence is not newly discovered when it strengthens an argument or defense that could have been presented at trial but was not.

In re Personal Restraint of Faircloth, 177 Wn. App. 161, 170 (n. 4), 311 P.3d 47, 52 (2013). This case is like *Faircloth* because in both cases the petitioner could have raised a science based challenge to the evidence presented at trial, but chose not to do so. In

²² Trial counsel's competence is presumed. *Strickland v. Washington*, 466 U.S. 668, 689, 104 S. Ct. 2052, 80 L. Ed. 2d 674 (1984).

²³ The defendant must overcome the presumption that, under the circumstances, the challenged action of trial counsel might be considered sound trial strategy. *Strickland*, 466 U.S. at 689, *Darden v. Wainwright*, 477 U.S. 168, 186, 106 S. Ct. 2464, 91 L. Ed. 2d 144 (1986).

²⁴ A newly discovered evidence claim "presupposes that all the essential elements of a presumptively accurate and fair proceeding were present...." *State v. Crawford*, 159 Wn.2d 86, 105, 147 P.3d 1288, 1298 (2006).

Faircloth, the petitioner sought to present better evidence of battered child syndrome; in this case petitioner seeks to present better evidence relating to abusive head trauma. In both cases, petitioner sought a chance to present a different strategy in a new trial. This Court, like the Court in *Faircloth* should reject that petition because petitioner has not proven that Dr. Ophoven's testimony would probably result in a not guilty verdict in a new trial.

Petitioner's fall-from-a-bunk-bed theory was a problematic theory when it was rejected by defense counsel in 2007. It depended on petitioner's truthfulness, petitioner's ability to relate facts he did not witness, and the jury's willingness to bind petitioner's speculative facts to an alternative medical explanation. Petitioner now presents this Court with a supposedly better medical explanation, but the prospects for a fall-from-a-bunk-bed defense theory are worse today than they were in 2007.

On March 20, 2007, a presentence investigator met petitioner in the Pierce County Jail after his trial. Appendix 18-19. Petitioner admitted to shaking Haydon back and forth:

He recalls cooking the children shrimp soup the night of February 20, 2006. He said he was in the kitchen doing dishes, the boys were taking a shower. He said his infant daughter was already in bed. After the boys finished with the shower, they were playing in the bedroom with bunk beds. He remembers hearing crying and going to see what was wrong with H.K.

He said that H.K. 's body "went stiff." He said that he got scared and starting shaking him back and forth. He admits that he shook him hard. He said when that didn't work, he took him into the bathroom and using H.K. 's body cleared the counter top. He said he then hit H.K. 's head on the sink and started splashing cold water on his face in an attempt to wake him. He said he "started loosing [sic] it."

He said he took him to the living room and in order to do CPR, placing H.K. on the couch. He remembers applying pressure to his chest but he was afraid he would hurt him too much so he started doing compressions on his abdominal area. He said H.K. was vomiting the entire time, he said when he started pushing on his stomach, "more crap came out of his mouth." He remembers seeing mucus coming out of his nose and mouth and that at one point H.K. was biting his tongue.

When he was asked to explain the extreme injuries H.K. received the night he was killed, he said that he couldn't. He elaborated more on his shaking of H.K. saying he remembered seeing his body fold over and that he was holding him so hard that he could almost feel his fingers touch as he squeezed his body. He said he kept shaking him and shaking him in hopes he would wake up. He is worried he caused the lacerations of his internal organs by applying pressure to his abdominal area while he was attempting CPR. He said that he knew he was doing it wrong.

Pre-Sentence Report, Appendix at 18-19. This statement is inconsistent with the story petitioner told to both his wife (7 RP 463-64), and to Officer Betts (5 VRP 104-07).

Petitioner's statement to the pre-sentence investigator is consistent with injury resulting from both "hard" shaking (see the testimony of Dr. Duralde) and blunt head trauma (see the testimony of Dr. Ramoso). That inconsistency was unavailable at petitioner's trial, but would demonstrate consciousness of guilt in any future trial. Petitioner's inconsistent statements to the treatment providers also demonstrate a certain indifference to Haydon's life, because petitioner withheld vital information from treatment providers.

Petitioner did not object to the admission of his statements at sentencing. *See* 17 VRP 3-6. Petitioner acknowledged that he played a causative role in Haydon's death:

That night I tried to save my son's life and my actions led and contributed to his death and I agree to that, my fault, but to sit here and say it was murder, false; to sit here and say it was homicide, false; to sit here and say I beat and abused my son is false.

17 VRP 18.

Defense counsel listed Dr. Emanuel Lacsina, a forensic pathologist,²⁵ as a witness. Appendix 70-71. It is reasonable to infer that petitioner's defense counsel informed Dr.

²⁵ Dr. Lacsina has been recognized as a forensic pathologist in published opinions. *In re Personal Restraint of Copland*, 176 Wn. App. 432, 450, 309 P.3d 626, 635 (2013); *State v. Townsend*, 97 Wn. App. 25, 28, 979 P.2d 453, 455 (1999), *affirmed*, 142 Wn.2d 838, 15 P.3d 145 (2001).

Lacsina of petitioner's version of the events surrounding Haydon's death. That version—violent, but devoid of intent to assault²⁶—tended to negate a finding of felony murder.

However, homicide by abuse does not require intent to assault:

Extreme indifference to human life may be proved by evidence of an aggravated form of recklessness which falls below a specific intent to kill. This element may be proved where the defendant engages in extremely reckless conduct that creates a grave risk of death.

Mr. Adams admitted that he head-butted his infant son twice in the back of the skull and that he forcibly stuffed a sock in Cadyn's mouth to stop him from crying. A reasonable juror could have concluded that this was extremely reckless conduct that created a grave risk of death. The evidence was sufficient to support Mr. Adams's conviction.

(quotation marks and citations omitted). *State v. Adams*, 138 Wn. App. 36, 50, 155 P.3d 989, 997 (2007). Petitioner admitted to shaking the two year old Haydon “hard” and “back and forth,” so far as to see Haydon’s body “fold over,” to squeezing his abdomen “so hard that he could almost feel his fingers touch as he squeezed his body,” and to hitting Haydon’s head on the sink while using Haydon’s body as a tool. Presentence Report, Appendix at 18-19. A juror could readily find that petitioner’s actions constituted extreme indifference to human life.

These concerns were borne out in trial counsel’s strategy. As long as the homicide by abuse charge stood, petitioner’s version of events placed him at grave risk of conviction. After the State rested, the trial court granted defense counsel’s motion to dismiss the homicide by abuse count (leaving only the murder charge). 10 VRP 729. Defense counsel then sought to call Dr. Lacsina to testify. 10 VRP 731-32. The trial court recessed, heard further argument, then reversed itself and denied the motion to dismiss the homicide by abuse charge. 10 VRP 759-60. Defense counsel then put on its case—absent

²⁶ Felony murder instruction (Appendix 57), assault definition (Appendix 53).

Dr. Lacsina. *See* 11 VRP 815, 816-902. Not calling Dr. Lacsina eliminated the risk that the jury would hear petitioner's version of what happened on the night of Haydon's death.

The PRP avoids the problem that petitioner's trial lawyers had to deal with by making petitioner's post-trial statements outside Dr. Ophoven's scope of review:

I was retained in this case to review and evaluate the medical testimony provided in Mr. Reyes' trial, the State's characterization and argumentation with regard to that testimony, and the underlying medical record, in light of recent advances in medical knowledge regarding SBS, or the hypothesis that violent shaking may be reliably diagnosed based on the triad of subdural hemorrhage, retinal hemorrhage, and encephalopathy, or the variants of the SBS hypothesis.

Ophoven at 3. Nevertheless, those post-trial statements would confront petitioner in any new trial. In such a trial, when Dr. Ophoven opines that Haydon's injuries were not caused by petitioner, she would be confronted with petitioner's self-admission to violent behavior causing Haydon's death. Ophoven at 26-32; Appendix 18-19. Dr. Ophoven response could only be "I was not asked to consider those statements."

Petitioner's newly discovered evidence claim does not challenge any of the evidence used at trial to prove beyond a reasonable doubt that prior to Haydon's death, petitioner "engaged in a pattern or practice of assault or torture of [Haydon K.]"²⁷ Jury Instruction 12, Appendix 45. That evidence demonstrates petitioner's malevolent disposition toward Haydon and undercuts petitioner's claim that he innocently shook Haydon "hard" and "back and forth" so hard that his body "folded over," innocently squeezed Haydon so hard he may have hurt Haydon internally, and that he innocently hit Haydon's head on the sink. (Pre-Sentence Report, Appendix 18-19). Petitioner's competent trial counsel foresaw the potential train wreck should petitioner's callous

²⁷ The facts tending to show that petitioner caused harm to Haydon before he ultimately killed him are related in detail, *supra*.

version of the events surrounding Haydon's death be admitted at trial. That is likely why petitioner's trial counsel did not call their forensic pathologist to testify.

D. THE ASSERTEDLY "NEW" OPINIONS PRESENTED BY DR. OPHOVEN ARE EITHER DEMONSTRABLY NOT NEW, INSUBSTANTIAL IN THE CONTEXT OF THIS CASE, OR BOTH.

The general rule about newly discovered expert testimony is straightforward: A new opinion predicated upon the same facts available at trial, cannot constitute newly discovered evidence. *State v. Evans*, 45 Wn. App. 611, 613–14, 726 P.2d 1009 (1986); *State v. Harper*, 64 Wn. App. 283, 294, 823 P.2d 1137, 1144 (1992). However, Courts are cognizant of the fact that it cannot be a rigid rule. *See Opie v. State*, 422 P.2d 84, 86 (Wyo. 1967):

We are inclined to believe, if appellant's theory were sanctioned, it would open the doors to endless requests for new trials in all kinds of cases. Nevertheless, we will not at this time say it is impossible to have circumstances where a court might see fit to grant a new trial because of newly discovered expert opinions on previously known facts. Instead, we will rest our decision on the proposition that the trial court in this instance was amply justified in refusing defendant's request, and its ruling was not erroneous for abuse of discretion.

Id. However, the general rule has strong arguments in its favor.

Certainly, testimony in the form of an expert's opinion is "evidence" in the literal sense. KRE 702. But an expert's opinion cannot fit the definition of "newly discovered evidence" unless it is based upon underlying facts that were not previously known and could not with reasonable diligence have been discovered. An opinion consisting simply of a reexamination and reinterpretation of previously known facts cannot be regarded as "newly discovered evidence." There would be no finality to a verdict if the facts upon which it was based were perpetually subject to whatever reanalysis might be conceived in the mind of a qualified expert witness.

Foley v. Commonwealth, 425 S.W.3d 880, 887 (Ky. 2014). In navigating this terrain, this court in *In re Fero* concluded that expert opinion testimony was newly discovered evidence because uncontroverted evidence established a new "generally accepted medical

paradigm.” *In re Personal Restraint of Fero*, 192 Wn. App. 138, 142, 367 P.3d 588 (2016), 190 Wn.2d 1, 409 P.3d 214 (2018).²⁸

Personal restraint petitions must be supported by evidence. *In re Rice, supra*. Petitioner must demonstrate a paradigm shift in order to get Dr. Ophoven’s opinions over a necessary newly discovered evidence hurdle. *In re Fero, supra*. “Evidence involving new methods of proof or new scientific principles is subject to a *Frye*²⁹ hearing.” *State v. Lizarraga*, 191 Wn. App. 530, 566, 364 P.3d 810 (2015) (citing *State v. Baity*, 140 Wn.2d 1, 10, 991 P.2d 1151 (2000)). To admit expert testimony under *Frye*, the court must find, among other things, that the underlying scientific theory is generally accepted in the relevant scientific community. *Anderson v. Akzo Nobel Coatings, Inc.*, 172 Wn.2d 593, 601, 260 P.3d 857, 860 (2011). Questions of admissibility under *Frye* are reviewed *de novo*. *Anderson v. Akzo Nobel Coatings, Inc.*, 172 Wn.2d at 600. Before petitioner can present evidence of a paradigm shift in any relevant medical community, petitioner must satisfy the evidentiary foundational requirement of proving that the purported paradigm shift evidence is generally accepted in that relevant medical community. *State v. Lizarraga*, 191 Wn. App. 530, 364 P.3d 801 (2015). A finding of general acceptance in the relevant community must be supported by substantial evidence in the record. *State v. Canaday*, 90 Wn.2d 808, 814, 585 P.2d 1185 (1978). “Whether a scientific method or technique is generally accepted requires more than the bare assertion by one expert witness

²⁸ “In Fero’s case, Dr. Barnes and Dr. Ophoven are new experts, but their opinions establish that the scientific explanations that were offered as evidence against Fero in her trial are no longer generally accepted in the medical community. Moreover, their opinions state that based on the record that existed at Fero’s trial and under the currently accepted paradigm, it is not medically possible to determine that Brynn’s injuries occurred when she was with Fero, nor is it medically possible to determine how Brynn’s injuries were caused. Therefore, we hold that Fero is entitled to relief from her post-conviction restraints, grant Fero’s petition, and remand for a new trial.” *In re Fero*, 192 Wn. App. 138, 165, 367 P.3d 588, 600 (2016), rev’d, 190 Wn.2d 1, 409 P.3d 214 (2018).

²⁹ *Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923).

that the technique is reliable.” *State v. Ahlfinger*, 50 Wn. App. 466, 469, 749 P.2d 190, 193 (1988). Nothing less should apply to opinion evidence.

1. The controversy over shaken baby syndrome was acknowledged in petitioner’s trial. That controversy is ongoing.

Dr. Ophoven’s declaration attacks the validity of the shaken baby syndrome theory,³⁰ but the cause of death in this case was attributed to blunt head trauma—not shaken baby syndrome. 6 VRP 291 (Dr. Ramoso’s testimony); 6 VRP 260 (Dr. Duralde’s concurrence). Opinion testimony that Haydon’s brain injuries resulted from shaking was admitted at trial, but it was not presented as a reasonable medical certainty.³¹ See 6 VRP 231-34. The existence of a controversy about shaken baby syndrome was acknowledged at trial. 6 VRP 302-03. Shaking was presented and argued as a likely cause of Haydon’s injuries at petitioner’s trial as it would be presented and argued as a likely cause of Haydon’s injuries in any future trial. Petitioner has presented no “paradigm shifting” opinion evidence ruling out shaking as a cause of Haydon’s brain injuries. *In re Fero*, 192 Wn. App. 138, 149, 367 P.3d 588, 593 (2016).³²

The controversy between some forensic pathologists and the pediatric medical community over abusive head trauma is ongoing. *Del Prete v. Thompson*, 10 F. Supp. 3d 907 (N.D. Ill. 2014), a case cited by Dr. Ophoven (applying a much lower standard of

³⁰ Ophoven at 6-16.

³¹ Dr. Paschall testified that the “trauma to the inside of Haydon’s brain, with subdural hematoma, causing the brain so shift to one side when there’s no skull fracture . . . was probably related to an acceleration/deceleration injury or shaking-type injury most likely.” (emphasis added) 6 VRP 177. Dr. Duralde testified:

Q . . . Now, first of all, you indicate that this – in your analysis of this, that’s essentially shaken baby syndrome; is that correct?

A Well, I think that there are elements of shaking this child, shaking with probable impact. (emphasis added) 6 VRP 257.

³² Dr. Ophoven does cite to a 2017 study involving the shaking of piglets. Ophoven at 19.

proof on the issue of new evidence), demonstrates that the controversy over shaken baby syndrome type evidence was still vibrant on January 27, 2014. *Id.* The controversy was ongoing on April 9, 2018, when the Maryland Court of Appeals rendered its opinion:

It remains the prevailing view within the relevant medical communities that there are some internal findings that are highly correlated with abusive head trauma, even in the absence of external findings; and when those internal findings are coupled with an inconsistent clinical history or one that is inadequate to explain them, and cannot be explained medically, a diagnosis of abusive head trauma is supported. *See Narang I* at 574–76 (listing organizations that endorse abusive head trauma as a medical diagnosis, including the American Association for Pediatric Ophthalmology, the American College of Radiology, the American Association of Neurologic Surgeons, the World Health Organization, and the Royal College of Pediatrics and Child Health). External findings associated with abusive head trauma include bruising or swelling of the scalp or other parts of the body. Internal findings include skull fractures; long bone fractures; rib fractures; retinal hemorrhages; subdural hematomas; subarachnoid hemorrhages; brain swelling; and cervical spine injuries. As noted, the consensus is that no single finding or combination of findings is pathognomonic for abusive head trauma. Rather, a differential diagnosis must be made based upon the totality of the circumstances in each individual case. A congruence of multiple findings, each of which independently correlates with abusive head trauma, narrows the field of potential diagnoses significantly, however, and absent a clinical history of accidental trauma or evidence of a disease process consistent with those findings, a diagnosis of abusive head trauma may be made. *See Greeley*³³ at 969.

Sissoko v. State, 236 Md. App. 676, 722–23, 182 A.3d 874, 901 (2018), *cert. denied*, 460 Md. 1, 188 A.3d 917 (2018).³⁴ *People v. McFarlane*, 336187, 2018 WL 3039901, at *4 (Mich. Ct. App. June 19, 2018), an unpublished Michigan opinion rendered sixty-four days before Dr. Ophoven signed her declaration³⁵ noted the continuing ongoing controversy.

The controversy was reported as recently as May 23, 2019 in another unpublished opinion:

Some understanding of the history of SBS, or the now-preferred term, abusive head trauma (AHT), helps to put this matter in context. The debate

³³ Christopher S. Greeley, *Abusive Head Trauma: A Review of the Evidence Base*, 204 Am. J. of Roentgenology 967, 968 (May 2015).

³⁴ *Sissoko* contains an extended discussion of the controversy.

³⁵ Ophoven at 32. This opinion is not cited for legal precedent. It is cited as evidence of the continuing dispute over abusive head trauma.

over SBS/AHT diagnoses has a lengthy history, with experts still coming to differing conclusions regarding whether injuries, such as those sustained by the victim in this case, are unique to intentional abuse.

People v. Ceasor, 338431, 2019 WL 2235820, at *2 (Mich. Ct. App. May 23, 2019). *Stern v. Schriro*, CV0600016TUCDCBJR, 2016 WL 11431554, at *2 (D. Ariz. Aug. 2, 2016), *report and recommendation adopted*, CV-06-00016-TUC-DCB, 2016 WL 5110443 (D. Ariz. Sept. 21, 2016); *State v. Galvez*, 144 Hawai'i 387, 442 P.3d 450 (Haw. Ct. App. May 30, 2019).³⁶ *See also*, *Commonwealth v. Epps*, 474 Mass. 743, 752, 53 N.E.3d 1247 (2016); *Commonwealth v. Millien*, 474 Mass. 417, 435 (n.16), 50 N.E.3d 808, 822 (2016).

A news article cited by Dr. Ophoven acknowledges the continuing debate in the scientific community.

Although they are outnumbered by the doctors who support the science, those who challenge it are gathering strength. More than a hundred share their ideas on a private email group called “Evidence-Based Medicine and Science.

They have published their concerns in medical journals and teamed up, sometimes as paid witnesses, with private defense attorneys and lawyers affiliated with the Innocence Network. . . .

Id. Debbie Cenziper et al., *Doctors Doubt Shaken Baby Syndrome Bad Convictions*, WASH. POST. Mar. 23, 2015.³⁷ Cited in Ophoven at 11.

Shaken baby syndrome testimony was utilized in motions for new trial made before petitioner’s 2007 trial. In *State v. Edmunds*, 308 Wis. 2d 374, 385–86, 746 N.W.2d 590, 596 (Wis. Ct. App. 2008), a motion for a new trial was filed in 2006.

Edmunds presented evidence that was not discovered until after her conviction, in the form of expert medical testimony, that a significant and legitimate debate in the medical community has developed in the past ten

³⁶ *McFarlane*, *Ceasor*, *Schriro*, and *Galvez* have no precedential value. They are not binding on any court. They are cited only for such persuasive value as the court deems appropriate. GR 14.1. *Crosswhite v. DSHS*, 197 Wn. App. 539, 544, 389 P.3d 731, 733, *review denied*, 188 Wn.2d 1009, 394 P.3d 1016 (2017). They are presented to show that the Abusive Head Trauma controversy is ongoing.

³⁷ <http://www.dailyherald.com/article/20150323/news/150329644/>.

years over whether infants can be fatally injured through shaking alone, whether an infant may suffer head trauma and yet experience a significant lucid interval prior to death, and whether other causes may mimic the symptoms traditionally viewed as indicating shaken baby or shaken impact syndrome. Edmunds could not have been negligent in seeking this evidence, as the record demonstrates that the bulk of the medical research and literature supporting the defense position, and the emergence of the defense theory as a legitimate position in the medical community, only emerged in the ten years following her trial.

State v. Edmunds, 308 Wis. 2d at 385–86. *State v. Weaver*, 554 N.W.2d 240, 249 (Iowa 1996) affirmed a motion for a new trial that a prior hit of the head on a table (itself newly discovered evidence) coupled with expert testimony that the deceased child’s bilateral retinal hemorrhages could have been attributable to an earlier accident, was sufficient to warrant a new trial where shaken baby syndrome evidence had provided the scientific basis for the jury’s verdict. *State v. Weaver*, 554 N.W.2d at 249-50. *Gulertekin v. Tinnelman-Cooper*, 340 F.3d 415, 425 (6th Cir. 2003) rejected an actual innocence claim involving the following assertions:

As to the prejudice element, Gulertekin presents the affidavit of Dr. Jan Leestma, a physician who provides consultation in forensic aspects of neuropathology, and whose opinions contradict that of the physicians called by the state. Dr. Leestma's ultimate opinion is that “the conclusions of these witnesses (that the injuries sustained by the infant could not have been caused unintentionally and could have occurred only within a temporal window of a few hours) cannot be established to a reasonable degree of medical certainty.” Gulertekin also presents two recent articles calling into question whether only extreme violence results in shaken baby syndrome.

Gulertekin v. Tinnelman-Cooper, 340 F.3d 415, 425 (6th Cir. 2003). *State ex rel. W. Virginia Dep't of Health & Human Res. v. Fox*, 218 W. Va. 397, 403–04, 624 S.E.2d 834, 840–41 (2005) reversed a finding of abuse and neglect of a child because of defense expert testimony that a “slight fall” from a bed, coupled with a coagulation disorder and a prior head injury likely contributed to the forming of a subdural hematoma which re-bled and caused a child’s death. Dr. Ophoven’s opinion on abusive head trauma and shaken baby

syndrome is just one more voice in a continuing debate which began before petitioner's trial commenced.

2. The "changing consensus" section of Dr. Ophoven's declaration does not present general acceptance in a relevant scientific community.

In this case, Dr. Ophoven's "changing consensus" section asserts no "general acceptance" of any paradigm shift and articulates no general acceptance in any relevant community. However, the last sentence of the section appears to imply general acceptance. Dr. Ophoven states: "A recent survey by a staunch SBS proponent found that only 40% of pathologists now believe that SBS is a 'valid' diagnosis, and there is now widespread belief that SBS has been over-diagnosed." Ophoven at 16. For this proposition, Dr. Ophoven cites Sandeep K. Narang et al., *Acceptance of Shaken Baby syndrome and Abusive Head Trauma as Medical Diagnoses*, 177 J. PEDIATR. 273, 277 (2016). Ophoven at 16. The Narang article is attached as Appendix at 72-77. Reference to the Narang article demonstrates that "40% of pathologists" that Dr. Ophoven cites as authority consists of eight doctors out of a survey size of over 600. *Id.* at 76.

3. The "retinal hemorrhages" section of Dr. Ophoven's declaration does not present general acceptance in a relevant scientific community.

Dr. Ophoven cites one source for her statement that "it is now generally accepted that a broad range of phenomena, including accidental falls from a very short height can cause retinal hemorrhaging:" Patrick D. Barnes, *Imaging of Nonaccidental Injury and the Mimics Issues and Controversies in the Era of Evidence-Based Medicine*, 49 Radiol. Clin. N. Am. 205, 209, 217 (2011). Ophoven at 17. A copy of the Barnes article is attached to this petition as Appendix 78-102. Reference to the cited page demonstrates that nothing like "general acceptance" of Dr. Ophoven's proposition is asserted. *Id.* Reference to page

217 of the article includes a reference to “RH” [retinal hemorrhage], but nothing suggesting any kind of consensus-much less “general acceptance.”

Alternatively, no evidence is presented as to the relevant community Dr. Ophoven references. There is nothing suggesting Dr. Ophoven speaks for the entire medical community when she makes this statement, and much to suggest otherwise.³⁸ Although Dr. Ophoven states that this opinion is now generally accepted, petitioner does not demonstrate that the opinion was not also generally accepted in 2007, or that opinions held in 2007 on the issue differed paradigmatically from opinions held now.

Dr. Ophoven makes the following ambiguous assertion:

Finally, it is worth noting that, today, even the most dogmatic SBS proponents claim that shaking causes “severe” or “extensive” retinal hemorrhages that are “multilayered, too numerous to count. [sic] and extending to the edge of the retina.” [sic] such that the mere presence of retinal hemorrhages does not indicate shaking in every case.

Ophoven at 19. The only community referenced is the “dogmatic SBS proponent” community. This ambiguous statement is not substantial evidence of general acceptance in a relevant community. Alternatively, this statement is irrelevant because no witness in this case testified that the mere presence of retinal hemorrhages indicates shaking in every case and this case does not involve massive retinal hemorrhages.

4. The “subdural hematoma and short falls” section.

Dr. Ophoven states “There is now general agreement that subdural hematomas in infants are not caused exclusively or almost exclusively by shaking or inflicted trauma.”

³⁸ The cases cited supra, and the Narang article, suggest petitioner should be held to his burden of proof. There is a current difference of opinion among subgroups of the medical community. In *State v. Thoss*, 120 N.E.3d 1274 (Ohio Ct. App. 2018) an expert testified that a short fall from a couch would not cause retinal hemorrhaging. In *Hawkins v. State*, 100 N.E.3d 313 (Ind. Ct. App. 2018) the treating physician testified that the victim also had retinal hemorrhages in both of his eyes, which supported a diagnosis of abusive head trauma and the defendant’s doctor presented a contrary argument. *Id.* at 315.

Ophoven at 20. This opinion would have no impact in any future trial because Haydon was not an infant when he was killed³⁹ and there has never been any testimony presented that subdural hematomas were exclusively caused by anything. Furthermore, petitioner has not proven that this opinion was unavailable at petitioner's 2007 trial. This testimony does not conflict with Dr. Duralde's testimony. Dr. Duralde testified that the Haydon's subdural hematoma "was probably related to an acceleration/deceleration injury or shaking-type injury most likely."⁴⁰ (emphasis added) 6 VRP 117. Finally, petitioner has not established general acceptance in any particular scientific community.

5. The "diffuse axonal injury, cerebral edema, and intracranial disequilibrium" section.

Dr. Ophoven states that "it is now generally accepted that encephalopathy virtually always reflects hypoxia-ischemia (lack of oxygen) rather than the traumatic tearing of axons." Ophoven at 23. Petitioner has also not established general acceptance of that opinion in any particular scientific community. Nor has petitioner proven that that opinion was unavailable at petitioner's 2007 trial. This opinion does not contradict the testimony presented at trial. Dr. Duralde testified that "a disruption of axonal paths . . . leads to not breathing well or seizures or other complications that you get from this type of injury." 6 VRP at 229. There is no suggestion that the prosecution in this case relied upon the

³⁹ Haydon was born on September 5, 2003. 7 VRP 385. Haydon died on February 22, 2006. 7 VRP 321. Haydon was over two years and five months old when he died. Haydon was not an infant.

⁴⁰ Dr. Ophoven challenges the conclusion "that a fall from a short distance (such as a fall from a parent's arms or a fall of a table or chair) could not cause a subdural hematoma in a child." Ophoven at 19. Dr. Duralde testified that short falls could result in subdural hematomas, just that "most of the time you're going to see that with skull fracture." 6 VRP 232. Dr. Duralde testified that "you can get some bleeding inside the skull without actually seeing a fracture, but it would be quite rare." 6 VRP 233. Dr. Ophoven concludes her discussion of subdural hematomas with the statement: "Children fall a lot and generally do not injure themselves seriously when they do, but the rarity of a condition is not sufficient to negate its etiological importance." Ophoven at 22. It is not clear that Dr. Ophoven contradicts Dr. Duralde's testimony.

traumatic tearing of axons to establish petitioner's guilt. Respondent also controverts that opinion with Dr. Woods' declaration. Dr. Woods Declaration at Appendix 109-110.

Dr. Ophoven states "It is now generally accepted that a child can be lucid and appear essentially symptom-free (at least to a layperson) for up to 72 hours after suffering injuries that manifest as cerebral edema, subdural hematoma and retinal hemorrhages." Ophoven at 25. Petitioner has not established that this opinion is generally accepted in any particular scientific community. Nor has petitioner proven that this opinion was unavailable at petitioner's 2007 trial. This opinion is irrelevant to the facts of this case because petitioner was clearly presenting symptoms in the week preceding his death. *See* section IV(I), *supra*. Also, great trauma had recently been inflicted upon Haydon's internal organs, so Haydon would obviously not be expected to be "symptom-free." *See* section IV(K), *supra*. Also, respondent controverts this opinion. Dr. Woods Declaration at Appendix 109.

Dr. Ophoven states: "It is now generally accepted that a short fall, such as a fall from a chair, can cause cerebral edema, subdural hematoma, and retinal hemorrhages and that short falls *can* be fatal, and it is no longer generally accepted that short falls of less than three or four feet can never cause the triad." Ophoven at 25. This is an attack on the shaken baby syndrome diagnosis—a diagnosis which was not relied upon in petitioner's trial. Nor has petitioner demonstrated that this opinion contradicts any evidence presented at petitioner's trial. Nor has petitioner established general acceptance of that opinion in any particular scientific community. Nor has petitioner proven that this opinion was unavailable at petitioner's 2007 trial. Furthermore, any future trial of this case would

provide the medical expert with more information than just the “triad” Dr. Ophoven disparages. *See* Declaration of Dr. Woods at Appendix 110-12; *See* Appendix at 18-19.

Dr. Ophoven testifies that “it is no longer generally accepted that massive force is required to cause the triad.” Ophoven at 25. Petitioner has also not established general acceptance of that opinion in any particular scientific community. Nor has petitioner proven that that opinion was unavailable at petitioner’s 2007 trial. Nor does this opinion appear to contradict testimony presented at trial. Dr. Duralde testified on cross-examination that Haydon’s injuries could have occurred from one incident and that one incident could very well have been less than ten seconds in duration. 6 VRP 263.

E. PETITIONER’S OPINION EVIDENCE IS NOT NEW, IS NOT PARADIGM-SHIFTING, AND NOT GENERALLY ACCEPTED IN ANY IDENTIFIED MEDICAL COMMUNITY.

Dr. Duralde and Dr. Paschall are pediatricians. 6 VRP 223-24; 163-164. The testimonies of Dr. Duralde and Dr. Paschall remain generally accepted in the pediatric medicine and child abuse medicine communities today. Declaration of Dr. Elizabeth Woods at Appendix 108-09. The PRP makes no attempt to demonstrate that either the testimony of Dr. Duralde or Dr. Paschall is no longer generally accepted in those communities.⁴¹ Dr. Ophoven’s declaration frequently asserts general acceptance of her opinions, but never identifies the relevant community which generally accepts those opinions. The personal restraint petition depends upon the assertion that the science underlying much of the testimony of Dr. Duralde and Dr. Paschall is no longer valid. That statement is both unproven, and factually incorrect. Declaration of Dr. Woods at Appendix 108-09 and 111-12.

⁴¹ Dr. Ramoso is a pathologist who did not rely upon the shaking mechanism in his diagnosis. 6 VRP273-76; 302-03. Petitioner takes no issue with his testimony.

Dr. Ophoven's opinions are one voice in an ongoing controversy—a controversy which was ongoing at the time of petitioner's trial. 6 VRP 302-03. Petitioner has established only that Dr. Ophoven's opinions are generally accepted by a subset of the forensic pathologist community. That is not paradigm-shifting and is not newly discovered evidence. *State v. Harper, supra; State v. Evans, supra, In re Fero, supra.*

V. CONCLUSION

Petitioner's brutal⁴² and violent attempt to make Haydon "wake up" informed the trial strategy of plaintiff's trial counsel:

There is no question in my mind, Haydon died a violent death. There shouldn't be any question in your mind that it was a violent death. It was from shaking. It was for probably around ten seconds. It doesn't take very long. It was out of frustration, probably. Probably from potty-training, the lack thereof. But even at that time -- but even at that, think, if the discipline went too far, if this effort to potty-train this child went too far, that doesn't mean that Mr. Reyes acted with extreme indifference, or that it was part of a practice or pattern of abuse. It was just frustration, you know.

(Closing Argument) 12 VRP 965. Petitioner argues that Dr. Ophoven's speculative expert opinion testimony—ignoring that violence—would prevail in a new trial. That argument would be overwhelmed. Petitioner fails to prove that the outcome of a new trial would probably be different.

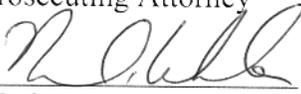
Alternatively, petitioner's trial counsel retained a forensic pathologist. Petitioner was informed as to the relevant science in 2007. The personal restraint petition has not demonstrated that any paradigm shifting new expert opinion presented in the petition could not have been discovered before the trial by exercising due diligence.

⁴² Evidence supports use of the word "brutal." Petitioner said that he took Haydon "into the bathroom and using H.K.'s body cleared the counter top. He said he then hit H.K.'s head on the sink and started splashing cold water on his face in an attempt to wake him. He said he "started loosing [sic] it." Appendix at 18-19.

Alternatively, Dr. Ophoven's claims of newly discovered scientific opinion evidence are factually unfounded because they are not new and are not generally accepted. The personal restraint petition should be dismissed.

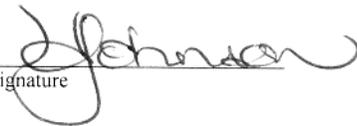
DATED: August 23, 2019

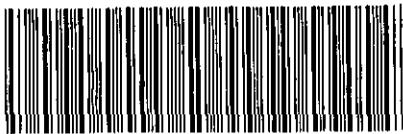
MARY E. ROBNETT
Pierce County
Prosecuting Attorney


Mark von Wahlde
Deputy Prosecuting Attorney
WSB #18373

Certificate of Service:

efile
The undersigned certifies that on this day she delivered by ~~U.S. mail~~ or ABC-LMI delivery to the attorney of record for the appellant and appellant c/o his or her attorney or to the attorney of record for the respondent and respondent c/o his or her attorney true and correct copies of the document to which this certificate is attached. This statement is certified to be true and correct under penalty of perjury of the laws of the State of Washington. Signed at Tacoma, Washington, on the date below.

8/23/19 
Date Signature



06-1-00890-3 27240218 JDSWCD 04-02-07



SUPERIOR COURT OF WASHINGTON FOR PIERCE COUNTY

STATE OF WASHINGTON,

Plaintiff,

CAUSE NO: 06-1-00890-3

MAR 30 2007

vs.

LEON LEE REYES,

Defendant.

WARRANT OF COMMITMENT

- 1) County Jail
- 2) Dept. of Corrections
- 3) Other Custody

THE STATE OF WASHINGTON TO THE DIRECTOR OF ADULT DETENTION OF PIERCE COUNTY:

WHEREAS, Judgment has been pronounced against the defendant in the Superior Court of the State of Washington for the County of Pierce, that the defendant be punished as specified in the Judgment and Sentence/Order Modifying/Revoking Probation/Community Supervision, a full and correct copy of which is attached hereto.

[] 1. YOU, THE DIRECTOR, ARE COMMANDED to receive the defendant for classification, confinement and placement as ordered in the Judgment and Sentence. (Sentence of confinement in Pierce County Jail).

X 2. YOU, THE DIRECTOR, ARE COMMANDED to take and deliver the defendant to the proper officers of the Department of Corrections, and

YOU, THE PROPER OFFICERS OF THE DEPARTMENT OF CORRECTIONS, ARE COMMANDED to receive the defendant for classification, confinement and placement as ordered in the Judgment and Sentence. (Sentence of confinement in Department of Corrections custody).

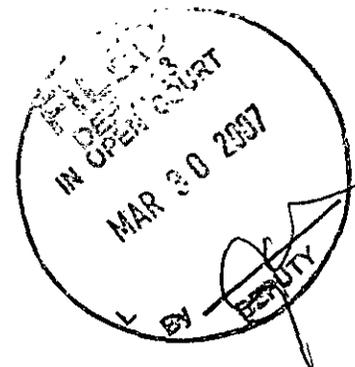
[] 3. YOU, THE DIRECTOR, ARE COMMANDED to receive the defendant for classification, confinement and placement as ordered in the Judgment and Sentence (Sentence of confinement or placement not covered by Sections 1 and 2 above).

Dated: 3/30/07

By direction of the Honorable
[Signature]
JUDGE
KEVIN STOCK
CLERK
By: *Melissa Engler*
DEPUTY CLERK

CERTIFIED COPY DELIVERED TO SHERIFF

MAR 30 2007 *Melissa Engler*
Deputy



STATE OF WASHINGTON

ss:

County of Pierce

I, Kevin Stock, Clerk of the above entitled Court, do hereby certify that this foregoing instrument is a true and correct copy of the original now on file in my office.
IN WITNESS WHEREOF, I hereunto set my hand and the Seal of Said Court this _____ day of _____,

KEVIN STOCK, Clerk
By: _____ Deputy

tjb

06-1-00890-3



SUPERIOR COURT OF WASHINGTON FOR PIERCE COUNTY

MAR 30 2007

STATE OF WASHINGTON,

Plaintiff,

CAUSE NO. 06-1-00890-3

vs.

JUDGMENT AND SENTENCE (FJS)

LEON LEE REYES

Defendant.

- Prison [] RCW 9.94A.712 Prison Confinement
- [] Jail One Year or Less
- [] First-Time Offender
- [] SSOSA
- [] DOSA
- [] Breaking The Cycle (BTC)
- [] Clerk's Action Required, para 4.5 (DOSA), 4.15.2, 5.3, 5.6 and 5.8

SID: 19538875
DOB: 01/26/1978

I. HEARING

1.1 A sentencing hearing was held and the defendant, the defendant's lawyer and the (deputy) prosecuting attorney were present.

II. FINDINGS

There being no reason why judgment should not be pronounced, the court FINDS:

2.1 CURRENT OFFENSE(S): The defendant was found guilty on by [] plea [X] jury-verdict [] bench trial of:

COUNT	CRIME	RCW	ENHANCEMENT TYPE*	DATE OF CRIME	INCIDENT NO.
I	HOMICIDE BY ABUSE, (D26)	9A.32.055	N/A	02/20/06	060511032

* (F) Firearm, (D) Other deadly weapons, (V) VUCSA in a protected zone, (VH) Veh. Hom, See RCW 46.61.520, (JP) Juvenile present, (SM) Sexual Motivation, See RCW 9.94A.533(8).

[X] The crimes charged in Counts I and II involved domestic violence.

07-9⁰⁰⁰⁰03874-5

2.2 CRIMINAL HISTORY (RCW 9.94A.525):

	CRIME	DATE OF SENTENCE	SENTENCING COURT (County & State)	DATE OF CRIME	A or J ADULT JUV	TYPE OF CRIME
1	ASSAULT 2	06/14/99	PIERCE	04/25/99	ADULT	V
2	ATT ASSAULT	06/24/03	HOUSTON, TX	04/18/03	ADULT	V

The court finds that the following prior convictions are one offense for purposes of determining the offender score (RCW 9.94A.525):

2.3 SENTENCING DATA:

COUNT NO.	OFFENDER SCORE	SERIOUSNESS LEVEL	STANDARD RANGE (not including enhancements)	PLUS ENHANCEMENTS	TOTAL STANDARD RANGE (including enhancements)	MAXIMUM TERM
I	2	XV	271-361 MOS.	NONE	271-361 MOS.	LIFE/50K

261 - 347 mo.

261 - 347 mo.

2.4 EXCEPTIONAL SENTENCE. Substantial and compelling reasons exist which justify an exceptional sentence above below the standard range for Count(s) I. Findings of fact and conclusions of law are attached in Appendix 2.4. The Prosecuting Attorney did did not recommend a similar sentence.

2.5 LEGAL FINANCIAL OBLIGATIONS. The judgment shall upon entry be collectable by civil means, subject to applicable exemptions set forth in Title 6, RCW. Chapter 379, Section 22, Laws of 2003.

The following extraordinary circumstances exist that make restitution inappropriate (RCW 9.94A.753):

The following extraordinary circumstances exist that make payment of nonmandatory legal financial obligations inappropriate:

2.6 For violent offenses, most serious offenses, or armed offenders recommended sentencing agreements or plea agreements are attached as follows: Exceptional sentence of 722 months.

III. JUDGMENT

3.1 The defendant is GUILTY of the Counts and Charges listed in Paragraph 2.1.

3.2 The court does not impose sentence for COUNT II (Murder in the Second Degree) for double jeopardy reasons. COUNT II is a valid conviction but the court finds that imposing a separate punishment would violate constitutional double jeopardy provisions. SEE APPENDIX A.

IV. SENTENCE AND ORDER

IT IS ORDERED:

4.1 Defendant shall pay to the Clerk of this Court: (Pierce County Clerk, 930 Tacoma Ave #110, Tacoma WA 98402)

JASS CODE

1
2
3 RTN/RJN \$ 6506.32 Restitution to: CVC
4 \$ _____ Restitution to: _____
(Name and Address--address may be withheld and provided confidentially to Clerk's Office).
5 PCV \$ 500.00 Crime Victim assessment
6 DNA \$ 100.00 DNA Database Fee
7 PUB \$ 1500⁰⁰ Court-Appointed Attorney Fees and Defense Costs
8 FRC \$ 200.00 Criminal Filing Fee
9 FCM \$ _____ Fine

OTHER LEGAL FINANCIAL OBLIGATIONS (specify below)

10 \$ _____ Other Costs for: _____
11 \$ _____ Other Costs for: _____

\$8006.32 TOTAL

[X] All payments shall be made in accordance with the policies of the clerk, commencing immediately, unless the court specifically sets forth the rate herein: Not less than \$ _____ per month commencing _____ RCW 9.94.760. If the court does not set the rate herein, the defendant shall report to the clerk's office within 24 hours of the entry of the judgment and sentence to set up a payment plan.

4.2 RESTITUTION

[] The above total does not include all restitution which may be set by later order of the court. An agreed restitution order may be entered. RCW 9.94A.753. A restitution hearing:
[] shall be set by the prosecutor.
[] is scheduled for _____
[] defendant waives any right to be present at any restitution hearing (defendant's initials): _____

~~X~~ RESTITUTION. Order Attached

4.3 COSTS OF INCARCERATION

[] In addition to other costs imposed herein, the court finds that the defendant has or is likely to have the means to pay the costs of incarceration, and the defendant is ordered to pay such costs at the statutory rate. RCW 10.01.160.

4.4 COLLECTION COSTS

The defendant shall pay the costs of services to collect unpaid legal financial obligations per contract or statute. RCW 36.18.190, 9.94A.780 and 19.16.500.

4.5 INTEREST

The financial obligations imposed in this judgment shall bear interest from the date of the judgment until payment in full, at the rate applicable to civil judgments. RCW 10.82.090

4.6 COSTS ON APPEAL

An award of costs on appeal against the defendant may be added to the total legal financial obligations. RCW. 10.73.

4.7 [] HIV TESTING

The Health Department or designee shall test and counsel the defendant for HIV as soon as possible and the defendant shall fully cooperate in the testing. RCW 70.24.340.

4.8 [X] DNA TESTING

The defendant shall have a blood/biological sample drawn for purposes of DNA identification analysis and the defendant shall fully cooperate in the testing. The appropriate agency, the county or DOC, shall be responsible for obtaining the sample prior to the defendant's release from confinement. RCW 43.43.754.

4.9 NO CONTACT

The defendant shall not have contact with _____ (name, DOB) including, but not limited to, personal, verbal, telephonic, written or contact through a third party for _____ years (not to exceed the maximum statutory sentence).

[] Domestic Violence Protection Order or Antiharassment Order is filed with this Judgment and Sentence.

4.10 OTHER:

Defendant may have no hostile contact with Laura Reyes.
- May have supervised contact w/ own mother (children) while incarcerated.
- No contact with minors upon release.

4.11 BOND IS HEREBY EXONERATED

4.12 CONFINEMENT OVER ONE YEAR. The defendant is sentenced as follows:

(a) CONFINEMENT. RCW 9.94A.589. Defendant is sentenced to the following term of total confinement in the custody of the Department of Corrections (DOC):

480 months on Count I. _____ months on Count _____
_____ months on Count _____ months on Count _____
_____ months on Count _____ months on Count _____

Actual number of months of total confinement ordered is: _____

(Add mandatory firearm and deadly weapons enhancement time to run consecutively to other counts, see Section 2.3, Sentencing Data, above).

[] The confinement time on Count(s) _____ contain(s) a mandatory minimum term of _____.

CONSECUTIVE/CONCURRENT SENTENCES. RCW 9.94A.589. All counts shall be served concurrently, except for the portion of those counts for which there is a special finding of a firearm or other deadly weapon as set forth above at Section 2.3, and except for the following counts which shall be served consecutively: _____

The sentence herein shall run consecutively to all felony sentences in other cause numbers prior to the commission of the crime(s) being sentenced. _____

Confinement shall commence immediately unless otherwise set forth here: _____

(b) The defendant shall receive credit for time served prior to sentencing if that confinement was solely under this cause number. RCW 9.94A.505. The time served shall be computed by the jail unless the credit for time served prior to sentencing is specifically set forth by the court: _____

395 days

4.13 [] COMMUNITY PLACEMENT (pre 7/1/00 offenses) is ordered as follows:

Count _____ for _____ months;

Count _____ for _____ months;

Count _____ for _____ months;

[] COMMUNITY CUSTODY is ordered as follows:

Count 1 for a range from: 24 to 48 Months;

Count _____ for a range from: _____ to _____ Months;

Count _____ for a range from: _____ to _____ Months;

or for the period of earned release awarded pursuant to RCW 9.94A.728(1) and (2), whichever is longer, and standard mandatory conditions are ordered. [See RCW 9.94A for community placement offenses -- serious violent offense, second degree assault, any crime against a person with a deadly weapon finding, Chapter 69.50 or 69.52 RCW offense. Community custody follows a term for a sex offense -- RCW 9.94A. Use paragraph 4.7 to impose community custody following work ethic camp.]

PROVIDED: That under no circumstances shall the combined term of confinement and term of community custody actually served exceed the statutory maximum for each offense

While on community placement or community custody, the defendant shall: (1) report to and be available for contact with the assigned community corrections officer as directed; (2) work at DOC-approved education, employment and/or community service; (3) not consume controlled substances except pursuant to lawfully issued prescriptions; (4) not unlawfully possess controlled substances while in community custody; (5) pay supervision fees as determined by DOC; and (6) perform affirmative acts necessary to monitor compliance with the orders of the court as required by DOC. The residence location and living arrangements are subject to the prior approval of DOC while in community placement or community custody. Community custody for sex offenders may be extended for up to the statutory maximum term of the sentence. Violation of community custody imposed for a sex offense may result in additional confinement.

[] The defendant shall not consume any alcohol.

[] Defendant shall have no contact with: _____

[] Defendant shall remain [] within [] outside of a specified geographical boundary, to wit:

[] The defendant shall participate in the following crime-related treatment or counseling services: _____

[] The defendant shall undergo an evaluation for treatment for [] domestic violence [] substance abuse

[] mental health [] anger management and fully comply with all recommended treatment.

[] The defendant shall comply with the following crime-related prohibitions: _____

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Other conditions may be imposed by the court or DOC during community custody, or are set forth here: _____

- 4.14 **WORK ETHIC CAMP.** RCW 9.94A.690, RCW 72.09.410. The court finds that the defendant is eligible and is likely to qualify for work ethic camp and the court recommends that the defendant serve the sentence at a work ethic camp. Upon completion of work ethic camp, the defendant shall be released on community custody for any remaining time of total confinement, subject to the conditions below. Violation of the conditions of community custody may result in a return to total confinement for the balance of the defendant's remaining time of total confinement. The conditions of community custody are stated above in Section 4.13.
- 4.15 **OFF LIMITS ORDER** (known drug trafficker) RCW 10.66.020. The following areas are off limits to the defendant while under the supervision of the County Jail or Department of Corrections: _____
- _____
- _____
- _____

V. NOTICES AND SIGNATURES

- 5.1 **COLLATERAL ATTACK ON JUDGMENT.** Any petition or motion for collateral attack on this Judgment and Sentence, including but not limited to any personal restraint petition, state habeas corpus petition, motion to vacate judgment, motion to withdraw guilty plea, motion for new trial or motion to arrest judgment, must be filed within one year of the final judgment in this matter, except as provided for in RCW 10.73.100. RCW 10.73.090.
- 5.2 **LENGTH OF SUPERVISION.** For an offense committed prior to July 1, 2000, the defendant shall remain under the court's jurisdiction and the supervision of the Department of Corrections for a period up to 10 years from the date of sentence or release from confinement, whichever is longer, to assure payment of all legal financial obligations unless the court extends the criminal judgment an additional 10 years. For an offense committed on or after July 1, 2000, the court shall retain jurisdiction over the offender, for the purpose of the offender's compliance with payment of the legal financial obligations, until the obligation is completely satisfied, regardless of the statutory maximum for the crime. RCW 9.94A.760 and RCW 9.94A.505.
- 5.3 **NOTICE OF INCOME-WITHHOLDING ACTION.** If the court has not ordered an immediate notice of payroll deduction in Section 4.1, you are notified that the Department of Corrections may issue a notice of payroll deduction without notice to you if you are more than 30 days past due in monthly payments in an amount equal to or greater than the amount payable for one month. RCW 9.94A.7602. Other income-withholding action under RCW 9.94A may be taken without further notice. RCW 9.94A.7602.
- 5.4 **CRIMINAL ENFORCEMENT AND CIVIL COLLECTION.** Any violation of this Judgment and Sentence is punishable by up to 60 days of confinement per violation. Per section 2.5 of this document, legal financial obligations are collectible by civil means. RCW 9.94A.634.
- 5.5 **FIREARMS.** You must immediately surrender any concealed pistol license and you may not own, use or possess any firearm unless your right to do so is restored by a court of record. (The court clerk shall forward a copy of the defendant's driver's license, identicard, or comparable identification to the Department of Licensing along with the date of conviction or commitment.) RCW 9.41.040, 9.41.047.

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5.6 SEX AND KIDNAPPING OFFENDER REGISTRATION. RCW 9A.44.130, 10.01.200. N/A

5.7 RESTITUTION AMENDMENTS. The portion of the sentence regarding restitution may be modified as to amount, terms, and conditions during any period of time the offender remains under the court's jurisdiction, regardless of the expiration of the offender's term of community supervision and regardless of the statutory maximum sentence for the crime.

5.8 OTHER: _____

DONE in Open Court and in the presence of the defendant this date: 3/30/07

JUDGE [Signature]
Print name Kathryn J. Nelson

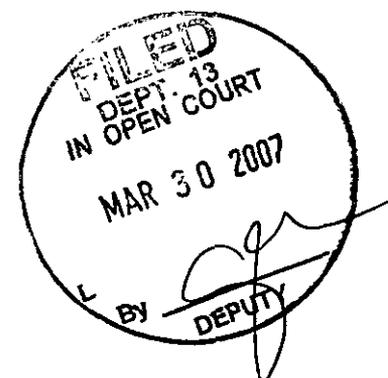
[Signature]
Deputy Prosecuting Attorney
Print name: SHAMI K.
WSB # 20428

[Signature]
Attorney for Defendant
Print name: CARNELL
WSB # 27860

[Signature]
Defendant
Print name: _____

VOTING RIGHTS STATEMENT: RCW 10.64.140. I acknowledge that my right to vote has been lost due to felony convictions. If I am registered to vote, my voter registration will be cancelled. My right to vote may be restored by: a) A certificate of discharge issued by the sentencing court, RCW 9.94A.637; b) A court order issued by the sentencing court restoring the right, RCW 9.92.066; c) A final order of discharge issued by the indeterminate sentence review board, RCW 9.96.050; or d) A certificate of restoration issued by the governor, RCW 9.96.020. Voting before the right is restored is a class C felony, RCW 92A.84.660.

Defendant's signature: [Signature]



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CERTIFICATE OF CLERK

CAUSE NUMBER of this case: 06-1-00890-3

I, KEVIN STOCK Clerk of this Court, certify that the foregoing is a full, true and correct copy of the Judgment and Sentence in the above-entitled action now on record in this office.

WITNESS my hand and seal of the said Superior Court affixed this date: _____

Clerk of said County and State, by: _____, Deputy Clerk

IDENTIFICATION OF COURT REPORTER

Court Reporter

APPENDIX "F"

The defendant having been sentenced to the Department of Corrections for a:

- sex offense
- serious violent offense
- assault in the second degree
- any crime where the defendant or an accomplice was armed with a deadly weapon
- any felony under 69.50 and 69.52

The offender shall report to and be available for contact with the assigned community corrections officer as directed:

The offender shall work at Department of Corrections approved education, employment, and/or community service;

The offender shall not consume controlled substances except pursuant to lawfully issued prescriptions:

An offender in community custody shall not unlawfully possess controlled substances;

The offender shall pay community placement fees as determined by DOC:

The residence location and living arrangements are subject to the prior approval of the department of corrections during the period of community placement.

The offender shall submit to affirmative acts necessary to monitor compliance with court orders as required by DOC.

The Court may also order any of the following special conditions:

_____ (I) The offender shall remain within, or outside of, a specified geographical boundary: _____

_____ (II) The offender shall not have direct or indirect contact with the victim of the crime or a specified class of individuals: _____

_____ (III) The offender shall participate in crime-related treatment or counseling services;

_____ (IV) The offender shall not consume alcohol; _____

_____ (V) The residence location and living arrangements of a sex offender shall be subject to the prior approval of the department of corrections; or

_____ (VI) The offender shall comply with any crime-related prohibitions.

_____ (VII) Other: _____

06-1-00890-3

IDENTIFICATION OF DEFENDANT

SID No. 19538875 Date of Birth 01/26/1978
 (If no SID take fingerprint card for State Patrol)

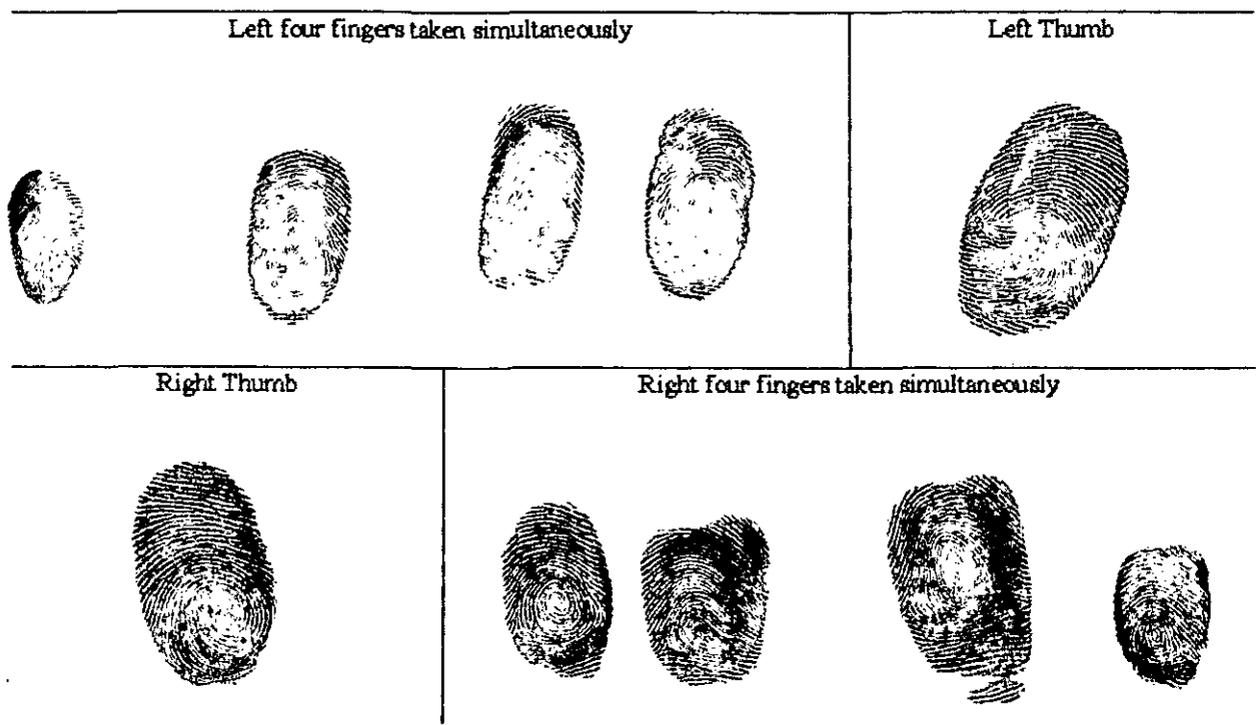
FBI No. 660601KB8 Local ID No. UNKNOWN

PCN No. UNKNOWN Other

Alias name, SSN, DOB: _____

Race: Asian/Pacific Islander Black/African-American Caucasian Hispanic Male
 Native American Other: Non-Hispanic Female

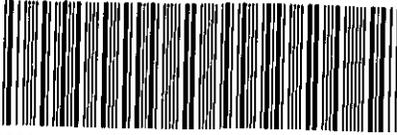
FINGERPRINTS



I attest that I saw the same defendant who appeared in court on this document affix his or her fingerprints and signature thereto. Clerk of the Court, Deputy Clerk, [Signature] Dated: 3/30/07

DEFENDANT'S SIGNATURE: [Signature]

DEFENDANT'S ADDRESS: DOC



06-1-00890-3 27240330 FPE 04-02-07



IN THE SUPERIOR COURT OF WASHINGTON, COUNTY OF PIERCE

STATE OF WASHINGTON,

Plaintiff ,

vs.

REYES, LEON LEE,

Defendant .

Cause No. 06-1-00890-3



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SUPERIOR COURT
REGISTRATION

STATE OF WASHINGTON

**DEPARTMENT OF CORRECTIONS
OFFICE OF CORRECTIONAL OPERATIONS**

755 Tacoma Avenue South • Tacoma, Washington 98402 • (253) 593-2550
FAX (253) 593-2159

**PRE-SENTENCE INVESTIGATION/RISK ASSESSMENT
REPORT
DISTRIBUTION LIST**

Date: March 20, 2007

From: Pierce County Intake / PSI Unit

RE: Reyes, Leon

DOC# 797818

Cause # 06-1-00890-3

Please distribute the attached report to the following:

- Pierce County Prosecutor
- Pierce County Judge
- Dept. of Assigned Counsel
- Defense Attorney (copy to Stephanie to mail)
- Other:



STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS

PRE-SENTENCE INVESTIGATION

TO: The Honorable Judge Nelson Pierce County Superior Court	DATE OF REPORT: 03/12/07
NAME: Reyes, Leon Lee	DOC NUMBER: 797818
ALIAS(ES):	COUNTY: Pierce
CRIME(S): Count I: Homicide by Abuse Count II: Murder 2 nd Degree	CAUSE #: 06-1-00890-3
DATE OF OFFENSE: 02/20/06	SENTENCING DATE: 03/30/07
PRESENT ADDRESS: Pierce County Jail	DEFENSE ATTORNEY: Laura Carnell

I. OFFICIAL VERSION OF OFFENSE:

The Official Version of the offense is a summary taken from the discovery documents filed under Pierce County Cause Number 06-1-0890-3. In this section of the report we have utilized the Original Information dated February 23, 2006; the Amended Information dated June 7, 2006; and the Declaration for the Determination of Probable Cause dated February 23, 2006. Additional documents contained in the discovery packet, such as police reports, have also been utilized for this report.

Pursuant to the Original Information, the Pierce County Prosecutor's Office charged Leon Reyes with Murder in the 2nd Degree on February 23, 2006. Charging documents indicate Reyes inflicted physical trauma upon two year old H.K. causing his death. On June 7, 2006, the charge of Homicide by Abuse was added to Reyes' original charge. On February 9, 2007, a jury found Reyes guilty of both Homicide by Abuse and Murder in the 2nd Degree. Additionally, the jury found there were special circumstances due to extreme youth of H.K. and said Reyes should've known he was particularly vulnerable.

Based on the Probable Cause and other information in regards to Count I, Reyes engaged in a pattern of assault or torture against H.K. between the dates of March 8, 2005 and February 20, 2006. That pattern of abuse eventually led to his death. In regards to Count II, while attempting to commit or committing the crime of Assault in the 2nd Degree on February 20, 2006, did inflict bodily harm which caused the death of H.K.

On February 20, 2006, Tacoma Police were summonsed to the home of two year old H.K., by the husband of H.K.'s mother, Leon Reyes. Upon arrival at the residence, police found Reyes bent over the body of H.K., he was attempting to administer first aide. Reyes yelled, "Help, he can't breathe." Police and then Fire Department personnel took over the care of H.K. and immediately transported him to Mary Bridge Children's Hospital. His conditions appeared to be severe as his pupils were fixed and his stomach was distended.

While the victim was being treated and transported, police were able to question Reyes. Reyes reported that he was home watching four children: his two sons Tristan Reyes, age 7, and Pacey Reyes, age 4; his wife's son H.K.; and Reyes' infant daughter, Keira. He reported that he was in the kitchen doing dishes, after dinner, when he heard H.K. crying. He was met by H.K. in the hallway, he told him "head, head." Reyes took this to mean his head hurt, Reyes said he reached out to pick up H.K., who suddenly went limp and started having "spasms." Reyes reported he shook H.K. several times in an attempt to wake him and eventually took him to the bathroom where he splashed water on H.K.'s face. Reyes admits H.K.'s head hit the sink during this process, he said that H.K. vomited repeatedly. He called 911 after he could not get H.K. to respond. Reyes said his two sons witnessed H.K. fall off the bunk beds located in the middle bedroom. He also said H.K. had been treated for a possible head injury the previous week.

Police began to survey the scene and noted H.K. didn't have any external signs of trauma. Pacey Reyes approached an officer on scene and said "Haydon hit his head." Pacey led the officer to a bedroom where the alleged accident happened. He said H.K. fell from the top bunk and after hitting his head on the top of the ladder and landed on a plastic push toy car. Officers asked Pacey if he witnessed H.K. fall and he said "Daddy told me he fell."

H.K. was examined at the hospital. They observed a large bump on the left side of his forehead and hemorrhaging of the eyes, he had severe head trauma and bleeding on his brain. There was both old and fresh damage to his brain. They noted this to be consistent with non-accidental trauma. A short time later, H.K. underwent brain surgery. Doctors contacted law enforcement and reported H.K.'s injuries were fatal and that he would not survive. Reports indicate his brain was so swollen, they couldn't close his head after surgery.

Reyes participated in a formal interview the night of H.K.'s death. He explained to detectives he was in not in the room when H.K. fell but that his sons were. He said he went to assist H.K. after he was hurt and said:

"After he started crying I picked him up and he spazzed out. He went stiff, he locked up. I grab him by the waist and take him to the bathroom and put his head in the sink and splash cold water on his face. I bang his head on the sink, I kept banging his head on the side of the sink. I wipe blood from his mouth, clear it. I then hold him up by the waist and he bends over backwards, completely over

backwards, he folds in half. He had a big fat belly, I see his big fat belly folded in half I was holding him tight, squeezing him, I could almost feel my fingers touching each other, putting cold water on him".

Detectives conducting the interview noticed a lack of emotion on Reyes part and noted that he did not inquire about the status of the victim. Reyes was informed he was under arrest for Assault 1st degree, he did not object to his arrest and was booked into Pierce County Jail without incident.

Upon further investigation of the case and forensic interviews it was determined H.K. had multiple injuries including broken bones, lacerations of internal organs, and brain damage. Some injuries were from the weeks proceeding his death. Interviews with family members who new the family indicated Reyes treated H.K. differently than his biological children. Family members remembered seeing injuries on H.K. prior to his death but Reyes always seemed to have an explanation for the injuries.

II. VICTIM CONCERNS:

On 03/16/07, I contacted the mother of the victim, Laura Reyes. I explained to her the purpose of my call, she agreed to meet me at my office later that day to provide information relating to the victim and the family.

Laura explained to me that the victim was her first born child and her only son, he was born September 15, 2003. She doesn't have a relationship with the victim's father. She married Leon Reyes on November 19, 2005, and had nothing negative to say about their relationship prior to February 20, 2006. She said she has two daughters with Reyes, Keira, 19 months old, and Renee, 8 months old. She said she was pregnant with Renee at the time H.K. was killed.

Laura said that day started out in a very typical way, she was at work at the time of H.K.'s death. She knew nothing of the incident until she arrived at home and saw emergency personnel. She was informed H.K. was hurt and at the hospital. She remembers arranging care for her other children, talking to police, and then being rushed to the hospital.

Laura said she doesn't believe Reyes abused H.K. prior to the day he was killed. She said all his previous injuries had explanations. She started out by saying she still loves Reyes but that she will never be with him again. When asked if she thought Reyes killer her son, she said she believes he did. She pointed out there is no other way to explain the extreme fatal injuries H.K. received that day. She said, "He lost control and then realized what happened."

Laura told me about H.K.'s birthday party when he turned two. She said they had a barbeque and bought him a piñata. She remembers him being a happy child and that his favorite person was his "Papa." Laura explained that H.K. called her dad by that name

and he loved spending time with him. Laura said her father had all daughters but always wanted a son. She said he finally got his "little boy" when H.K. was born.

Laura credited H.K. with getting her "on the straight and narrow." When asked what she misses the most, she said his smile. She said H.K. had the most beautiful blue eyes and blonde hair. She shared pictures of her son, several of which she carries with her in her wallet. One of the pictures showed a smiling H.K. on the on the day Laura and Reyes were married.

When asked if she is participating in counseling, Laura responded by saying that her daughters are her counseling and that she stays strong for them. She said after Reyes' arrest, she was forced to move from her home due to financial reasons. She lost Reyes' income and has had to rely on family for assistance.

When asked what she thinks should happen to Reyes, Laura said that she didn't know but that she did want him to go to prison. When asked how she felt about the guilty findings to both charges, she disagreed with the Homicide by Abuse charge. She said she wants the order prohibiting contact removed so Reyes can see his daughters. She said, "I want him to see his daughters and know I get to spend everyday with them."

She said that she wants the Court to know that "Haydon was an innocent child."

III. DEFENDANT'S STATEMENT REGARDING OFFENSE:

On 03/20/07, I met with Reyes at the Pierce County Jail. I explained to him the purpose of our meeting and outlined the information we would discuss. Reyes indicated he wanted to participate in the pre-sentence investigation process; he attempted to answer questions and provide information.

Reyes explained to me what happened up to and the night of H.K.'s death. He said the events of that day were like those of any other day he watched the children. He talked about meeting a friend earlier who came over to visit him at his home, leaving shortly before H.K. was killed. He talked about how much he loved his children and how he would never hurt them, he said he considered H.K. to be his son.

He recalls cooking the children shrimp soup the night of February 20, 2006. He said he was in the kitchen doing dishes, the boys were taking a shower. He said his infant daughter was already in bed. After the boys finished with the shower, they were playing in the bedroom with bunk beds. He remembers hearing crying and going to see what was wrong with H.K.

He said that H.K.'s body "went stiff." He said that he got scared and starting shaking him back and forth. He admits that he shook him hard. He said when that didn't work, he took him into the bathroom and using H.K.'s body cleared the counter top. He said he then hit

H.K.'s head on the sink and started splashing cold water on his face in an attempt to wake him. He said he "started losing it."

He said he took him to the living room and in order to do CPR, placing H.K. on the couch. He remembers applying pressure to his chest but he was afraid he would hurt him too much so he started doing compressions on his abdominal area. He said H.K. was vomiting the entire time, he said when he started pushing on his stomach, "more crap came out of his mouth." He remembers seeing mucus coming out of his nose and mouth and that at one point H.K. was biting his tongue.

He said he then began yelling for one of his children to find the phone. Tristian, the oldest child, brought him the phone and he called 911. He remembers trying to follow the emergency operator's instructions and a knocking at the door. He said he then asked one of the boys to answer the door, at that point, the police entered and attempted to help H.K.

Reyes denies ever intentionally hurting H.K. and that his only actions on the night of his death were to help him. He maintains H.K.'s previous injuries were not caused by him and were the results of accidents. He said he did everything in his power to help H.K. When asked about the time line, he said he has no idea how long it took for the events to unfold, when asked why he didn't call 911 earlier, he said "I couldn't tell you why I didn't pick up the phone."

When he was asked to explain the extreme injuries H.K. received the night he was killed, he said that he couldn't. He elaborated more on his shaking of H.K. saying he remembered seeing his body fold over and that he was holding him so hard that he could almost feel his fingers touch as he squeezed his body. He said he kept shaking him and shaking him in hopes he would wake up. He is worried he caused the lacerations of his internal organs by applying pressure to his abdominal area while he was attempting CPR. He said that he knew he was doing it wrong.

When asked what he felt compelled the jury to find him guilty, he said "A child is dead, someone has to be blamed." He also said he felt he was not represented fairly in Court and had numerous negative comments about his assigned attorneys.

When Reyes was asked what he thought a fair sentence would be, he said "I don't care anymore, I've lost everything, and it makes you not care anymore." He feels as though he has the support of his wife but is certain he will not have it for much longer. He said, "I have only one more thing to lose and when I do, I'm just another animal in a cage."

He felt like there was nothing else the Court needed to know prior to sentencing. He said that he wanted to tell his wife, "No matter what happens stay strong and never give up, and that I love you."

IV. CRIMINAL HISTORY:

In preparation for the completion of this report we have researched Reyes' criminal history the information that was obtained has been incorporated into the Criminal History section of this report to provide the Court with a fundamental profile of Reyes based on his past criminal conduct.

Since the best predictor of an offenders' future risk and behavior is largely founded on his past behavior, we have attempted to combine the information that we've gathered to provide the Court with a more detailed description of the potential risk and harm this offender presents. Unfortunately in some instances the requested documents may not be available at the time this report was produced.

When the official version, documenting an accurate account of the offense has not been available we have had to rely on the offenders self report. Because the accuracy and the integrity of the information are presented from the offender's perspective, we recognize the information is highly questionable and is generally unreliable.

SOURCES:

1. National Crime Information Center (NCIC) and Washington Crime Information Center (WASCIC).
2. Washington State Department of Corrections Offender Based Tracking System.
3. Superior Court Operations Management Information System (SCOMIS).
4. Law Enforcement Support Agency (LESA).
5. District Court Information System (DISCIS).

<u>Juvenile Felony:</u>	No known juvenile convictions.
--------------------------------	--------------------------------

<u>Adult Felony:</u>	
Date of Offense/	03/08/05 – 02/20/07
Crime:/	Homicide by Abuse
County / Cause No.:	Pierce / 06-1-00890-3
Date of Sentence:	03/30/07
Disposition:	Current Score / Wash

<u>Adult Felony:</u>	
Date of Offense/	02/20/07
Crime:/	Murder in the 2 nd Degree
County / Cause No.:	Pierce / 06-1-00890-3
Date of Sentence:	03/30/07
Disposition:	Other Current Score / Wash S,2

<u>Adult Felony:</u>	
Date of Offense/	04/18/03
Crime:/	Assault of a Family Member – 2 Counts
County / Cause No.:	Huntsville County, Texas / 094613101010
Date of Sentence:	06/24/03

Disposition:	Guilty; 12 Months Confinement	Score / Wash
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Adult Felony:			
Date of Offense/	04/25/99		
Crime:/	Assault in the 2 nd Degree		
County / Cause No.:	Pierce / 99-1-01792-9		
Date of Sentence:	06/14/99		
Disposition:	Guilty – 89 days confinement; 12 months probation	Score / Wash	S,2

Misdemeanor(s):			
Date of Offense:	03/15/00		
Crime:	Assault 4 th Degree – Domestic Violence		
County / Cause No.:	Puyallup Municipal / 00020724		
Date of Sentence:	unknown		
Disposition:	Guilty	Score / Wash	

V. SCORING:			
	SERIOUSNESS LEVEL	OFFENDER SCORE	STANDARD RANGE
Count I	Homicide by Abuse	4	From 165 to 265 Months
Count II	Murder 2 nd Degree	4	From 281 to 374 Months

VI. COMMUNITY CUSTODY (If applicable):			
	SERIOUSNESS LEVEL	OFFENDER SCORE	STANDARD RANGE
Count I	Homicide by Abuse	4	From 24 to 48 Months
Count II	Murder 2 nd Degree	4	From 24 to 48 Months

VIII. RISK / NEEDS ASSESSMENT:

A risk / needs assessment interview was completed with the offender. The following risk / needs area(s) and strengths have implications for potential risk, supervision, and interventions. Unless otherwise noted, the following information was provided by the offender and has not been verified.

Criminal History:**04/18/03: Assault of a Family Member – 2 Counts - Guilty**

Reyes reports he was arrested and charged with this offense while residing with former wife Charlene Birnel and living in Houston, Texas. Reyes reported at the time of the offense, he was unemployed due to a work related injury and taking pain medications for that injury. He was having financial stress and had just learned that a van he recently purchased and fixed was going to be taken back by the original owner. He reports that he was taking belongings from the van and throwing them into the house, he said a car seat he threw slid across a table and then hit his infant son.

This outraged his wife and they began to argue. He claims that she slapped him, he slapped her back three times. He was arrested and served 12 months in jail. No official version.

03/15/00: Assault 4th Degree – Domestic Violence - Guilty

Reyes reports this assault was against former wife Charlene Birnel. He said they began arguing, he doesn't recall why. He said that he grabbed her by the arm and left bruises. When asked if the reason why they argued was over him hitting his son Tristian, he said he thinks he "swatted" him that day.

A hand written statement given by Birnel that day says:

"I heard the baby cry and I went over to his room to see what was wrong and I told Leon to stop hiting the baby and he told me that Tristian fell and he got real mad at me and told me to stop acusing him of always hiting the baby witch he never hits the baby so he pushed me and grabbed my arm and twisted it and I started to cry and said I wanted to leave he wouldn't let me and I tried to grab the phone and he grabed it from me. . . "

04/25/99: Assault in the 2nd Degree - Guilty

Reyes claimed that on the above date, he and victim got into an argument. He admitted to drinking at the time. He said they talked some issues over then had sex. After that, they began to argue again, he reports he placed her in a head lock but denies forcing her to have sex.

Reports indicate Reyes was originally charged with Rape in the 2nd degree. The Probable Cause statement indicated Reyes used force to engage in sexual intercourse with the victim. It also said that he pushed her and threatened to break her neck while applying pressure and twisting her neck. The victim fled the residence and called 911 from a neighbor's home. After his arrest, both the victim and Reyes agreed they hadn't had sexual relations in over a month. This contradicts Reyes' version given during my interview. He was sentenced to 89 days confinement.

In addition to the above offenses, Reyes has numerous traffic violations. It should be noted that Reyes was arrested on his Assault in the 4th Degree charge while he was on probation for his previous Assault 2 charge.

Education / Employment:

Reyes reports he is a 1997 graduate from Bethel High School, he reports he graduated with a 4.0 grade point average. He reports no incidents of being suspended or expelled and said he had good relationships with teachers and other students. He said most of his schooling was competed in Texas and that he completed technical training after graduation.

Reyes said his trade is working in the concrete business. At the time of his arrest, he was employed by Concrete technologies and had been working for that company for four months. Prior to that, he reports he was working at Concrete Products of Washington for

two years, he terminated when his most recent employer offered him a job with better pay.

He reports he got along well with co-workers and his supervisors. He recalled celebrating birthday parties outside of work with them and going to weekend parties.

Financial:

Reyes reported no financial problems up until the time of arrest, he denied having any bills in collections. While he reports financial stability, he reports receiving food stamps from the State and received government medical benefits.

Family / Marital:

Leon Lee Reyes was born to Cynthia Gonzales and Leon Lee Reyes Sr., on January 26, 1978. He reports his mother was twelve years old at the time of his birth and married his biological father a short time later. He reports his parents relationship as being abusive. His parents union also produced two other children, Brandi, aged 27, and Bennio, who died at age six. He reports his mother later remarried and produced two more daughters.

Reyes reports he and his siblings were used as "punching bags" by their father. He said he suffered severe physical abuse at the hands of his father. He denied being sexually abuse by his father but said that he was sexually victimized by others. He recalls witnessing his father physically abuse his mother.

Shortly after his biological parents separated, Reyes reports he and his family were involved in a car accident. He was injured during the accident and said that his six year old brother died in his arms.

Reyes said he married his high school girlfriend Charlene Birmel in 2000 and divorced her in 2005. Their union produced two sons; Tristian born April 14, 1998, and Pacey born February 28, 2001.

Reyes married the former Laura Kostelecky in November of 2005. She brought with her into their marriage, her son, the victim H.K. Together Reyes and Kostelecky had two daughters; Keira age 19 months, and Renee age 8 months.

Reyes said he remains in contact with his grandfather, he reports he is supportive. He views his grandfather as his father figure and said he played a major role in his upbringing.

Accommodation:

Reyes was born and raised in Texas. He reports moving to Washington State in August of 1996 to care for an injured family member. He reports returning to Texas in 2002 where he was subsequently arrested and served prison time. He moved back to Washington after his release in 2004.

Prior to his arrest, Reyes resided with his wife and children at 8833 Yakima Ave, Tacoma WA. He reports he was buying that house together with his wife Laura.

Leisure / Recreation:

In his spare time, Reyes reports he liked to go fishing. He reported he worked long hours, often well over 40 hours a week. He also enjoyed spending time with his children. He reports no involvement in groups, organizations, or the religious community.

Companions:

Reyes denies being a social isolate. He said he has friends with whom he associates often. He denies having friends who are involved in criminal or drug activity.

Alcohol / Drug Use:

Reyes was questioned regarding possible drug and alcohol issues. Reyes denied ever having an alcohol problem despite alcohol being involved in his previous assault offenses. Reyes denies ever using any type of illegal drug. He told of an experience he had when he was younger where he smoked cigarettes and used chewing tobacco. He recalls becoming ill and said that deterred him from using drugs.

Emotional / Personal:

Reyes denied currently taking any mental health medications, an instance of ever being hospitalized for mental health reasons, or an official mental health diagnosis. In 1999, he reported taking medications for depression but doesn't recall the circumstances around being prescribed the medications.

Since his incarceration on the instant offenses, he reports he has taken Trazadone and Zoloft to help him deal with anxiety. He reports he quit taking these medications as he doesn't want to go to prison under the influence of any medications, saying "I can take care of myself." He denied receiving a mental health evaluation since being arrested on these offenses.

IX. CONCLUSIONS:

Leon Lee Reyes appears before the Court to receive his sentencing after being found guilty by jury trial of Homicide by Abuse and Murder in the Second Degree. Reyes is responsible for the death of two-year old H.K. and for the abuse leading up to his killing. Due to Reyes actions, there is a mother without a son, a grandfather who lost his "little boy," a family left dealing with the aftermath of Reyes' violence.

Reyes denies the offense but admits to treating H.K. roughly during his attempts to "save his life." Reyes has a history of assaults, a former victim's written statement given on March 15, 2000, was a chilling forecast of what was to come. The statement spoke of a child being harmed at the hands Reyes, and Reyes blaming the child's tears on an accident.

Reyes described a horrific childhood, where he himself suffered emotional, physical, and sexual abuse and witnessed violence. He pointed out several times that he thought it made him a better father and that he never wanted to be like his father. He recalled an incident where his father attempted to cut his mothers throat. Looking back on these acts, he said "My father was a pierce of crap like me."

Reyes feels as though he is being blamed for an accident and feels like his life is over now that he is convicted. During my two hour interview with Reyes, never did he voluntarily express guilt for H.K.'s death or remorse for the pain he has caused his family. His emotions were self-centered, focusing on his future and the injustice of the situation. When asked about his lack of remorse, he said that he would do anything to bring H.K. back but that he is not responsible for his death.

The jury has found that there was reason for a special verdict considering that H.K. particularly vulnerable due to his extreme youth and incapability of resistance.

X. SENTENCE OPTIONS:

- Confinement within the Standard Range Sentence
- Work Ethic Program
- Exceptional Sentence
- First-time Offender Waiver (FTOW)
- Drug Offender Sentencing Alternative (DOSA)
- Special Sex Offender Sentencing Alternative (SSOSA)
- Mentally Ill Offender Sentencing Option (MIOSO)
- Community Custody Board (CCB) RCW 9.94A.712

XI. RECOMMENDATIONS:

According to the Adult Sentencing Guideline Manual, Counts I and II are classified as Class A serious violent felony offenses. As such, the sentencing option that would afford the community with the greatest degree of safety and security would be to sentence Reyes to a term of confinement in the Department of Corrections – Divisions of Prisons. With an offender score of four, the standard range is between 281-374 months of confinement on Count I and 165-265 months on Count II. Being as though the jury returned a special verdict finding exceptional circumstances, sentencing above the standard range is appropriate and justified due to the magnitude of the offense.

Sentence Type / Option: Exceptional Sentence

Confinement: Count I: 540 Months Confinement

Count II: 480 Months Confinement

Supervision Type & Duration: Community Custody

Length of Community Placement: 24 – 48 months

Conditions of Supervision: See Appendix F

XII. MONETARY OBLIGATIONS:

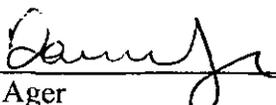
Restitution: TBD
Victim Penalty: \$500.00
Drug Fund: \$0.00

Court Costs: \$0.00
Attorney Fees: \$0.00
Fine: \$0.00

Other: \$0.00

Submitted By:

Approved By:



3/21/07



3/21/07

Daina Ager
Community Corrections Officer III
Pierce County PSI Unit
755 Tacoma Ave S
Tacoma, WA 98402
(253) 207-4716

Date

Joshua Wolff
Community Corrections Supervisor
Tacoma Intake / PSI Unit
755 Tacoma Ave S
Tacoma, WA 98402
(253) 207-4710

Date

Distribution: **ORIGINAL** - Court **COPY** - Prosecuting Attorney, Defense Attorney, File, WCC / RC
(Prison)

**IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF Pierce**

STATE OF WASHINGTON)	Cause No.: 06-1-00890-3
)	
	Plaintiff)	JUDGEMENT AND SENTENCE (FELONY)
	v.)	APPENDIX F
Leon Lee Reyes)	ADDITIONAL CONDITIONS OF SENTENCE
	Defendant)	
)	
DOC No. 797818)	

CRIME RELATED PROHIBITIONS:

Defendant additionally is sentenced on convictions herein, for each sex offense and serious violent offense committed on or after June 6, 1996 to community placement/custody for three years or up to the period of earned early release awarded pursuant to RCW 9.94A.150 (1) and (2) whichever is longer; and on conviction herein for an offense categorized as a sex offense or serious violent offense committed on or after July 1, 1990, but before June 6, 1996, to community placement for two years or up to the period of earned release awarded pursuant to RCW 9.94A.150 (1) and (2) whichever is longer; and on conviction herein for an offense categorized as a sex offense or a serious violent offense committed after July 1, 1988, but before July 1, 1990, assault in the second degree, any crime against a person where it is determined in accordance with RCW 9.94A.125 that the defendant or an accomplice was armed with a deadly weapon at the time of commission, or any felony under chapter 69.50 or 69.52 RCW, committed on or after July 1, 1988, to a one-year term of community placement.

(a) **MANDATORY CONDITIONS:** Defendant shall comply with the following conditions during the term of community placement/custody:

- (1) Report to and be available for contact with the assigned Community Corrections Officer as directed;
- (2) Work at Department of Corrections' approved education, employment, and/or community service;
- (3) Not consume controlled substances except pursuant to lawfully issued prescriptions;
- (4) While in community custody not unlawfully possess controlled substances;

06-1-00890-3

Leon Lee Reyes 797818

Page 1 of 2

- (5) Pay supervision fees as determined by the Department of Corrections;
- (6) Receive prior approval for living arrangements and residence location;
- (7) Defendant shall not own, use, or possess a firearm or ammunition when sentenced to community service, community supervision, or both (RCW 9.94A, 120 (13));
- (8) Notify community corrections officer of any change in address or employment; and
- (9) Remain within geographic boundary, as set fourth in writing by the Community Corrections Officer.

AFFIRMATIVE CONDUCT REQUIREMENTS: (First Time Offender Waiver Only)

DATE

JUDGE, Pierce COUNTY SUPERIOR COURT

TYPYST/CCO/09-130.rf
DATE

Leon Lee Reyes
797818
03/22/2007
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IN THE COURT OF APPEALS
OF THE STATE OF WASHINGTON
DIVISION II

IN RE THE PERSONAL RESTRAINT
PETITION OF:

LEON REYES,

Petitioner.

NO. 52449-0-II

DECLARATION OF DAINA NUÑEZ

I, Daina Nuñez, declare under penalty of perjury under the laws of the State of Washington, the following is true and correct:

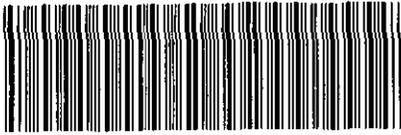
1. I am presently employed by the United States Department of Homeland Security.

2. In March, 2007 I was known as Daina Ager.

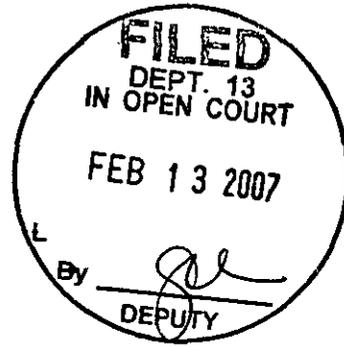
3. In March, 2007, I was employed by the Washington State Department of Corrections as a Community Corrections Officer III.

4. Part of my duties as a community corrections officer was the preparation of presentence reports after a finding of guilt has been made in a criminal case.

5. Attached to this declaration, and incorporated by reference herein, is a copy of a presentence investigation report I prepared on March 21, 2007 for the criminal case of State v. Leon Reyes, Pierce County Superior Court case number 06-1-00890-3.



06-1-00890-3 28995677 CTINJY 02-20-07



SUPERIOR COURT OF WASHINGTON FOR PIERCE COUNTY

STATE OF WASHINGTON,

Plaintiff,

CAUSE NO. 06-1-00890-3

vs.

LEON LEE REYES

Defendant.

COURT'S INSTRUCTIONS TO THE JURY

DATED this 4 day of February, 2007.

[Signature]
JUDGE Kathryn J. Nelson

ORIGINAL
0031

INSTRUCTION NO. 1

It is your duty to decide the facts in this case based upon the evidence presented to you during this trial. It also is your duty to accept the law from my instructions, regardless of what you personally believe the law is or what you personally think it should be. You must apply the law from my instructions to the facts that you decide have been proved, and in this way decide the case.

Keep in mind that a charge is only an accusation. The filing of a charge is not evidence that the charge is true. Your decisions as jurors must be made solely upon the evidence presented during these proceedings.

The evidence that you are to consider during your deliberations consists of the testimony that you have heard from witnesses, stipulations, and the exhibits that I have admitted, during the trial. If evidence was not admitted or was stricken from the record, then you are not to consider it in reaching your verdict.

Exhibits may have been marked by the court clerk and given a number, but they do not go with you to the jury room during your deliberations unless they have been admitted into evidence. The exhibits that have been admitted will be available to you in the jury room.

One of my duties has been to rule on the admissibility of evidence. Do not be concerned during your deliberations about the reasons for my rulings on the evidence. If I have ruled that any evidence is inadmissible, or if I have asked you to disregard any

evidence, then you must not discuss that evidence during your deliberations or consider it in reaching your verdict.

In order to decide whether any proposition has been proved, you must consider all of the evidence that I have admitted that relates to the proposition. Each party is entitled to the benefit of all of the evidence, whether or not that party introduced it.

You are the sole judges of the credibility of each witness. You are also the sole judges of the value or weight to be given to the testimony of each witness. In considering a witness's testimony, you may consider these things: the opportunity of the witness to observe or know the things he or she testifies about; the ability of the witness to observe accurately; the quality of a witness's memory while testifying; the manner of the witness while testifying; any personal interest that the witness might have in the outcome or the issues; any bias or prejudice that the witness may have shown; the reasonableness of the witness's statements in the context of all of the other evidence; and any other factors that affect your evaluation or belief of a witness or your evaluation of his or her testimony.

The lawyers' remarks, statements, and arguments are intended to help you understand the evidence and apply the law. It is important, however, for you to remember that the lawyers' statements are not evidence. The evidence is the testimony and the exhibits. The law is contained in my instructions to you. You must disregard any remark, statement, or argument that is not supported by the evidence or the law in my instructions.

You may have heard objections made by the lawyers during trial. Each party has the right to object to questions asked by another lawyer, and may have a duty to do so. These objections should not influence you. Do not make any assumptions or draw any conclusions based on a lawyer's objections.

Our state constitution prohibits a trial judge from making a comment on the evidence. It would be improper for me to express, by words or conduct, my personal opinion about the value of testimony or other evidence. I have not intentionally done this. If it appeared to you that I have indicated my personal opinion in any way, either during trial or in giving these instructions, you must disregard this entirely.

You have nothing whatever to do with any punishment that may be imposed in case of a violation of the law. You may not consider the fact that punishment may follow conviction except insofar as it may tend to make you careful.

The order of these instructions has no significance as to their relative importance. They are all important. In closing arguments, the lawyers may properly discuss specific instructions. During your deliberations, you must consider the instructions as a whole.

As jurors, you are officers of this court. You must not let your emotions overcome your rational thought process. You must reach your decision based on the facts proved to you and on the law given to you, not on sympathy, prejudice, or personal preference. To assure that all parties receive a fair trial, you must act impartially with an earnest desire to reach a proper verdict.

INSTRUCTION NO. 2

The defendant has entered a plea of not guilty. That plea puts in issue every element of each crime charged. The State is the plaintiff and has the burden of proving each element of each crime beyond a reasonable doubt. The defendant has no burden of proving that a reasonable doubt exists as to these elements.

A defendant is presumed innocent. This presumption continues throughout the entire trial unless during your deliberations you find it has been overcome by the evidence beyond a reasonable doubt.

A reasonable doubt is one for which a reason exists and may arise from the evidence or lack of evidence. It is such a doubt as would exist in the mind of a reasonable person after fully, fairly, and carefully considering all of the evidence or lack of evidence. If, from such consideration, you have an abiding belief in the truth of the charge, you are satisfied beyond a reasonable doubt.

INSTRUCTION NO. 3

Evidence may be either direct or circumstantial. Direct evidence is that given by a witness who testifies concerning facts that he or she has directly observed or perceived through the senses. Circumstantial evidence is evidence of facts or circumstances from which the existence or nonexistence of other facts may be reasonably inferred from common experience. The law makes no distinction between the weight to be given to either direct or circumstantial evidence. One is not necessarily more or less valuable than the other.

INSTRUCTION NO. 4

A witness, who has special training, education or experience in a particular science, profession or calling, may be allowed to express an opinion in addition to giving testimony as to facts. You are not bound, however, by such an opinion. In determining the credibility and weight to be given such opinion evidence, you may consider, among other things, the education, training, experience, knowledge and ability of that witness, the reasons given for the opinion, the sources of the witness' information, together with the factors already given you for evaluating the testimony of any other witness.

INSTRUCTION NO. 5

The defendant is not compelled to testify, and the fact that the defendant has not testified cannot be used to infer guilt or prejudice him in any way.

INSTRUCTION NO. 6

A separate crime is charged in each count. You must decide each count separately. Your verdict on one count should not control your verdict on any other count.

INSTRUCTION NO. 7

Homicide is the killing of a human being by the voluntary act of another if death occurs within three years and a day and is either murder, manslaughter, excusable homicide, or justifiable homicide.

INSTRUCTION NO. 8

A person commits the crime of homicide by abuse if, under circumstances manifesting an extreme indifference to human life, the person causes the death of a child under sixteen years of age, and the person has previously engaged in a pattern or practice of assault or torture of the child under sixteen years of age unless the killing is excusable or justifiable.

INSTRUCTION NO. 9

To act with "extreme indifference to human life" means that one does not care whether the decedent lives or dies.

INSTRUCTION NO. 10

"Pattern or practice of assault or torture" means regular or habitual assault or torture of the victim.

INSTRUCTION NO. 11

An assault is an intentional touching or striking or cutting of another person with unlawful force, that is harmful or offensive regardless of whether any physical injury is done to the person. A touching or striking or cutting is offensive, if the touching or striking or cutting would offend an ordinary person who is not unduly sensitive.

INSTRUCTION NO. 12

To convict the defendant of the crime of homicide by abuse, each of the following elements of the crime must be proved beyond a reasonable doubt:

- (1) That on or about the 20th day of February, 2006, the defendant Leon Reyes engaged in conduct resulting in the death of Haydon Kostelecky
- (2) That the defendant acted under circumstances manifesting an extreme indifference to human life.
- (3) That the defendant's acts caused the death of Haydon Kostelecky.
- (4) That Haydon Kostelecky was a child under sixteen years of age.
- (5) That the defendant previously engaged in a pattern or practice of assault or torture of Haydon Kostelecky; and
- (6) That the acts occurred in the State of Washington.

If you find from the evidence that each of these elements has been proved beyond a reasonable doubt, then it will be your duty to return a verdict of guilty.

On the other hand, if, after weighing all of the evidence, you have a reasonable doubt as to any one of these elements, then it will be your duty to return a verdict of not guilty.

INSTRUCTION NO. 13

If you are not satisfied beyond a reasonable doubt that the defendant is guilty of homicide by abuse, the defendant may be found guilty of any lesser crime, the commission of which is necessarily included in the crime charged, if the evidence is sufficient to establish the defendant's guilt of such lesser crime beyond a reasonable doubt.

The crime of homicide by abuse necessarily includes the lesser crime(s) of manslaughter in the 1st degree.

When a crime has been proven against a person and there exists a reasonable doubt as to which of two or more crimes that person is guilty, he or she shall be convicted only of the lowest crime.

INSTRUCTION NO. 14

A person commits the crime of manslaughter in the first degree when he or she recklessly causes the death of another person unless the killing is excusable or justifiable.

INSTRUCTION NO. 15

A person is reckless or acts recklessly when he or she knows of and disregards a substantial risk that a wrongful act may occur and the disregard of such substantial risk is a gross deviation from conduct that a reasonable person would exercise in the same situation.

INSTRUCTION NO. 16

To convict the defendant of the crime of manslaughter in the first degree, each of the following elements of the crime must be proved beyond a reasonable doubt:

- (1) That on or about the 20th day of February, 2006, the defendant engaged in conduct resulting in the death of Haydon Kostelecky;
- (2) That the defendant's conduct was reckless;
- (3) That Haydon Kostelecky died as a result of the defendant's acts; and
- (4) That the acts occurred in Pierce County, Washington.

If you find from the evidence that each of these elements have been proved beyond a reasonable doubt, then it will be your duty to return a verdict of guilty.

On the other hand, if, after weighing all of the evidence, you have a reasonable doubt as to any one of these elements, then it will be your duty to return a verdict of not guilty.

INSTRUCTION NO. 17

If you are not satisfied beyond a reasonable doubt that the defendant is guilty of manslaughter in the 1st degree, the defendant may be found guilty of any lesser crime, the commission of which is necessarily included in the crime charged, if the evidence is sufficient to establish the defendant's guilt of such lesser crime beyond a reasonable doubt.

The crime of manslaughter in the 1st degree necessarily includes the lesser crime(s) of manslaughter in the 2nd degree.

When a crime has been proven against a person and there exists a reasonable doubt as to which of two or more degrees that person is guilty, he or she shall be convicted only of the lowest degree.

INSTRUCTION NO. 18

A person commits the crime of manslaughter in the second degree when, with criminal negligence, he or she causes the death of another person unless the killing is excusable or justifiable.

INSTRUCTION NO. 19

A person is criminally negligent or acts with criminal negligence when he or she fails to be aware of a substantial risk that a wrongful act may occur and the failure to be aware of such substantial risk constitutes a gross deviation from the standard of care that a reasonable person would exercise in the same situation.

INSTRUCTION NO. 20

To convict the defendant of the crime of manslaughter in the second degree, each of the following elements of the crime must be proved beyond a reasonable doubt:

- (1) That on or about the 20th day of February, 2006, the defendant engaged in conduct resulting in the death of Haydon Kostecky;
- (2) That the defendant's conduct was criminally negligent;
- (3) That Haydon Kostecky died as a result of the defendant's acts; and
- (4) That the acts occurred in Pierce County, Washington.

If you find from the evidence that each of these elements have been proved beyond a reasonable doubt, then it will be your duty to return a verdict of guilty.

On the other hand, if, after weighing all of the evidence, you have a reasonable doubt as to any one of these elements, then it will be your duty to return a verdict of not guilty.

INSTRUCTION NO. 21

A person commits the crime of murder in the second degree when he or she commits an assault in the second degree and in the course of and in furtherance of such crime he or she causes the death of a person, other than one of the participants.

INSTRUCTION NO. 22

A person commits the crime of assault in the second degree when he or she intentionally assaults another and thereby recklessly inflicts substantial bodily harm.

INSTRUCTION NO. **23**

Substantial bodily harm means bodily injury that involves a temporary but substantial disfigurement, or that causes a temporary but substantial loss or impairment of the function of any bodily part or organ, or that causes a fracture of any bodily part.

INSTRUCTION NO. 24

A person acts with intent or intentionally when acting with the objective or purpose to accomplish a result which constitutes a crime.

INSTRUCTION NO. 25

A person knows or acts knowingly or with knowledge when he or she is aware of a fact, circumstance or result which is described by law as being a crime, whether or not the person is aware that the fact, circumstance or result is a crime.

If a person has information which would lead a reasonable person in the same situation to believe that facts exist which are described by law as being a crime, the jury is permitted but not required to find that he or she acted with knowledge.

Acting knowingly or with knowledge also is established if a person acts intentionally.

INSTRUCTION NO. 26

To convict the defendant of the crime of murder in the second degree, each of the following elements of the crime must be proved beyond a reasonable doubt:

- (1) That on or about the 20th day of February, 2006, Haydon Kostelecky was killed;
- (2) That the defendant was committing Assault in the Second Degree ;
- (3) That the defendant caused the death of Haydon Kostelecky in the course of and in furtherance of such crime or in immediate flight from such crime;
- (4) That Haydon Kostelecky was not a participant in the crime; and
- (5) That the acts, which caused the death of the decedent, occurred in Pierce County Washington.

If you find from the evidence that each of these elements have been proved beyond a reasonable doubt, then it will be your duty to return a verdict of guilty.

On the other hand, if, after weighing all of the evidence, you have a reasonable doubt as to any one of these elements, then it will be your duty to return a verdict of not guilty.

INSTRUCTION NO. 27

It is a defense to a charge of murder and manslaughter that the homicide was excusable as defined in this instruction.

Homicide is excusable when committed by accident or misfortune in doing any lawful act by lawful means, without criminal negligence, or without any unlawful intent.

The State has the burden of proving the absence of excuse beyond a reasonable doubt. If you find that the State has not proved the absence of this defense beyond a reasonable doubt, it will be your duty to return a verdict of not guilty.

INSTRUCTION NO. 28

Accident means a sudden unexpected and unintentional happening or event.

INSTRUCTION NO. **29**

When you begin deliberating, you should first select a presiding juror. The presiding juror's duty is to see that you discuss the issues in this case in an orderly and reasonable manner, that you discuss each issue submitted for your decision fully and fairly, and that each one of you has a chance to be heard on every question before you.

During your deliberations, you may discuss any notes that you have taken during the trial, if you wish. You have been allowed to take notes to assist you in remembering clearly, not to substitute for your memory or the memories or notes of other jurors. Do not assume, however, that your notes are more or less accurate than your memory.

You will need to rely on your notes and memory as to the testimony presented in this case. Testimony will rarely, if ever, be repeated for you during your deliberations.

If, after carefully reviewing the evidence and instructions, you feel a need to ask the court a legal or procedural question that you have been unable to answer, write the question out simply and clearly. For this purpose, use the form provided in the jury room. In your question, do not state how the jury has voted. The presiding juror should sign and date the question and give it to the bailiff. I will confer with the lawyers to determine what response, if any, can be given.

You will be given the exhibits admitted in evidence, these instructions, and four verdict forms, A and B, C and D. Some exhibits and visual aids may have been used in court but will not go with you to the jury room. The exhibits that have been admitted into evidence will be available to you in the jury room.

When completing the verdict forms, you will first consider the crime of Homicide by Abuse as charged in Count I of the Information. If you unanimously agree on a verdict, you must fill in the blank provided in verdict form A the words "not guilty" or the word "guilty," according to the decision you reach. If you cannot agree on a verdict, do not fill in the blank provided in Verdict Form A.

If you find the defendant guilty on verdict form A, do not use verdict form B or C. If you find the defendant not guilty of the crime of Homicide by Abuse, or if after full and careful consideration of the evidence you cannot agree on that crime, you will consider the lesser crime of Manslaughter in the First Degree. If you unanimously agree on a verdict as to that crime, you must fill in the blank provided in verdict form B the words "not guilty" or the word "guilty", according to the decision you reach. If you cannot agree on a verdict, do not fill in the blank provided in Verdict Form B.

If you find the defendant guilty on verdict form B, do not use verdict form C. If you find the defendant not guilty of the crime of Manslaughter in the First Degree, or if after full and careful consideration of the evidence you cannot agree on that crime, you will consider the lesser crime of Manslaughter in the Second Degree. If you unanimously agree on a verdict, you must fill in the blank provided in verdict form C the words "not guilty" or the word "guilty," according to the decision you reach. If you cannot agree on a verdict, do not fill in the blank provided in Verdict form C.

When completing Verdict Form D, you will consider the crime of Murder in the Second Degree. If you unanimously agree on a verdict, you must fill in the blank provided in Verdict Form D the words "not guilty" or the word "guilty," according to the

decision that you reach. If you cannot agree on a verdict, do not fill in the blank provided in Verdict Form D.

Because this is a criminal case, each of you must agree for you to return a verdict. When all of you have so agreed, fill in the proper form of verdict or verdicts to express your decision. The presiding juror must sign the verdict forms and notify the bailiff. The bailiff will bring you into court to declare your verdict.

INSTRUCTION NO. **30**

As jurors, you have a duty to discuss the case with one another and to deliberate in an effort to reach a unanimous verdict. Each of you must decide the case for yourself, but only after you consider the evidence impartially with your fellow jurors. During your deliberations, you should not hesitate to re-examine your own views and to change your opinion based upon further review of the evidence and these instructions. You should not, however, surrender your honest belief about the value or significance of evidence solely because of the opinions of your fellow jurors. Nor should you change your mind just for the purpose of reaching a verdict.

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF PIERCE

STATE OF WASHINGTON,)
)
) Plaintiff,)
 vs.)
)
 LEON REYES,)
)
) Defendant.)
 _____)

NO. 06-1-00890-3
VERDICT FORM A

We, the jury, find the defendant Leon Reyes _____ of the crime
(Write in "not guilty" or "Guilty")
of Homicide by Abuse as charged in Count I.

DATE: _____

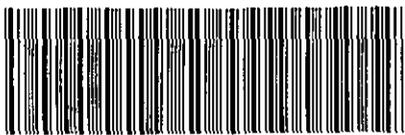
Presiding Juror

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF PIERCE

STATE OF WASHINGTON,)	
)	
Plaintiff,)	NO. 06-1-00890-3
vs.)	
)	VERDICT FORM B
LEON REYES,)	
)	
Defendant.)	
_____)	

We, the jury, having found the defendant, not guilty of the crime of Homicide by Abuse in
Count I as charged, or being unable to unanimously agree as to that charge, find the defendant
Leon Reyes _____ of the lesser included crime of Manslaughter
 (Write in "Guilty" or "Not Guilty")
in the First Degree.

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IN COUNTY CLERK'S OFFICE

A.M. JAN 12 2007 P.M.

PIERCE COUNTY, WASHINGTON
KEVIN STOCK, County Clerk
BY _____ DEPUTY

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF PIERCE

STATE OF WASHINGTON,)
Plaintiff,)
vs.)
LEON REYES,)
Defendant.)

NO. 06-1-00890-3
DEFENDANT'S WITNESS LIST

The following is a list of the defendant's witnesses:

- | | |
|--|---|
| 1. JULIE JOHNSON, CPS
1949 STATE ST
TACOMA, WA
(253)983-6351 | 4. CHRIS ROBERTS
10020 167TH ST CRT E #D-20
PUYALLUP, WA
(253) 548-5055 |
| 2. DR VICTORIA SILAS
311 SO. L ST
TACOMA, WA 98405
(253) 403-3131 | 5. JASMINE ROBERTS
10020 167TH ST CRT E #D-20
PUYALLUP, WA
(253) 548-5055 |
| 3. DR THOMAS CHARBONNEL
UNION AVENUE PEDIATRICS
1530 SO. UNION AVE
TACOMA, WA 98405
(253) 759-3333 | 6. MARY JANE GUTIERREZ
631 WHISPERVIEW CIRCLE
GRANDBURY, TX
(817) 573-2208 |

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7. EMMANUEL LACSINA, M.D.
FORENSIC PATHOLOGIST
4109 BRIDGEPORT WAY, STE E4
UNIVERSITY PLACE, WA 98466

DATED this 10th day of Jan., 2007.


JOHN CHIN, WSBA #7160
Attorney for Defendant


LAURA CARNELL, WSBA #27860
Attorney for Defendant

Acceptance of Shaken Baby Syndrome and Abusive Head Trauma as Medical Diagnoses

Sandeep K. Narang, MD, JD¹, Cynthia Estrada², Sarah Greenberg², and Daniel Lindberg, MD³

Objective To assess the current general acceptance within the medical community of shaken baby syndrome (SBS), abusive head trauma (AHT), and several alternative explanations for findings commonly seen in abused children.

Study design This was a survey of physicians frequently involved in the evaluation of injured children at 10 leading children's hospitals. Physicians were asked to estimate the likelihood that subdural hematoma, severe retinal hemorrhages, and coma or death would result from several proposed mechanisms.

Results Of the 1378 physicians surveyed, 682 (49.5%) responded, and 628 were included in the final sample. A large majority of respondents felt that shaking with or without impact would be likely or highly likely to result in subdural hematoma, severe retinal hemorrhages, and coma or death, and that none of the alternative theories except motor vehicle collision would result in these 3 findings. SBS and AHT were considered valid diagnoses by 88% and 93% of the respondents, respectively.

Conclusions Our empirical data confirm that SBS and AHT are still generally accepted by physicians who frequently encounter suspected child abuse cases, and are considered likely sources of subdural hematoma, severe retinal hemorrhages, and coma or death in young children. Other than a high-velocity motor vehicle collision, no alternative theories of causation for these findings are generally accepted. (*J Pediatr* 2016;■■■:■■-■■).

Although shaking, with or without impact, has been recognized as a dangerous form of child physical abuse since the early 1970s,^{1,2} the validity of shaken baby syndrome (SBS) and abusive head trauma (AHT) has recently been called into question in prominent national newspapers such as the *New York Times* and *Washington Post*,^{3,4} judicial decisions,^{5,6} and some medical literature.^{7,8} In fact, a US Supreme Court Justice recently commented in a dissenting opinion that there is widespread "controversy" within the medical community regarding the concepts of AHT and SBS.^{9,10} Not surprisingly, this has resulted in confusion in the courts and a chilling effect on child protection hearings and criminal prosecutions.¹¹

Legal interventions are an important part of primary safety determinations and secondary prevention for victims of maltreatment. In that process, courts frequently rely on medical expert testimony to opine on the most likely source of a child's injuries. To determine the admissibility of scientific testimony, courts must assess whether concepts are "generally accepted" in the medical community. In approximately one-half of the US jurisdictions, known as Frye jurisdictions, "general acceptance" is the sole criterion for admitting expert testimony on a certain concept.¹¹ In the remainder of US jurisdictions, known as Daubert jurisdictions, "general acceptance" is one of several criteria used to assess reliability, but is still afforded significant weight.¹² In addition, several professional medical society ethical guidelines for expert testimony state that testimony should reflect generally accepted opinions, and/or that an expert who endorses a minority opinion should volunteer that information.¹³⁻¹⁶

In courts, evidence of what is generally accepted in the medical community has typically been adduced by the opinion of a solitary expert or a small cadre of experts. This approach is susceptible to the biases and knowledge base of the testifying physicians, and leaves open the possibility that a small group could create an incorrect impression about whether or not any particular concept is generally accepted. Courts are ill-equipped to measure the broad opinion of the wider medical field or to assess the validity of a single physician's assessment of that broad opinion. Although SBS has historically been considered a valid medical diagnosis,¹⁷ to date no well-conducted study has measured the acceptance of SBS or AHT as diagnoses, or of the likelihood that shaking will result in subdural hematoma (SDH), retinal hemorrhages (RH), or coma or death, the findings commonly associated with SBS and AHT.^{18,19}

Given the importance of this issue to child protection and legal outcomes, we aimed to attain empirical data on the acceptance of SBS and AHT as valid medical

AHT	Abusive head trauma
MVC	Motor vehicle collision
REDCap	Research Electronic Data Capture
RH	Retinal hemorrhages
SBS	Shaken baby syndrome
SDH	Subdural hematoma

From the ¹Department of Pediatrics, Division of Child Abuse Pediatrics, Northwestern University Feinberg School of Medicine, Chicago, IL; ²Department of Pediatrics, University of Texas Health Science Center at Houston, Houston, TX; and ³Department of Pediatrics, Division of Pediatric Emergency Medicine, University of Colorado School of Medicine, Aurora, CO

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diagnoses by the physicians most commonly involved in those cases. We also sought to determine whether shaking, with or without impact, and other mechanisms of injury are generally accepted as reasonable explanations for SDH, RH, and coma or death.

Methods

This observational survey study was reviewed and approved by the University of Texas-Houston Institutional Review Board, and was conducted between March and October 2015. To identify a feasible sample size and limit enrollment or response bias, we surveyed hospitals identified from the 2014-15 *US News & World Report* Honor Roll of Children's Hospitals.²⁰ From the 10 leading children's hospitals, we identified faculty physicians (MD, DO) within the specialty departments most commonly involved in suspected AHT cases: Emergency Medicine, Critical Care, Child Abuse Pediatrics, Pediatric Ophthalmology, Pediatric Radiology, Pediatric Neurosurgery, and Child Neurology. Because forensic pathologists are not typically located within children's hospitals, we contacted the medical examiners' offices that jurisdictionally comported with the surveyed hospitals and offered participation in the survey. If no medical examiner's office comported with a particular jurisdiction, we contacted the responsible coroner's office and offered participation in the survey.

We obtained contact information (e-mail and mailing addresses) from hospital websites or physician collaborators. In March 2015, physicians were invited to participate by e-mail, and were informed that the survey was voluntary and anonymous. Using a modified Dillman method,²¹ the lead investigator (S.N.) sent an e-mail to eligible physicians, providing a summary of the study's objective and methods, along with a unique, anonymous online link to the survey. After the initial e-mail, nonresponders were sent a reminder e-mail (with survey links) every 2 weeks on 2 separate occasions. If a physician had not completed the survey after 3 e-mail attempts, then a hard copy of the survey (with \$1 attached) was mailed to the physician's office address on 2 separate occasions at 2-week intervals. After this, if the participant still had not responded, he or she was logged as a nonresponder, and his or her contact information was permanently deleted. Data collection efforts were completed in October 2015. As an incentive to improve response rates, participants were entered into up to 5 randomized, biweekly drawings for a \$200 gift card (depending on the time of response, with earlier responders being eligible for and entered into more drawings).

To minimize the potential for bias, we did not approach nonresponders and used no additional methods to encourage recruitment by any respondent. To ensure an appropriate sampling frame, we asked each respondent to report his or her specialty on the survey, and those who reported specialties other than those being sought to be surveyed excluded.

Study data were collected and managed using REDCap (Research Electronic Data Capture) tools hosted at the Univer-

sity of Texas at Houston.²² REDCap is a secure, web-based application designed to support data capture for research studies. No identifying information was recorded in REDCap, and once a physician completed the survey, his or her contact information was permanently deleted, thereby preserving anonymity.

Survey

Each participant reported his or her age (20-30, 31-40, 41-50, 51-60, 61+ years), board certification status, and years in practice (0-5, 6-10, 11-20, 20-30, 31-40, or 41+ years). Each participant was also asked to choose his or her field of specialty from the list of specialties sought (ie, Emergency Medicine, Critical Care, Child Abuse Pediatrics, Pediatric Ophthalmology, Pediatric Radiology, Pediatric Neurosurgery, and Child Neurology), or to report another specialty. Those reporting more than 1 surveyed specialty (n = 8) were included under each specialty for the report of respondent characteristics, but were only counted once in the remainder of the survey. Those reporting a specialty that was included in the sampling frame and a specialty that was not included (eg, Pediatric Emergency Medicine, General Pediatrics) were counted within the included specialty. Those identified within a division of pediatric emergency medicine who listed their specialty as "urgent care" were included with Emergency Medicine. Those listing only exclusion specialties (eg, General Pediatrics, Allergy and Immunology, Anesthesia, Pulmonology) were excluded.

Respondents rated the likelihood of each finding (SDH, RH, coma or death) to result from several proposed mechanisms in a child aged <3 years using a 5-point Likert scale (from "highly unlikely" to "highly likely"). "Severe RH" was defined as too numerous to count, multilayered hemorrhages extending to the periphery. Proposed mechanisms included shaking without impact, shaking with impact against a soft surface (eg, a bed), a very short fall (<3 feet) with impact against a hard surface, a high-velocity motor vehicle collision (MVC), hypoxia, dysphagic choking, vitamin D deficiency rickets, and adverse reaction to vaccines.

Finally, respondents were asked whether they believed SBS to be a valid medical diagnosis (yes, no, don't know/unsure), whether they believed AHT to be a valid medical diagnosis (yes, no, don't know/unsure), and the basis for those opinions (clinical experience, medical literature, both, or neither). Respondents were offered the chance to ask questions or to comment on the survey or the study as a whole by contacting the principal investigator.

For analysis, we defined a "fringe opinion" as one in which <5% of respondents deemed a given mechanism for a finding as likely/highly likely or unlikely/highly unlikely (Table 1). For analysis of shaking with impact versus shaking without impact results, we defined "discordance" as a rating that changed from highly unlikely or unlikely to likely or highly likely (or vice versa), depending on whether or not impact was present. Descriptive statistics were used to determine the prevalence of each response along with associated 95% CIs. Comparisons were conducted using OR with 95% CI.

Table I. Fringe opinions

	Likely/highly likely	%	Unlikely/highly unlikely	%
SDH	Vaccines	0.0	Shake WITH impact	3.2
	Vitamin D	2.3		
	Choking	2.7		
	Hypoxia	4.0		
RH	Vaccines	0.0	Shake WITH impact	1.0
	Vitamin D	0.8	Shake NO impact	1.8
	Short fall	3.2		
Coma/death	Vitamin D	0.6	Shake NO impact	3.7
	Vaccines	1.0	Shake WITH impact	4.8
	Short fall	3.1	MVC	3.5
	SBS invalid		4.8	
	AHT invalid		1.0	

A causative mechanism was considered a fringe opinion if the combined percentage of respondents rating it as likely or highly unlikely or as unlikely or highly unlikely was <5%.

Results

The survey was sent to 1378 clinicians, of whom 682 (49.5%) responded. A department of child neurology (n = 22) at 1 institution declined as a block to participate, and were counted as nonresponders. We excluded 54 (8%) survey respondents because they either did not list their specialty (n = 9) or listed only specialties that were not included in our sampling frame (23 general, primary, or hospitalist pediatricians and 22 other pediatric subspecialists). The remaining 628 respondents composed the main cohort for this analysis. Characteristics of the respondents are summarized in **Table II**. Among the respondents, the most common specialties listed were Emergency Medicine, Critical Care, Neurology, and Radiology. The large

Table II. Respondent characteristics

Characteristics	n (%)
Specialty*	
Emergency Medicine	192 (30.9)
Critical Care	108 (17.4)
Neurology	101 (16.3)
Radiology	96 (15.5)
Ophthalmology	45 (7.2)
Neurosurgery	30 (4.8)
Child Abuse	30 (4.8)
Pathology	27 (4.3)
Board-certified†	548 (88.2)
Age, y‡	
20-30	4 (0.6)
31-40	240 (38.6)
41-50	180 (29.0)
51-60	128 (20.6)
61+	68 (11.0)
Years in practice§	
0-5	148 (23.8)
6-10	135 (21.7)
11-20	164 (26.4)
21-30	106 (17.1)
31-40	48 (7.7)
41+	16 (2.6)

*Sums to 629 because 8 respondents listed 2 specialties.

†Six respondents did not report board certification status.

‡One respondent did not report age.

§Four respondents did not report years in practice.

majority (88.2%) of respondents reported being board-certified in their specialty.

Ninety-nine respondents (15.8%) omitted answers for at least 1 question. The most common scenarios in which more than 3 responses were omitted were nonophthalmologists omitting questions about RH and, conversely, ophthalmologists exclusively answering questions related to RH. No question was omitted by more than 22 respondents.

Respondents' opinions about the most likely source of SDH, severe RH, and coma or death are shown in the **Figure**. More than 80% of respondents felt that shaking with or without impact was likely or highly likely to produce SDH, more than 90% reported that it was likely or highly likely to produce RH, and more than 78% reported that it was likely or highly likely to result in coma or death. The corresponding results for a short fall were 18%, 3%, and 3%, respectively.

Either SBS or AHT was characterized as a valid diagnosis by 607 respondents (96.7%; 95% CI, 94.9%-97.9%). SBS was endorsed as valid by 554 respondents (88.1%; 95% CI, 85.3%-90.5%); AHT, by 584 respondents (93.0%; 95% CI, 90.7%-94.9%). Pathologists were statistically significantly more likely to be divergent with respect to the validity of AHT and SBS, with 8 of 27 stating that SBS is not a valid diagnosis, but that AHT is valid (OR, 13.5; 95% CI, 4.7-38.1, relative to other specialties) (**Table III**). Two pathologists responded that SBS is valid, but AHT is not.

Among the respondents stating that SBS or AHT is a valid diagnosis, 545 (89.7%) reported that they were informed by both the scientific literature and their own clinical experience, 48 (8%) were informed only by their clinical experience, and 11 (1.8%) were informed only by the scientific literature. One respondent did not answer the question, and 2 respondents listed "other" as the reason for considering the diagnosis valid. With respect to specific findings (SDH, RH, coma or death), the respondents showed very little discordance in their responses according to the presence or absence of impact.

Using our definition of "fringe opinion," 165 respondents (26.6%) reported at least 1 fringe opinion. We also included respondents who stated that either SBS (n = 30; 4.8%) or AHT (n = 6, 1.0%) were not valid. Of the 6 respondents who stated that they thought AHT was not a valid diagnosis, 5 agreed that shaking with or without impact was likely or highly likely to result in SDH and RH. All 5 of these respondents agreed that shaking with impact was likely or highly likely to result in coma or death; 2 of the 5 were neutral about the likelihood of shaking without impact resulting in coma or death. One respondent reported that AHT was invalid, and that shaking with or without impact is unlikely or highly unlikely to result in SDH, RH, or coma or death. This respondent reported that only a MVC or a short fall were likely to result in SDH, no option was likely to result in RH, and only a MVC was likely to result in coma or death.

Discussion

Our survey results represent national, multidisciplinary physician opinions on the validity of SBS and AHT, and of the

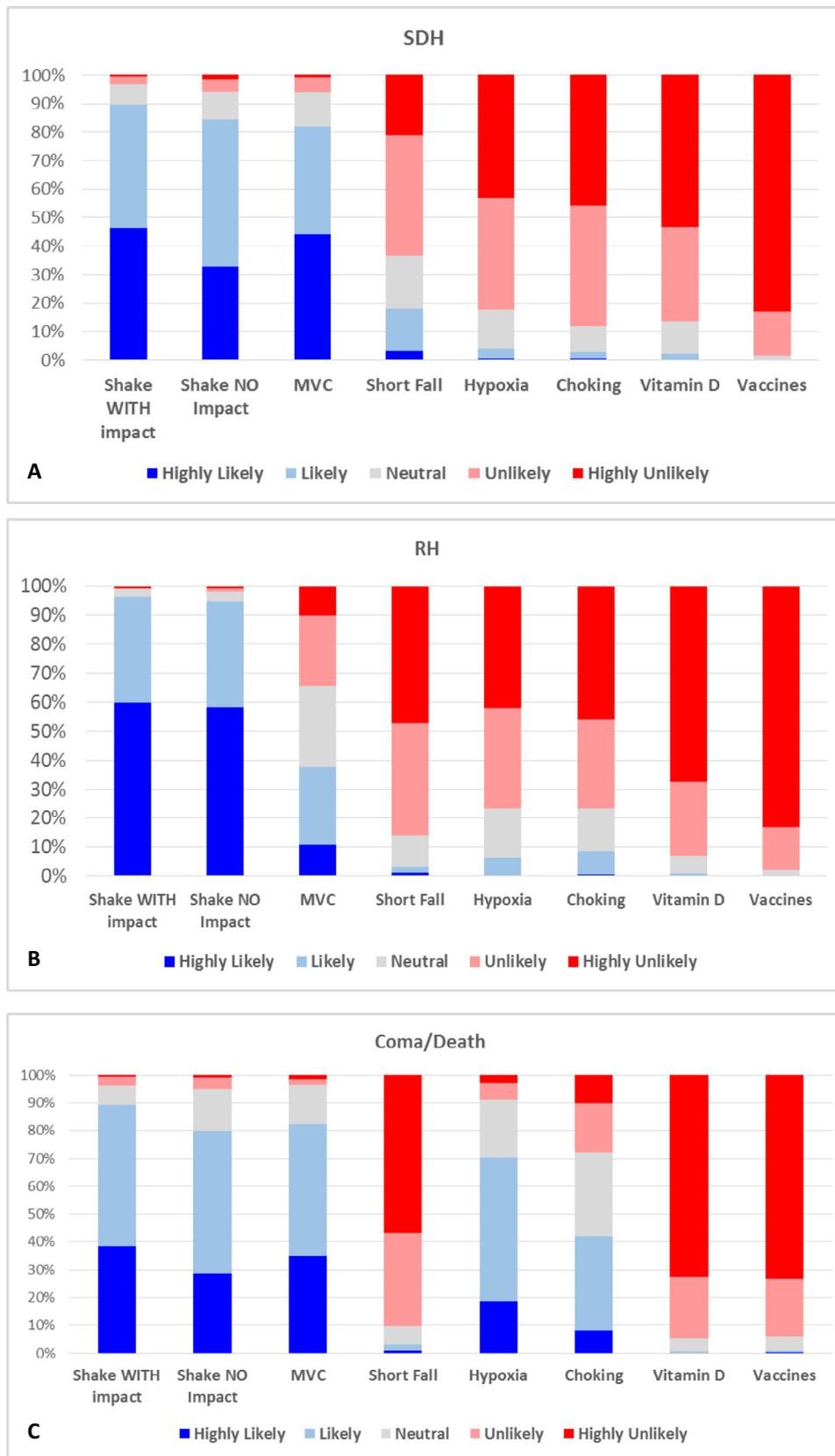


Figure. Percentage of respondents who believe that SDHs, severe RHs, and coma/death would result from the above events.

Table III. Validity of AHT and SBS by specialty

Specialties	n	Yes, n (%)	No	Don't know/ unsure	Blank
AHT valid					
Emergency Medicine	196	184 (93.9)	0	10	2
Critical Care	108	102 (94.4)	2	3	1
Neurology	103	95 (92.2)	1	5	2
Radiology	96	82 (88.5)	2	8	4
Ophthalmology	46	44 (95.7)	0	2	0
Neurosurgery	30	30 (100.0)	0	0	0
Child Abuse Pediatrics	30	30 (100.0)	0	0	0
Pathology	27	25 (92.6)	1	1	0
SBS valid					
Emergency Medicine	196	175 (89.3)	7	11	3
Critical Care	108	99 (91.7)	2	7	0
Neurology	103	96 (93.2)	4	1	2
Radiology	96	84 (87.5)	2	6	4
Ophthalmology	46	45 (97.8)	0	1	0
Neurosurgery	30	23 (76.6)	5	2	0
Child Abuse Pediatrics	30	28 (93.3)	2	0	0
Pathology	27	11 (40.7)	8	8	0

Totals sum to 636 because 8 respondents listed 2 specialties: 4 for Child Abuse Pediatrics and Emergency Medicine, 2 for Critical Care and Emergency Medicine, and 2 for Critical Care and Neurology.

likelihood that findings commonly seen in those cases—SDH, severe RH, and coma or death—result from various causal mechanisms. Although “general acceptance” is not defined by a definitive numerical threshold in legal settings (although acceptance by <50% of field clearly would not meet the criterion for “general acceptance”), our results provide empirical data that clearly support the conclusion that SBS and AHT are still generally accepted as valid medical diagnoses across a broad range of specialties. Furthermore, our data show that shaking with or without impact (in contradistinction to several other alternative theories) is generally accepted to be a dangerous form of child physical abuse and capable of producing SDH, RH, and coma or death. Several alternative explanations that have been proposed to cause SDH, RH, and coma or death are not generally accepted. This high degree of consensus, irrespective of specialty, experience, or age, refutes recent reports in the lay press and legal commentary of a substantial controversy within the medical community regarding SBS and AHT. Other authors have discussed the various motivations for those media sources to proffer such assertions.^{22,23}

As a specialty, forensic pathologists were discordant from other respondents, being more likely to question the validity of SBS as a diagnosis, although not more likely to question the validity of AHT (Table III). In this respect, our results are similar to the results of a survey of forensic pathologists that showed 35% questioning SBS.²³ That survey did not address the topic of AHT separately from SBS, however.

Our survey results demonstrate that physicians, irrespective of specialty, viewed the risks of shaking, with or without impact, to be similar to a high-velocity MVC and dissimilar to a very short fall. Although this finding may seem unremarkable to clinicians, it is important in light of some biomechanical literature arguing that shaking without impact cannot generate sufficient forces to cause SDH,^{24,25} and biomechanical²⁴ and pathology²⁶ literature suggesting very short

falls as a reasonable explanation for those findings. We believe the divergence of our results from this literature represents a recognition of the limitations of biomechanical data, a primacy of clinical literature and experience in relation to that literature, or both.

Our study has several limitations. First, we did not include general pediatricians in our sampling frame, even though some general pediatricians have substantial experience caring for children who have sustained physical abuse. Thus, our results are susceptible to selection bias. However, we chose to include only those specialties with the greatest likelihood of evaluating and treating pediatric traumatic brain injury. Our results could be different if general pediatricians with high rates of exposure to traumatic brain injury had systematically different opinions about the risks and injuries associated with shaking or other suggested mechanisms.

Second, as with all survey studies, ours might have been subject to response bias if respondents held systematically different opinions from nonrespondents. If present, this could have affected our results by increasing or decreasing the true proportion of clinicians who accept SBS or AHT. We do not feel that this limitation significantly affected our results, however, for several reasons. First, our sampling frame was chosen to reflect practicing clinicians from 10 leading hospitals, rather than groups that are most active in legal proceedings involving child abuse and neglect (and thus more motivated to respond). Second, our relatively high response rate (nearly 50% of those surveyed, with more than 600 clinicians) limits the potential that a small cadre of clinicians with divergent opinions would significantly affect results. Finally, our results show remarkable unanimity. Thus, nearly all nonresponders would have to harbor opinions that are diametrically opposed to responders for AHT or SBS to have an acceptance rate of <50% or for fringe opinions to be generally accepted.

The limitations of the *US News & World Report* hospital rankings have been discussed elsewhere.²⁷ Our intention in using these rankings was not to endorse a ranking of any particular children’s hospital; rather, we sought to identify a relatively large and diverse cohort of clinicians likely to care for child victims of trauma, and to decrease the possibility that the survey would be preferentially distributed to clinicians whose opinion regarding AHT or SBS was known to the authors. It is possible that our results would differ if we were to use different hospitals or a different ranking system; however, given the degree of consensus, we believe it unlikely that such different choices would change the conclusion regarding whether SBS, AHT, or the other alternative hypotheses are generally accepted.

Finally, some respondents indicated confusion about the questions. For example, 1 respondent (who contacted the lead investigator) noted that there are important developmental and anatomic differences between infants aged <12 months and young children aged <3 years that could significantly impact the likelihood of the resulting findings. Another respondent noted that it would have been more appropriate to ask about the likely mechanism, given a particular finding, than to ask about the likely findings resulting from a given mechanism.

Although we recognize both points, we believe that any ambiguity in the survey design would bias against a high level of consensus. ■

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Reprint requests: Sandeep K. Narang, MD, JD, Lurie Children's Hospital, 225 E Chicago Ave, Box 16, Chicago, IL 60611. E-mail: sanarang@luriechildrens.org

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Imaging of Nonaccidental Injury and the Mimics: Issues and Controversies in the Era of Evidence-Based Medicine

Patrick D. Barnes, MD

KEYWORDS

- Evidence-based medicine • Nonaccidental injury
- Nonaccidental trauma • Nonaccidental head injury
- Child abuse

Nonaccidental injury (NAI) is reportedly the most frequent cause of traumatic injury in infants (peak incidence age 6 months; 80% of traumatic brain injury deaths under the age of 2 years).^{1–4} NAI, nonaccidental trauma (NAT), and nonaccidental head injury are more recently used terms instead of the traditional labels, child abuse, battered child syndrome, and shaken baby syndrome (SBS). The traditional definition of NAI/SBS is intentional or inflicted physical injury to infants characterized by the triad of (1) subdural hemorrhage (SDH), (2) retinal hemorrhage (RH), and (3) encephalopathy (ie, diffuse axonal injury [DAI]) occurring in the context of inappropriate or inconsistent history (particularly when unwitnessed) and commonly accompanied by other apparently inflicted injuries (eg, skeletal).^{1–4} This empirical formula is under challenge by evidence-based medical and legal principals.^{4–14}

TRAUMATIC BRAIN INJURY

Traumatic brain injury has been categorized in several ways.^{1,4} Primary injury directly results from the initial traumatic force and is immediate

and irreversible (eg, contusion or shear injury). Secondary injury arises from or is associated with the primary injury and is potentially reversible (eg, swelling, hypoxia-ischemia, seizures, or herniation). Traditional biomechanics describes impact loading as linear forces that produce localized cranial deformation and focal injury (eg, fracture, contusion, or epidural hematoma). Accidental injury (AI) is considered typically associated with impact and, with the exception of epidural hematoma, is usually not life threatening. Impulsive loading refers to angular acceleration/deceleration forces resulting from sudden nonimpact motion of the head on the neck (ie, whiplash) and produces diffuse injury with tissue disruption (eg, bridging vein rupture with SDH and white matter shear with DAI). Young infants are thought particularly vulnerable to the latter mechanism (ie, SBS) because of weak neck muscles, a relatively large head, and an immature brain. SBS is traditionally postulated to result in the triad of primary traumatic injury (ie, SDH, RH, and DAI), which has been reportedly associated with the most severe and fatal CNS injuries. Stated assault mechanisms

Disclosure: Dr Barnes provides expert consultation and testimony in child abuse cases, occasionally with compensation, and including on behalf of the defense.

Department of Radiology, Lucile Packard Children's Hospital, Stanford University Medical Center, 725 Welch Road, Palo Alto, CA 94304, USA

E-mail address: pbarnes@stanford.edu

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in NAI include battering, shaking, impact, shaking-impact, strangulation, suffocation, and combined assaults (shake-bang-choke).¹⁻⁴ Although the spectrum of injury in NAI overlaps that of AI, certain patterns have been previously reported as characteristic of or highly suspicious for NAI.¹⁻⁴ These include multiple or complex cranial fractures (Fig. 1), acute interhemispheric SDH (Fig. 2), acute-hyperacute SDH (Fig. 3), DAI, chronic SDH, and the combination of chronic and acute SDH (Fig. 4). The latter combination is thought indicative of more than one abusive event. Imaging evidence of brain injury may occur with or without other clinical findings of trauma (eg, bruising) or other traditionally higher-specificity imaging findings of abuse (eg, classic metaphyseal lesions or rib fractures) (Fig. 5).¹⁻⁴ Therefore, clinical and imaging findings of injury out of proportion to the history of trauma and injuries of different ages have been the basis of making a medical diagnosis and offer expert testimony that such “forensic” findings are “proof” of NAI/SBS, particularly when encountered in premobile, young infants.

EVIDENCE-BASED MEDICINE

Evidence-based medicine (EBM) is now the guiding principle as medicine moves from an

authoritarian to an authoritative era to overcome bias and ideology.^{4,15-20} EBM quality-of-evidence ratings of the literature (eg, classes I-IV) are based on levels of accepted scientific methodology and biostatistical significance (eg, *P* values) and apply to the formulation of standards and guidelines for every aspect of medicine, including diagnostics, therapeutics, and forensics. EBM analysis reveals that few published reports in the traditional NAI/SBS literature merit a quality-of-evidence rating above class IV (eg, expert opinion alone).⁵ Such low ratings do not meet EBM recommendations for standards (eg, level A) or for guidelines (eg, level B). Difficulties exist in the rational formulation of a medical diagnosis or forensic determination of NAI/SBS based on an alleged event (eg, shaking) that is inferred from clinical, imaging, or pathology findings in the subjective context of (1) an unwitnessed event, (2) a noncredible history, or (3) an admission or confession under dubious circumstances.⁶ This problem is further confounded by the lack of consistent and reliable criteria for the diagnosis of NAI/SBS and because much of the traditional literature on child abuse consists of anecdotal case series, case reports, reviews, opinions, and position papers.^{5,6,10,11,21,22} Many reports include cases having impact injury, which

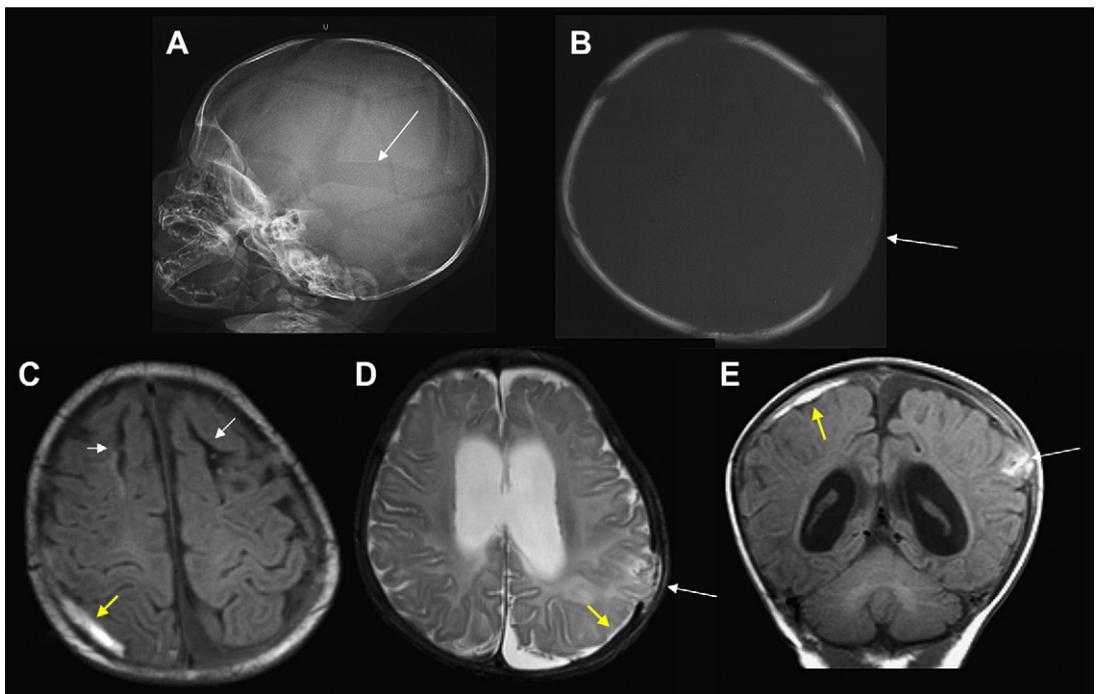


Fig. 1. Nine-week-old infant with triad and alleged NAI; also, history of traumatic labor and delivery. Skull film (A), CT (B) plus FLAIR (C), T2 (D), and T1 (E) MR imaging shows bilateral skull fractures with left growing fracture (long white arrows), chronic bifrontal cerebral white matter clefts (short white arrows) (C) plus acute, subacute, and chronic SDHs/rehemorrhages (yellow arrows).

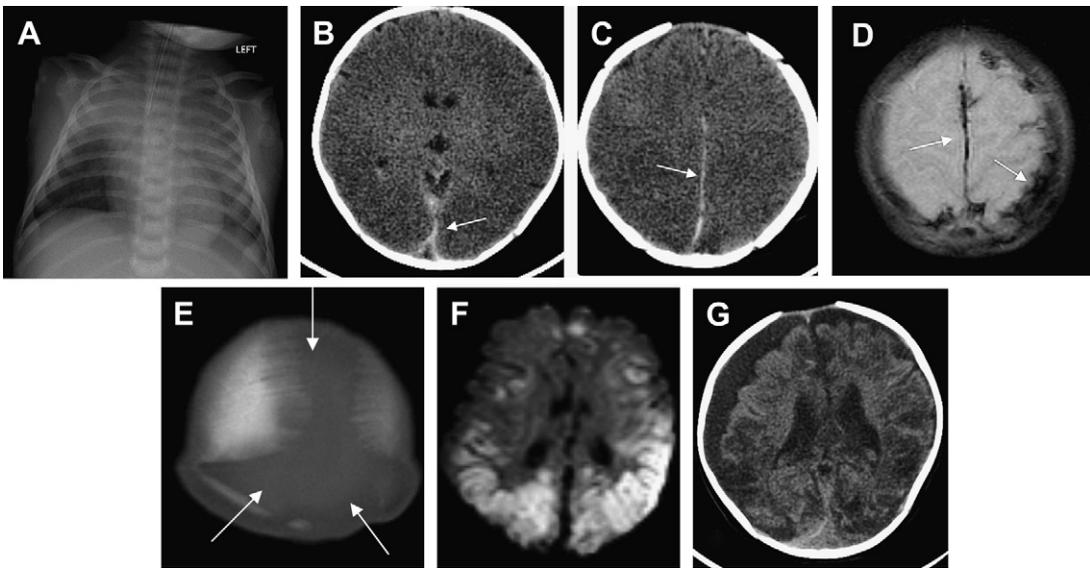


Fig. 2. Five-week-old infant with triad and alleged NAI; also, cold symptoms, vitamin D undersupplemented, acute choking episode during feeding, and status epilepticus. Chest film (A) shows bilateral lung opacities. CT (B, C) plus T2* MR imaging (D) shows bilateral cerebral edema with bilateral thin, acute-subacute hemorrhages (or thromboses) about the falx, tentorium, and convexities (arrows). Vertex CT (E) shows suture diastasis versus pseudodiastasis (arrows) (craniotabes?). DWI (F) shows global hypoxic-ischemic injury. Later CT (G) shows atrophy and chronic SDH.

undermines the SBS hypothesis by imposing a shaking-impact syndrome. Also, the inclusion criteria provided in many reports are criticized as arbitrary. Examples include suspected abuse, presumed abuse, likely abuse, and

indeterminate.^{21,22} Furthermore, the diagnostic criteria often seem to follow circular logic, such that the inclusion criteria (eg, the triad equals SBS/NAI) becomes the conclusion (ie, SBS/NAI equals the triad).

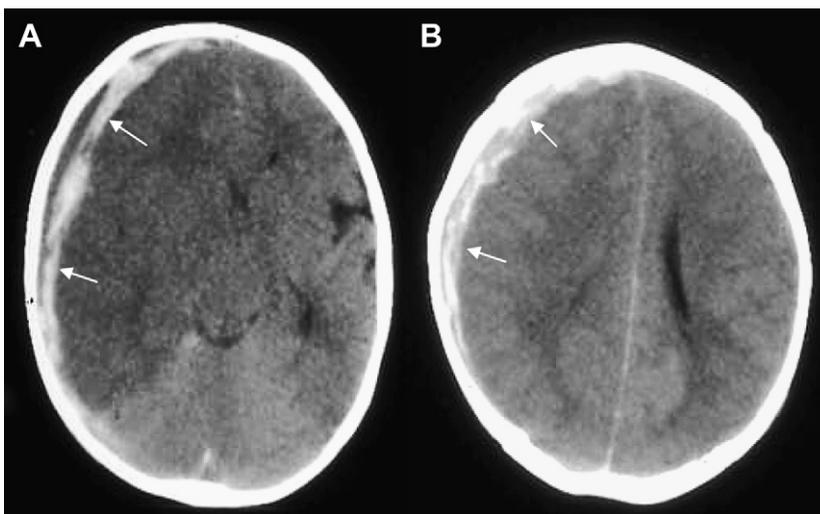


Fig. 3. Eight-month-old infant with triad and alleged NAI; also, right occipital skull fracture (age indeterminate; not shown) and 4- to 6-week-old wrist fracture. Hyperacute right SDH versus chronic SDH with rehemorrhage? CT (A, B) shows mixed high- plus low-density right extracerebral collection (arrows) with right cerebral edema, mass effect, and left shift. Question of subdural membrane on autopsy.

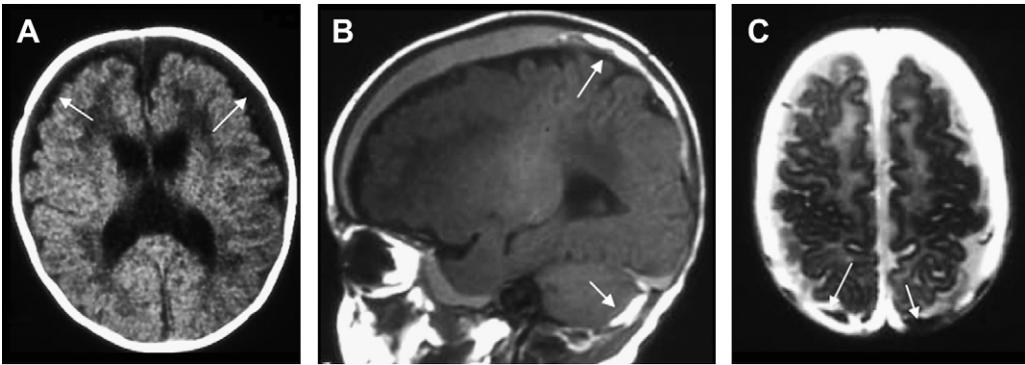


Fig. 4. Six-month-old infant with macrocephaly, the triad, and alleged NAI: BECC versus chronic SDH with rehemorrhage versus acute SDHG plus SDH? CT (A) shows bilateral frontal isohypodense extracerebral collections (arrows) with minute high densities (not shown). T1 MR imaging (B) shows smaller extracerebral high intensities (arrows) superimposed on larger isohypointensities. T2 MR imaging (C) shows small extracerebral T2 hypointensities (arrows) superimposed on large isohyperintensities.

RULES OF EVIDENCE AND EXPERT TESTIMONY

Regarding rules of evidence within the justice system, there are legal standards for the admissibility of expert testimony.^{7,8,11,23} The Frye standard requires only that the testimony be generally accepted in the relevant scientific community. The Daubert standard requires assessment of the scientific reliability of the testimony. A criticism of the justice system is that the application of these standards varies with the jurisdiction (eg, according to state versus federal law). Additional legal standards regarding proof are also applied in order for the trier of fact (eg, judge or jury) to make the determination of civil liability or criminal guilt. In a civil action (eg, medical malpractice lawsuit), money is primarily at risk for the

defendant health care provider, and proof of liability is based on a preponderance of the evidence (ie, at least 51% scientific or medical probability or certainty). In a criminal action, life or liberty is at stake for the defendant, including the permanent loss of child custody.^{7,8,11,23,24} In such cases, the defendant has the constitutional protection of due process that requires a higher level of proof. This includes the principles of innocent until proved guilty beyond a reasonable doubt with the burden of proof on the prosecution and based on clear and convincing evidence. No percentage of level of certainty is provided, however, for these standards of proof in most jurisdictions. Furthermore, only a preponderance of the medical evidence (ie, minimum of 51% certainty) is required to support proof of guilt whether or not the medical expert testimony

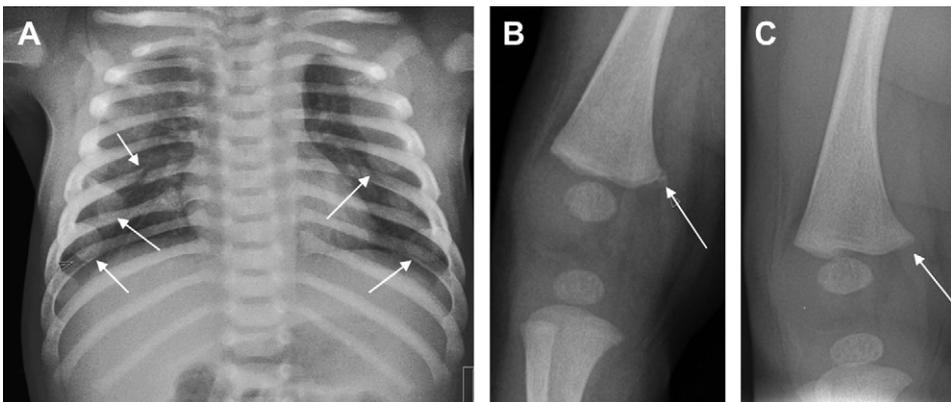


Fig. 5. Three-month-old infant with alleged NAI; also, history consistent with congenital rickets. Chest film (A) shows bilateral recent and old, healing rib fractures (pseudofractures? rachitic rosary? [arrows]). Knee films before (B) and after (C) vitamin D supplementation show healing classic metaphyseal lesions (arrows)?

complies with the Frye standard (ie, general acceptance requirement) or the Daubert standard (ie, scientific reliability requirement). Further criticism of the criminal justice process is that in NAI cases, medical experts have defined SBS/NAI as “the presence of injury (eg, the triad) without a sufficient historical explanation” and that this definition unduly shifts the burden to the defendant to establish innocence by proving the expert theory wrong.

THE MEDICAL PROSECUTION OF NAI AND ITS EBM CHALLENGES

Traditionally, the prosecution of NAI has been based on the presence of one or more aspects of the triad as supported by the premises that (1) shaking alone in an otherwise healthy child can cause SDH leading to death, (2) such injury can never occur on an accidental basis (eg, short-distance fall) because it requires a massive violent force equivalent to a motor vehicle accident or a fall from a multistory building, (3) such injury is immediately symptomatic and cannot be followed by a lucid interval, and (4) changing symptoms in a child with prior head injury indicates newly inflicted injury and not a spontaneous re-bleed.^{1–4,7,8,11} Using this reasoning, the last caretaker is automatically guilty of inflicted injury, especially if not witnessed by an independent observer. Also, it has been asserted that RHs of a particular pattern are diagnostic of SBS/NAI.

Reports from clinical, biomechanical, pathology, forensic, and legal disciplines, within and outside of the child maltreatment literature, have challenged the evidence base for NAI/SBS as the only cause for the triad.^{5–12} Such reports indicate that the triad may also be seen with AI (including witnessed short-distance falls, lucid intervals, and rehemorrhage) (Figs. 6 and 7) as well as in medical conditions. These are the mimics of NAI and often present as acute life-threatening events (ALTEs).^{25,26} The medical mimics include hypoxia-ischemia (eg, apnea, choking, or respiratory or cardiac arrest) (see Figs. 2, 6, and 7), ischemic injury (eg, arterial versus venous occlusive disease) (Fig. 8), vascular anomalies (eg, arteriovenous malformation [AVM]) (Fig. 9), seizures (see Fig. 2), infectious or postinfectious conditions (Fig. 10), coagulopathies (Fig. 11), fluid-electrolyte derangement, and metabolic or connective tissue disorders, including vitamin deficiencies and depletions (eg, C, D, or K) (see Figs. 1 and 5; Fig. 12).^{2,4}

Many ALTEs seem multifactorial and involve a combination, sequence, or cascade of predisposing and complicating events or conditions.^{4,25} As an example, an infant may suffer a head impact,

or choking spell, followed by seizures or apnea, and then undergo a series of interventions, including prolonged or difficult resuscitation and problematic airway management with subsequent hypoxia-ischemia and coagulopathy (see Figs. 2, 6, 7, and 11). Another example is a young infant with a predisposing condition, such as infectious illness, fluid-electrolyte imbalance, metabolic disorder, or a coagulopathy, who then suffers seizures, respiratory arrest, and resuscitation with hypoxia-ischemia (see Figs. 10–12; Fig. 13). In many cases of alleged SBS/NAI, it is often assumed that nonspecific premorbid symptoms (eg, irritability, lethargy, and poor feeding) in an otherwise healthy infant are indicators of ongoing abuse or that such symptoms become the inciting factor for the abuse. A thorough and complete medical investigation in such cases may reveal that the child is not otherwise healthy and is suffering from a medical condition that progresses to an ALTE.^{2,4,25}

BIOMECHANICAL CHALLENGES

The mechanical basis for SBS as hypothesized by Guthkelch, Caffey, and other investigators,²⁷ was originally extrapolated from Ommaya,²⁸ who used an animal whiplash model to determine the angular acceleration threshold (ie, 40 g) for head injury (ie, concussion, SDH, and shear injury). It was assumed that manual shaking of an infant could generate these same forces and produce the triad. Duhaime and colleagues²⁹ measured the angular accelerations associated with adult manual shaking (ie, 11 g) and impact (ie, 52 g) in a 1-month-old infant anthropomorphic test device (ATD). Only accelerations associated with impact (4 to 5 times that associated with shakes) on an unpadded or padded surface exceeded the injury thresholds determined by Ommaya. In the same study, the Duhaime and colleagues reported a series of 13 fatal cases of NAI/SBS in which all had evidence of blunt head impact (more than half noted only at autopsy).²⁹ The investigators concluded that CNS injury in SBS/NAI in its most severe form is usually not caused by shaking alone. Their results contradicted many of the original reports that had relied on the whiplash mechanism as causative of the triad. They suggested the use of the new term, shaken-impact syndrome. More recently, Prange and colleagues,³⁰ using a 1.5 month-old ATD, showed that inflicted impacts against hard surfaces were more likely associated with brain injury than falls from less than 1.5 m or from vigorous shaking. With further improvements in ATDs, more recent experiments indicate that maximum head

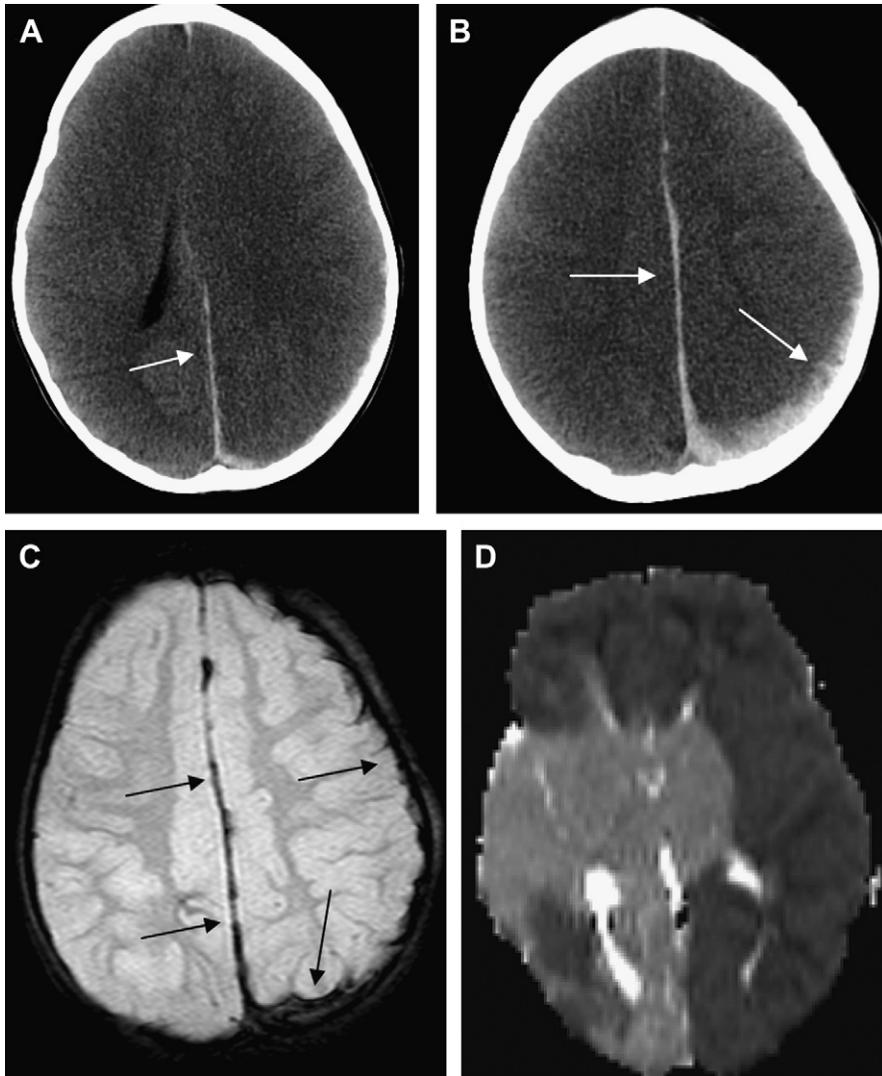


Fig. 6. Twenty-one-month-old toddler with triad and alleged NAI; also, history of prior head impact. Question prior injury with lucid interval versus hyperacute injury. CT (A, B) acute left convexity and interhemispheric SDH and SAH (arrows) with cerebral swelling, left more than right. T2* MR imaging (C) shows low intensity SDH (arrows) with T1/T2 isointensity (not shown). ADC map (D) shows asymmetric cerebral restricted diffusion (left > right). Autopsy confirms impact with acute SDH, SAH, and hypoxic-ischemic injury.

accelerations may exceed injury reference values at lower fall heights than previously determined (Fig. 14).³¹ Critics of the Duhaime and Prange studies contend that there is no adequate human infant surrogate yet designed to properly test shaking versus impact.³² Other reports also show that shaking alone cannot result in brain injury (ie, the triad) unless there is concomitant injury to the neck, cervical spinal column, or cervical spinal cord, because these are the weak links between the head and body of the infant.^{33–35} Spinal cord injury without radiographic abnormality (SCIWORA), whether or not AI or

NAI, is an important example of primary neck and spinal cord injury with secondary brain injury (see Fig. 7).³⁵ For example, a falling infant experiences a head-first impact with subsequent neck hyperextension (or hyperflexion) from the force of the trailing body mass. There is resultant upper spinal cord injury without detectable spinal column injury on plain films or CT. Compromise of the respiratory center at the cervicomedullary junction results in hypoxic brain injury, including the thin SDH (see Fig. 7). CT often shows the brain injury, but only MR imaging may show the additional neck or spinal cord injury.

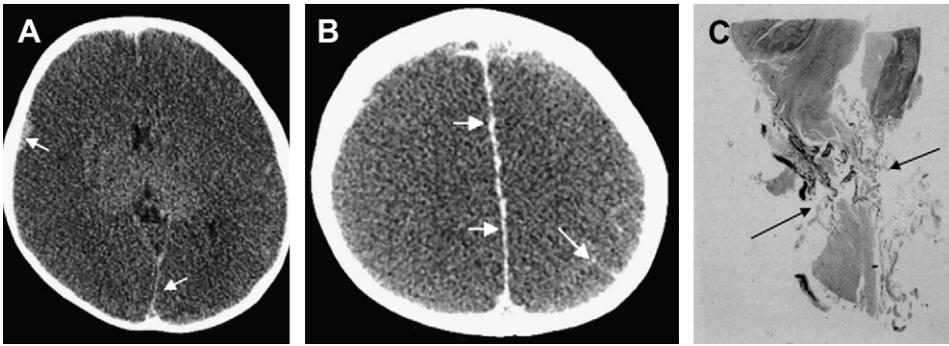


Fig. 7. Twenty-one-month-old with triad and alleged NAI; also, history of 4-ft fall. CT (A, B) with high-density SAH and thin SDH (arrows) plus cerebral edema. Sagittal plane photomicrograph (C) from autopsy shows upper cervical spinal cord disruption (arrows) resulting in global hypoxic-ischemic injury.

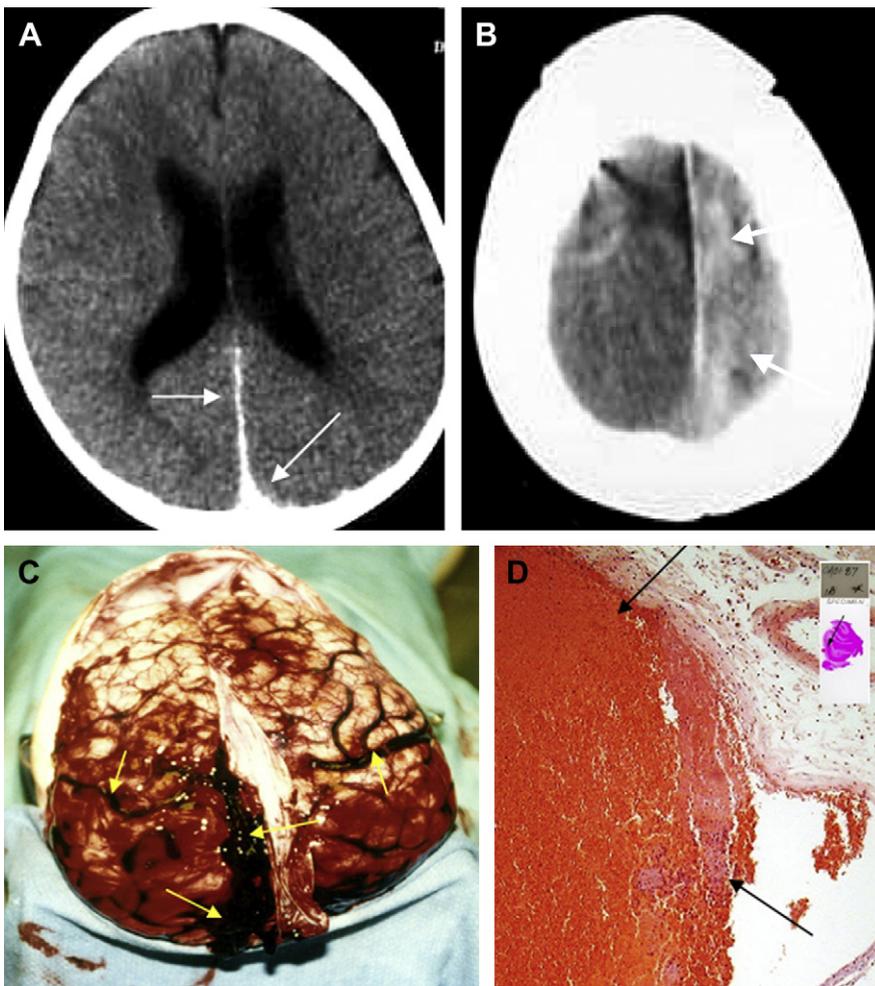


Fig. 8. Fourteen-month-old infant with triad and alleged NAI; also, recent infectious illness: dural and cortical venous sinus thrombosis with dural hemorrhage: CT (A, B) shows high densities along the falx and dural venous sinuses (white arrows). (C) Gross specimen—reflected superior sagittal sinus and cortical venous thromboses with distended veins (yellow arrows); (D) photomicrograph of cortical venous thrombus with inflammatory reaction (black arrows) plus SDH with neomembrane (7–14 days old; not shown). (Pathology courtesy of J. Leestma, MD.)

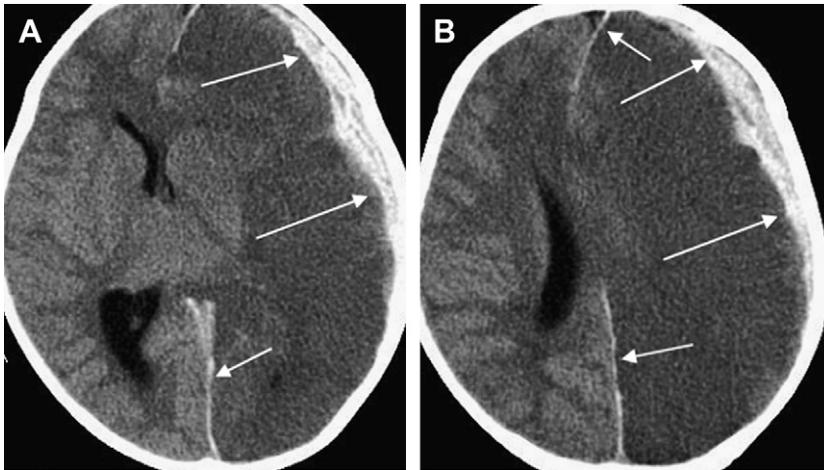


Fig. 9. Twenty-month-old infant with triad and alleged NAI. Left SDH with cerebral cortical and pial AVM at autopsy. CT (A, B) shows left mixed-density SDH and SAH (long arrows) plus interhemispheric hemorrhage (short arrows) with marked left cerebral swelling and shift.

The minimal force required to produce the triad has yet to be established. From the current biomechanical evidence base, however, it can be concluded that (1) shaking may not produce direct brain injury but may cause indirect brain injury if associated with neck and cervical spinal cord injury; (2) angular acceleration/deceleration injury forces clearly occur with impact trauma; (3) such injury on an accidental basis does not require a force that can only be associated with a motor vehicle accident or a multistory fall; (4) household (ie, short-distance) falls may produce direct or indirect brain injury; (5) in addition to fall height, impact surface and type of landing are important factors; and (6) head-first impacts in young infants not having developed a defensive reflex (eg,

extension of a limb to break the fall) are the most dangerous and may result in direct or indirect brain injury (eg, SCIWORA).

NEUROPATHOLOGY CHALLENGES

In their landmark neuropathology study of 53 victims of alleged SBS/NAI,^{36,37} Geddes and colleagues showed in 37 infants (ages <9 months) that (1) 29 had evidence of impact with only one case of admitted shaking; (2) cerebral swelling was more often due to DAI of hypoxic-ischemic encephalopathy (HIE) rather than shear or traumatic axonal injury (TAI); (2) although fracture, thin SDH (eg, dural vascular plexus origin), and RH are commonly present, the usual cause of

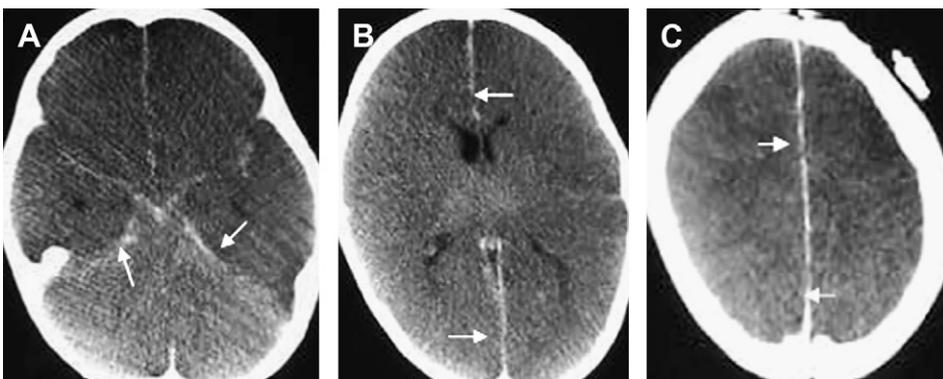


Fig. 10. Twenty-one-month-old infant with triad and alleged NAI. Pneumococcal meningitis, herniation, and hypoxic-ischemic injury confirmed at autopsy. CT (A–C) shows high-density thin SDH (arrows) plus cerebral edema.

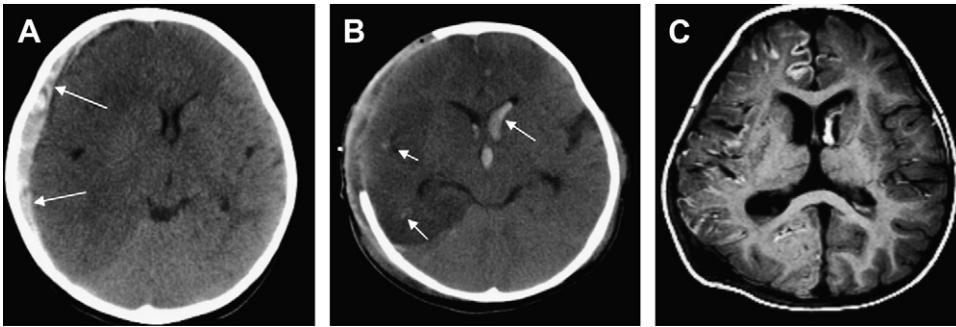


Fig. 11. Nine-month-old girl with triad and alleged NAI; also, recent fall and coagulopathy (later confirmed platelet disorder). Initial CT (A) shows mixed-density right SDH (arrows) with right cerebral edema. Postoperative CT 5 days later (B) shows other cerebral and intraventricular hemorrhages (arrows). T1 MR imaging (C) 11 days postoperatively shows evolving right cerebral high-intensity cortical injury and hemorrhages.

death was increased intracranial pressure from brain swelling associated with HIE (see Fig. 2); and (4) cervical epidural hemorrhage and focal axonal brainstem, cervical cord, and spinal nerve root injuries were characteristically seen in these infants (most with impact). Upper cervical cord/brainstem injury may result in apnea/respiratory arrest and be responsible for the HIE. In the 16 older victims (ages 13 months to 8 years), the pathology findings were primarily those of the battered child or adult trauma syndrome, including extracranial injuries (eg, abdominal), large SDH (ie, bridging vein rupture), and TAI. Additional neuropathology series by Geddes and colleagues³⁸ have shown that SDHs are also seen in nontraumatic fetal, neonatal, and infant brain injury cases and that such SDHs are actually of intradural vascular plexus origin rather than bridging cortical vein origin.

The common denominator in all these cases is likely a combination of vascular immaturity and fragility further compromised by HIE or infection, cerebral venous hypertension or congestion, arterial hypertension, and brain swelling (see Fig. 2). Although the unified hypothesis of Geddes and colleagues^{13,14,39} has received criticism, their findings and conclusions have been validated by the research of Cohen and Scheimberg,⁴⁰ Croft and Reichard,⁴¹ and others. In their postmortem series, Cohen and colleagues described 25 fetuses (26–41 weeks) and 30 neonates (1 hour–19 days) with HIE who also had macroscopic intradural hemorrhage (IDH), including frank parietal SDH in two-thirds. The IDH was most prominent along the posterior falx and tentorial vascular plexuses (ie, interhemispheric fissure) (see Fig. 2). They concluded from their work, along with the findings of other cited

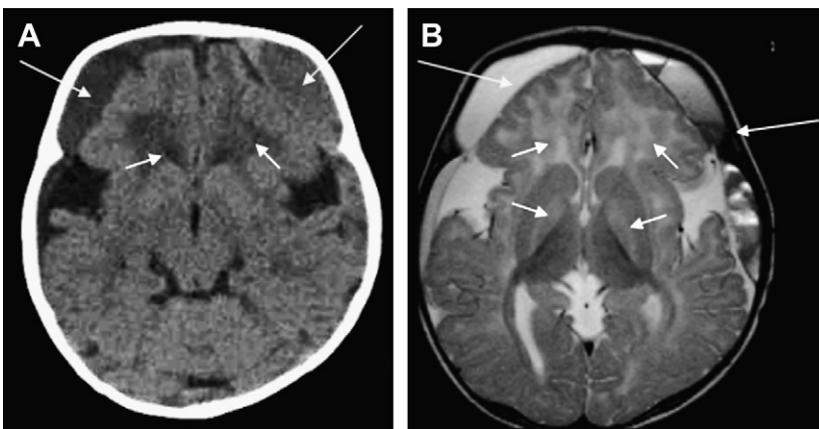


Fig. 12. Twelve-month-old infant with triad and alleged NAI. Glutaric acidopathy type 1. CT (A) and T2 MR imaging (B) shows bilateral SDH of varying age (long arrows), wide sylvian fissures plus basal ganglia, and cerebral white matter abnormalities (short arrows).

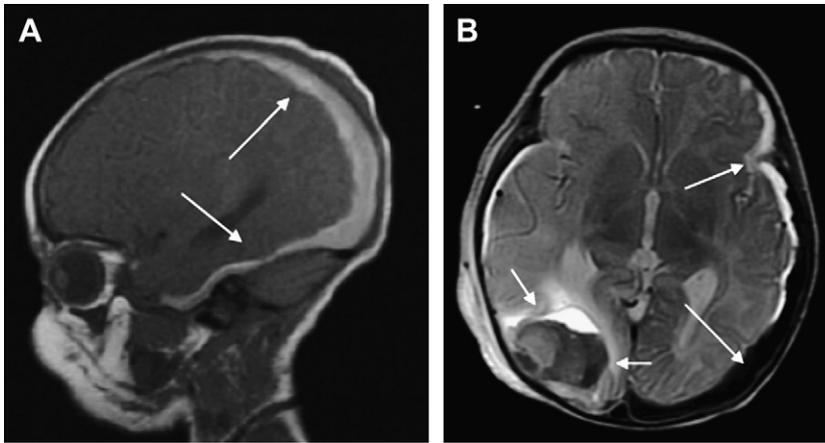


Fig. 13. Home-delivered newborn with seizures at 1 week of age; also, no vitamin K given at birth. T1 (A) and T2 (B) MR imaging shows acute-subacute left SDH (*long arrows*) plus right cerebral hemorrhage (*short arrows*); vitamin K deficiency confirmed and treated.

researchers, that IDH and SDH are commonly associated with HIE, particularly when associated with increases in central venous pressure. This also explains the frequency of RH associated with perinatal events.⁴²

From the current forensic pathology evidence base, it may be concluded that (1) shaking may not cause direct brain injury but may cause indirect brain injury (ie, HIE) if associated with cervical spinal cord injury; (2) impact may produce direct

or indirect brain injury (eg, SCIWORA); (3) the pattern of brain edema with thin SDH (dural vascular plexus origin) may reflect HIE whether or not due to AI or NAI; and (4) the same pattern of injury may result from nontraumatic or medical causes (eg, HIE from any cause of ALTE). Furthermore, because the observed edema does not represent TAI (which results in immediate neurologic dysfunction), a lucid interval is possible, particularly in infants whose sutured skull and

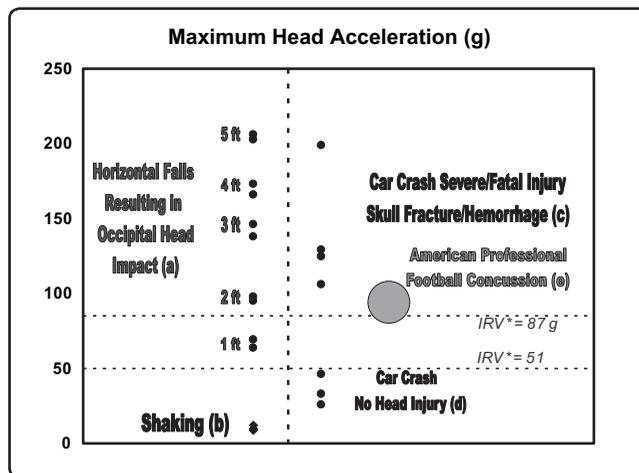


Fig. 14. Maximum head accelerations versus trauma mechanisms as correlated with injury thresholds. CRABI, child restraint air bag interaction; IRV, injury reference values. (Data from Van Ee C, PhD. Design research engineering. Available at: www.dreng.com. Accessed September 12, 2010; Leestma J. Forensic neuropathology. 2nd edition. Boca Raton [FL]: CRC Press; 2009; Mertz H. Anthropomorphic test devices. In: Melvin J, Nahum A, editors. Accidental injury: biomechanics and prevention. 2nd edition. New York: Springer; 2002. p. 84; Klinich JD, Hulbert G, Schneider LW. Estimating infant head injury criteria and impact response using crash reconstruction and finite element modeling. Society of Automotive Engineers Paper # 2002-22-0009, 2002; CRABI 12 [a, b]; CRABI 6 [c, d]; and [e] Pellman EJ, Viano DC, Tucker AM, et al. Concussion in professional football: reconstruction of game impacts and injuries. *Neurosurgery* 2003;53[4]:799-812.)

dural vascular plexus have the distensibility to tolerate early increases in intracranial pressure. Also, the lucid interval invalidates the premise that the last caretaker is always responsible in alleged NAI.

CLINICAL CHALLENGES

In the prosecution of NAI, it is often stipulated that short-distance falls cannot be associated with the triad, serious (eg, fatal) head injury, or a lucid interval. Traditionally, it has also been stipulated that nonintentional new bleeding in an existing SDH is always minor, that SDH does not occur in benign extracerebral collections (BECCs), and that symptomatic or fatal new bleeding in SDH requires newly inflicted trauma.^{1–4,7,8,11} Several past and current reports refute the significance of low level falls in children, including in-hospital and outpatient clinic series.^{43–51} There are other reports, however, including emergency medicine, trauma center, neurosurgical, and medical examiner series, that indicate a heightened need for concern regarding the potential for serious intracranial injury associated with minor or trivial trauma scenarios, particularly in infants.^{52–74} This includes reports of skull fracture or acute SDH from accidental simple falls in infants, SDH in infants with predisposing wide extracerebral spaces (eg, BECCs of infancy, chronic subdural hygromas, arachnoid cyst, and so forth) (see **Fig. 4**; **Figs. 15** and **16**), and fatal pediatric head injuries due to witnessed, accidental short-distance falls, including those with a lucid interval, SDH, RH, and malignant cerebral edema (see **Fig. 6**). Also included are infants with chronic SDH from prior trauma (eg, at birth) who then develop rehemorrhage (see **Figs. 1, 4, and 15**).

Short-Distance Falls, Lucid Intervals, and Malignant Edema

Hall and colleagues⁴⁴ reported that 41% of childhood deaths (mean age 2.4 years) from head injuries associated with AI were from low level falls (3 feet or less) while running or down stairs. Chadwick and colleagues⁴⁵ reported fatal falls of less than 4 feet in seven infants but considered the histories unreliable. Plunkett⁵⁶ reported witnessed fatal falls of 2 to 10 feet in 18 infants and children, including those with SDH, RH, and lucid intervals. Greenes and Schutzman⁵⁷ reported intracranial injuries, including SDH, in 18 asymptomatic infants with falls of 2 feet to 9 stairs. Christian and colleagues⁶³ reported three infants with unilateral RH and SDH/SAH due to witnessed accidental household trauma. Denton and Mileusnic⁵⁹ reported a witnessed, accidental 30-inch fall in a 9-month-old infant with a 3-day lucid interval before death. Murray and colleagues⁶⁰ reported more intracranial injuries in young children (49% <age 4 y; 21% <age 1 y) with reported low level falls (<15 ft), both AI and NAI. Kim and colleagues⁶¹ reported a high incidence of intracranial injury in children (ages 3 mo to 15 y; 52% <age 2 y) accidentally falling from low heights (3 to 15 ft; 80% <6 ft; including 4 deaths). Because of the lucid intervals in some patients, including initially favorable Glasgow Coma Scale scores (GCS) with subsequent deterioration, Murray and colleagues⁶⁰ and others expressed concern regarding caretaker delays and medical transfer delays contributing to the morbidity and mortality in these patients.^{53–56,58–61} Bruce and colleagues^{54,55} reported one of the largest pediatric series of head trauma (63 patients, ages 6 months to 18 years), both AI and NAI, associated with malignant brain edema and SAH/SDH (see **Fig. 6**). In the higher GCS (>8) subgroup,

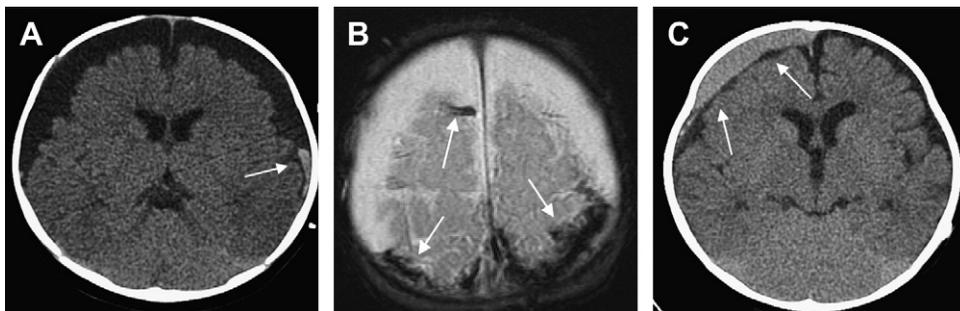


Fig. 15. Five-month-old infant with the triad and alleged NAI; also, macrocephaly from birth, recent seizure but no trauma. CT (A) and T2* MR imaging (B) shows large extracerebral collections with smaller recent hemorrhages (arrows). CT 3 months postdrainage (C) shows rehemorrhage (arrows). Diagnosis: BECC or chronic SDHG with rehemorrhage?

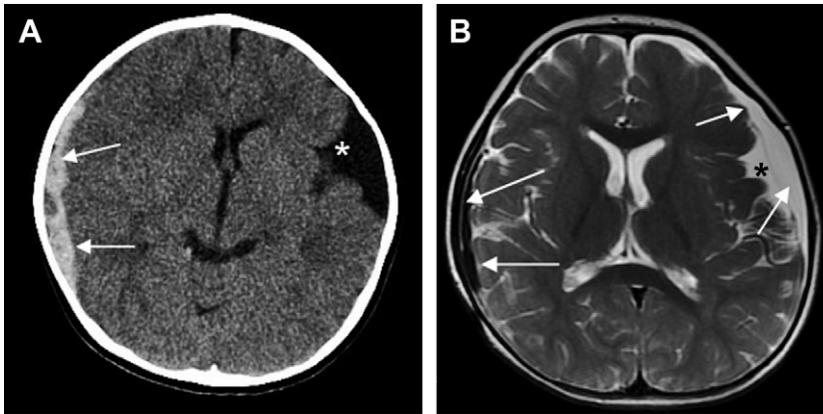


Fig. 16. Sixteen-month-old with triad (right RH) and alleged NAI; also, short-distance fall with right scalp impact. CT (A) shows left sylvian arachnoid cyst (*) and right hyperacute SDH (arrows). T2 MR imaging (B) 2 days later shows acute right SDH (long arrows) and smaller left sylvian arachnoid cyst (*) with subdural hygroma (short arrows).

there were 8 with a lucid interval and all 14 had complete recovery. In the lower GCS (≤ 8) subgroup, there were 34 with immediate and continuous coma, 15 with a lucid interval, 6 deaths, and 11 with moderate to severe disability. More recently, Steinbok and colleagues⁶² reported 5 children (4 <age 2 y; 3 falls) with witnessed AI, including SDH and cerebral edema detected by CT 1 to 5 hours post event. All experienced immediate coma with rapid progression to death (see Fig. 6).

Benign Extracerebral Collections

BECCs of infancy (also known as benign external hydrocephalus or benign extracerebral subarachnoid spaces) is a common and well-known condition characterized by diffuse enlargement of the subarachnoid spaces.^{65–74} A transient disorder of cerebrospinal fluid (CSF) circulation, probably due to delayed development of the arachnoid granulations, is widely accepted as the cause and develops from birth. BECC is typically associated with macrocephaly but may also occur in infants with normal or small head circumferences, including premature infants. As with any cause of craniocerebral disproportion (eg, BECC, hydrocephalus, chronic SDH or hygroma, arachnoid cyst, or underdevelopment or atrophy), there is a susceptibility to SDH that may be spontaneous or associated with trivial trauma (see Figs. 4 and 15). A recent large series report and review by Hellbusch⁷³ emphasizes the importance of this predisposition and cites other confirmatory series and case reports (30 references). Papasian and Frim⁶⁸ designed a theoretic model that

predicts the predisposition of benign external hydrocephalus to SDH with minor head trauma. Piatt's⁶⁶ case report of BECC with SDH (27 references), including RH, along with McNeely and colleagues⁷² case series are further warnings that this combination is far from specific for SBS/NAI.

Birth Issues

In addition to the examples discussed previously (eg, short-distance falls and BECCs), another important but often overlooked factor is birth-related trauma.^{1,4,75–89} This includes normal as well as complicated labor and delivery events (pitocin augmentation, prolonged labor, vaginal delivery, instrumented delivery, cesarean section, and so forth). It is well known that acute SDH often occurs even with the normal birth process and that this predisposes to chronic SDH, including in the presence of BECC (see Figs. 1, 4, and 15). Intracranial hemorrhages, including SDH and RH, have been reported in several CT and MR imaging series of normal neonates including a frequency of 50% by Holden and colleagues,⁸¹ 8% by Whitby and colleagues,⁷⁶ 26% by Looney and colleagues,⁸² and 46% by Rooks and colleagues.⁷⁸ Chamnanvanakij and colleagues⁷⁵ reported 26 symptomatic term neonates with SDH over a 3-year period after uncomplicated deliveries. Long-term follow-up imaging has not been provided in many of these series, although Rooks and colleagues⁷⁸ reported one child in their series who developed SDH with rehemorrhage superimposed on BECC (Fig. 17).

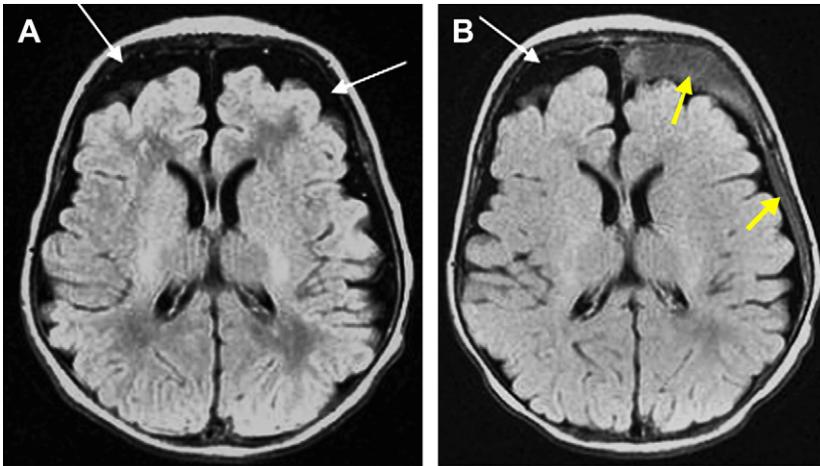


Fig. 17. BECC versus SDHG at birth (A) (*long arrows*) with SDH versus rehemorrhage 1 month later (B) (*yellow arrows*) on axial FLAIR MR images. (Courtesy of Veronica J. Rooks, MD, Tripler Army Medical Center, Honolulu, HI.)

Chronic SDH and Rehemorrhage

Chronic SDH is one of the most controversial topics in the NAI versus AI debate.^{1–4,12,21,22,36–41} Unexplained SDH is often ascribed to NAI. By definition, a newly discovered chronic SDH started as an acute SDH that, for whatever reason, may have been subclinical. There is likely more than one mechanism for SDH that has prompted a revisiting of the concept of the subdural compartment.^{12,40,41,90,91} Mack and colleagues⁹⁰ have provided an updated review on this important topic. In some cases of infant trauma, dissection at the relatively weak dura-arachnoid border zone (ie, dural border cell layer) may allow CSF to collect and enlarge over time as a dural interstitial (ie, intradural) hygroma. In other cases, there is bridging vein rupture within the dural interstitium that results in an acute subdural or intradural hematoma that extends along the dural border cell layer. Furthermore, traumatic disruption of the dural vascular plexus (ie, venous, capillary, or lymphatic), which is particularly prominent in young infants, may also produce an acute intradural hematoma. Some of these collections undergo resorption whereas others progress to become chronic SDH. Some progressive collections may represent mixed CSF-blood collections (see **Figs 1, 4, and 15**).

The pathology and pathophysiology of neomembrane formation in chronic SDH, including rebleeding, is well established in adults and seems similar, if not identical, to that in infants.^{83,92–112} Although acute SDH is most often due to impact or deformational trauma, whether or not AI or NAI, it must be differentiated from chronic SDH

with rehemorrhage. Progression of chronic SDH and rehemorrhage is likely related to capillary leakage and intrinsic thrombolysis.^{92,93} Other factors include dural vascular plexus hemorrhage associated with increases in intracranial or central venous pressures (eg, birth trauma, congenital heart disease, venous thrombosis, or dysphagic choking) or with increased meningeal arterial pressure (eg, reperfusion after hypoxia-ischemia) with resultant acute hemorrhage (or rehemorrhage) in normal infants or superimposed on predisposing chronic BECC, hygromas, hematomas, or arachnoid cysts (see **Figs. 1, 2, 4, and 15–17**).^{12,38,40,65–74,90,91} The phenomenon of acute infantile SDH, whether or not AI or NAI, evolving to chronic SDH and rehemorrhage, including RH, is well documented in several neurosurgical series reports, including those by Aoki and colleagues,^{97,98} Ikeda and colleagues,⁹⁹ Parent,⁹⁴ Howard and colleagues,¹⁰² Hwang and Kim,⁹⁵ Vinchon,^{103,104} and others.

Conclusions

From the clinical evidence base, in addition to the biomechanical and neuropathology evidence bases, it may be concluded that (1) significant head injury, including SDH and RH, may result from low fall levels; (2) such injury may be associated with a lucid interval; (3) in some, the injury may result in immediate deterioration with progression to death; (4) BECC predisposes to SDH; (5) SDH may date back to birth; and (6) rehemorrhage into an existing SDH occurs in childhood and may be serious.

RH CHALLENGES

Many guidelines for diagnosing NAI depend on the presence of RH, including those of a particular pattern (eg, retinal schisis, and perimacular folds) and based on the theory of vitreous traction due to inflicted acceleration/deceleration forces (eg, SBS).^{1–4,113–132} The specificity of RH for NAI has been repeatedly challenged, however. Plunkett⁵⁶ reported RH in two-thirds of eye examinations in children with fatal AI. Goldsmith and Plunkett¹³² reported a child with extensive bilateral RH in a videotaped fatal accidental short-distance fall. Lantz and colleagues¹²² reported RH with perimacular folds in an infant crush injury. Gilles and colleagues¹²⁰ reported the appearance and progression of RH with increasing intracranial pressure after head injury in children. Obi and Watts¹²⁵ reported RH with schisis and folds in two children, one with AI and the other with NAI. Forbes and colleagues¹²⁶ reported RH with epidural hematoma in five infant AI cases. From a research perspective, Brown and colleagues¹²⁸ found no eye pathology in their fatal shaken animal observations. Binenbaum and colleagues¹²⁷ observed no eye abnormalities in piglets subjected to acceleration/deceleration levels greater than 20 times what Prange and colleagues³⁰ predicted possible in inflicted injury. Emerson and colleagues¹²⁹ found no support for the vitreous traction hypothesis as unique to NAI. The eye and optic nerve are an extension of, and therefore a window to, the CNS, including their shared vascularization, meningeal coverings, innervation, and CSF spaces. RH has been reported with a variety of conditions, including AI, resuscitation, increased intracranial pressure, increased venous pressure, subarachnoid hemorrhage, sepsis, coagulopathy, certain metabolic disorders, systemic hypertension, and other conditions.^{121,123,131} The common pathophysiology seems to be increased intracranial pressure or increased intravascular pressure. Furthermore, many cases of RH (and SDH) are confounded by the sequence or cascade of multiple conditions (eg, the unified hypothesis of Geddes) that often has a synergistic influence on the type and extent of RH. For example, consider the common situation of a child who has had trauma (factual or assumed) followed by seizures, apnea, or respiratory arrest and resuscitation with resultant HIE or coagulopathy. In much of the traditional NAI/SBS literature, little if any consideration has been given to any predisposing or complicating factors, and often there is no indication of the timing of the eye examinations relative to the clinical course or the brain imaging.^{113,114,119,130}

From the research and clinical evidence base, it may be concluded that (1) RH is not specific for NAI, (2) RH may occur in AI and medical conditions, and (3) predisposing factors and complicating cascade effects must be considered in the pathophysiology of RH.

MEDICAL CONDITIONS MIMICKING NAI

A significant part of the controversy is the medical conditions that may mimic the clinical presentations (ie, the triad) and imaging findings of NAI.^{1,2,4,25,26,89,101} Furthermore, such conditions may predispose to or complicate AI or NAI, as part of a cascade that results in or exaggerates the triad. In some situations, it may be difficult or impossible to tell which of these elements are causative and which are the effects. These include HIE, seizures, dysphagic choking ALTE, cardiopulmonary resuscitation, infectious or post-infectious conditions (eg, sepsis, meningoen- cephalitis, or postvaccinial), vascular diseases, coagulopathies, venous thrombosis, metabolic disorders, neoplastic processes, certain therapies, extracorporeal membrane oxygenation, and other conditions.^{4,25,89,101} Regarding pathogenesis of the triad (with or without other organ system involvement [eg, skeletal]) and whether or not due to NAI, AI, or medical etiologies, the pathophysiology seems to be a combination or sequence of factors, including increased intracranial pressure, increased venous pressure, systemic hypotension or hypertension, vascular fragility, hematologic derangement, and/or a collagenopathy imposed on the immature CNS, including the vulnerable dural vascular plexus as well as other organ systems.^{4,12,25,38,90} Although the initial medical evaluation, including history, laboratory tests, and imaging studies, may suggest an alternative condition, the diagnosis may not be made because of a rush to judgment regarding NAI.^{4–11} Such bias may have devastating effects on an injured child and family. It is important to be aware of these mimics, because a more extensive work-up may be needed beyond routine screening tests. Also, lack of confirmation of a specific condition does not automatically indicate the default diagnosis of NAI. In all cases, it is critical to review all past records dating back to the pregnancy and birth as well as the postnatal pediatric records, family history, more recent history preceding the acute presentation, details of the acute event itself, resuscitation, and the subsequent management, all of which may contribute to the clinical and imaging findings. An incomplete medical evaluation may result in unnecessary cost shifting to

child protection and criminal justice systems and have further adverse effects regarding transplantation organ donation in brain death cases and custody/adoptive dispositions for the surviving child and siblings.

Sirotnak's⁸⁹ recent review, along with others', extensively catalogs the many conditions that may mimic NAI^{4,25,101}:

Birth Trauma and Neonatal Conditions

Manifestations of birth trauma, including fracture, SDH, and RH, may persist beyond the neonatal period. Other examples are the sequelae of extracorporeal membrane oxygenation therapy, at-risk prematurity, and congenital heart disease. When evaluating a young infant with apparent NAI, it is important to consider that the clinical and imaging findings may actually stem from parturitional and neonatal issues.^{75–112} These include hemorrhage or rehemorrhage into extracerebral collections existing from birth (see **Figs. 1, 4, 13, and 15**). There may be associated skeletal findings of birth trauma (eg, new or healing clavicle, rib, or long bone fractures), particularly in the presence of a bone fragility disorder (see **Figs. 1, 2 and 5**).^{133–137}

Developmental Anomalies and Congenital Conditions

Vascular malformations are rarely reported causes for the triad but may be underdiagnosed (see **Fig. 9**). BECCs and arachnoid cysts are also known to be associated with SDH and RH, spontaneously and with trauma (see **Figs. 4, 15–17**).^{65–74}

Genetic and Metabolic Disorders

Several conditions in the genetic and metabolic disorders category may present with intracranial hemorrhage (eg, SDH) or RH. These include osteogenesis imperfecta, glutaric aciduria type I (see **Fig. 12**), Menkes' kinky hair disease, Ehlers-Danlos and Marfan syndromes, homocystinuria, and others.^{4,89,101,138–142}

Hematologic Disease and Coagulopathy

Conditions in the hematologic disease and coagulopathy category predispose to intracranial hemorrhage and RH (see **Figs. 11 and 13**). The bleeding or clotting disorder may be primary or secondary. A more extensive work-up beyond the usual screening tests is needed, including a hematology consultation. Conditions in the category include the anemias, hemorrhagic disease of the newborn (vitamin K deficiency), the hemophilias, thrombophilias, disseminated intravascular coagulation and consumption coagulopathy, liver or kidney

disease, hemophagocytic lymphohistiocytosis, and anticoagulant therapy.^{4,89,101,143–145} Venous thrombosis includes dural venous sinus thrombosis (DVST) and cerebral venous thrombosis (CVT). DVST or CVT may be associated with primary or secondary hematologic or coagulopathic states.^{4,89,101,146–152} Risk factors include acute systemic illness, dehydration, fluid-electrolyte imbalance, sepsis, perinatal complications, chronic systemic disease, cardiac disease, connective tissue disorder, hematologic disorder, oncologic disease and therapy, head and neck infection, hypercoagulable, and trauma states. Infarction, SAH, SDH, or RH may be seen, especially in infants. High densities on CT may be present along the dural venous sinuses, tentorium, falx, or the cortical, subependymal, or medullary veins and be associated with SAH, SDH, or intracerebral hemorrhage (see **Fig. 8**). There may be focal infarctions, hemorrhagic or nonhemorrhagic, intraventricular hemorrhage, and massive, focal, or diffuse edema. Orbit, paranasal sinus, or otomastoid disease may be present. The thromboses and associated hemorrhages have variable MR imaging appearances depending on their age. CT venography (CTV) or magnetic resonance venography (MRV) may readily detect DVST but not CVT. The latter may be better detected as abnormal hypointensities on susceptibility-weighted T2* sequences but difficult to distinguish from hemorrhage (SDH or SAH), hemorrhagic infarction, contusion, or hemorrhagic shear injury.

Infectious and Postinfectious Conditions

Meningitis, encephalitis, or sepsis may involve the vasculature resulting in vasculitis, arterial or venous thrombosis, mycotic aneurysm, infarction, and hemorrhage.^{4,89,101} SDH and RH may also be seen (see **Fig. 10**). Postinfectious illnesses may also be associated with these findings. Included in this category are the encephalopathies of infancy and childhood, hemorrhagic shock and encephalopathy syndrome, and postvaccinal encephalopathy.^{4,89,101,153–158}

Toxins, Poisons, and Nutritional Deficiencies

The category of toxins poisons, and nutritional deficiencies includes lead poisoning, cocaine, anticoagulants, over-the-counter cold medications, prescription drugs, and vitamin deficiencies or depletions (eg, K, C, or D).^{4,89,101,136,143,155–159} Preterm neonates, and other chronically ill infants, are particularly vulnerable to nutritional deficiencies and complications of prolonged immobilization that often primarily effect bone development. Furthermore, the national and

international epidemic of vitamin D deficiency and insufficiency in pregnant mothers, their term fetuses, and their undersupplemented breastfed term neonates predisposes them to rickets (ie, congenital). Such infants, who have also been subjected to the trauma of birth, may have skeletal imaging findings (eg, multiple healing fractures or pseudofractures) that are misinterpreted as NAI, especially in the presence of the triad (see **Figs. 2 and 5**).^{136,137}

Dysphagic Choking ALTE as a Mimic of NAI

Apnea is an important and common form of ALTE in infancy whose origin may be central, obstructive, or combined.²⁵ The obstructive and mixed forms may present with choking, gasping, coughing, or gagging due to mechanical obstruction. When paroxysmal or sustained, the result may be severe brain injury or death due to a combination of central venous hypertension and hypoxia-ischemia. It is this synergism that produces cerebral edema and dural vascular plexus hemorrhage with SDH, SAH, and RH (see **Fig. 2**; **Fig. 18**). Examples include dysphagic choking (eg, aspiration of a feed or gastroesophageal reflux), viral airway infection (eg, RSV), and pertussis, particularly when occurring in a predisposed child (eg, prematurity, Pierre Robin syndrome, or sudden infant death syndrome).^{25,160–167}

IMAGING CHALLENGES AND THE IMPORTANCE OF A DIFFERENTIAL DIAGNOSIS CT

Because of the evidence-based challenges to NAI, imaging protocols should be designed to evaluate not only NAI versus AI but also the medical mimics.

Noncontrast CT has been the primary modality for brain imaging because of its access, speed, and ability to show lesions (eg, hemorrhage and edema) requiring immediate neurosurgical or medical intervention.^{4,77,83–99,102–112,168–181} Cervical spinal CT may also be needed. CT angiography (CTA) or CTV may be helpful to evaluate the cause of hemorrhage (eg, vascular malformation or aneurysm) or infarction (eg, dissection or venous thrombosis). A radiographic or scintigraphic skeletal survey should also be obtained according to established guidelines.^{179,180}

MR Imaging

Brain and cervical spinal MR imaging should be done as soon as possible because of its sensitivity and specificity regarding pattern of injury and timing parameters.^{4,104,181–190} Brain MR imaging should include T1, T2, T2*, fluid-attenuated inversion recovery (FLAIR), and diffusion-weighted imaging/apparent diffusion coefficient (DWI/ADC). Gadolinium-enhanced T1 images should probably be used along with MRA and MRV. T1 and T2 are necessary for estimating the timing of hemorrhage, thrombosis, and other collections using published criteria.^{4,104,181} T2* techniques are most sensitive for detecting hemorrhage or thromboses but may not distinguish new (eg, deoxyhemoglobin) from old (eg, hemosiderin). DWI plus ADC can be quickly obtained to show hypoxia-ischemia or vascular occlusive ischemia.^{4,154,189,190} Restricted or reduced diffusion, however, may be seen with other processes, including encephalitis, seizures, or metabolic disorders, and with suppurative collections and some tumors.^{4,154,189,190} Gadolinium-enhanced sequences and MRS can be used to evaluate for these other processes. Additionally, MRA and

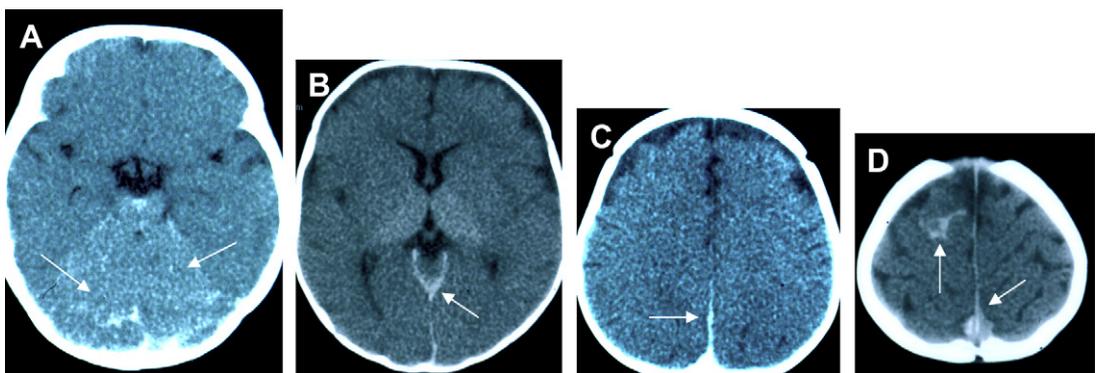


Fig. 18. Six-month-old infant with triad and alleged NAI; acute choking event while feeding. CT (A–D) shows bilateral cerebral edema with acute SAH and SDH (arrows), including along the falx, and tentorium. Autopsy confirmed the hemorrhages, a subdural membrane, and hypoxic-ischemic brain injury. (Courtesy of The Wisconsin Innocence Project.)

MRV are important to evaluate for arterial occlusive disease (eg, dissection) or venous thrombosis, although they cannot rule out small vessel disease. The STIR technique is particularly important for cervical spine imaging.

Scalp and Skull Abnormalities

Scalp injuries (eg, edema, hemorrhage, and laceration) are difficult to precisely time on imaging studies and depend on the nature and number of traumatic events or other factors (circulatory compromise, coagulopathy, medical interventions, and so forth).^{1,4} Skull abnormalities may include fracture and suture splitting. Fracture may not be readily distinguished from sutures, synchondroses, their normal variants, or from wormian bones (eg, osteogenesis imperfecta) on CT or skull films. 3-D—CT surface reconstructions may be needed. In general, the morphology of a fracture cannot differentiate NAI from AI and must be correlated with the trauma scenario (eg, biomechanically) (see **Fig. 1**). Skull fractures are also difficult to time because of the lack of periosteal reaction.^{1,4} Suture diastasis may be traumatic or a reflection of increased intracranial pressure but must be distinguished from pseudodiastasis due to a metabolic or dysplastic bone disorder (eg, congenital rickets) (see **Fig. 2**).^{1,4,136,137} The growing fracture (eg, leptomeningeal cyst) is not specific for NAI and may follow any diastatic fracture in a young infant, including birth related (see **Fig. 1**).^{1,2,4} Nondetection of scalp or skull abnormalities on imaging should not be interpreted as the absence of impact injury.

Intracranial Collections

It should not be assumed that such collections are always traumatic in origin. A differential diagnosis is always necessary and includes NAI, AI, coagulopathy (hemophilic and thrombophilic conditions), infectious and postinfectious conditions, metabolic disorders, and so forth.^{2,4,22,89,90,101,106–110} It may not be possible to specify with any precision the components or age of an extracerebral collection because of meningeal disruptions (eg, acute or subacute subdural hygroma [SDHG] versus chronic SDH, or subarachnoid versus thin SDH).^{1,4,103,104,173–176,181} Vezina¹⁸¹ has recently summarized the literature regarding the complexity of timing of intracranial collections. Subarachnoid and subdural collections, hemorrhagic or nonhemorrhagic, may be localized or extensive and may occur about the convexities, interhemispheric (along the falx), and along the tentorium. With time and gravity, these collections may redistribute to other areas, including into or

out of the spinal canal, and cause confusion.^{4,177,181,191} For example, a convexity SDH may migrate to the peritentorial and posterior interhemispheric regions or into the intraspinal spaces. SDH migration may lead to a misinterpretation that there are hemorrhages of different timing. The distribution or migration of the sediment portion of a hemorrhage with blood levels (ie, hematocrit effect) may cause further confusion because density/intensity differences between the sediment and supernatant may be misinterpreted as hemorrhages (and trauma) of differing age and location.^{4,104,178,181} Prominent subarachnoid CSF spaces are commonly present in infants (ie, BECCs). This entity predisposes infants to SDH, which may be spontaneous or associated with trauma of any type (eg, dysphagic choking ALTE) (see **Figs. 4, 15, and 17**).^{4,65–73} A hemorrhagic collection may continually change or evolve with regard to size, extent, location, and density/intensity characteristics. Rapid spontaneous resolution and redistribution of acute SDH over a few hours to 1 to 2 days has been reported.^{4,177,191} A tear in the arachnoid may allow SDH washout into the subarachnoid space or CSF dilution of the subdural space.

For apparent CT high densities, it may be difficult to differentiate cerebral hemorrhage from subarachnoid hemorrhage or from venous thrombosis (see **Figs. 2, 3, 6–11, 15, 16, and 18**).⁴ According to the literature, hemorrhage or thromboses that are high density (ie, clotted) on CT (ie, acute to subacute) have a wide timing range of 0 to 3 hours up to 7 to 10 days.^{4,104,178,181} Hemorrhage that is isohypodense on CT (ie, nonclotted) may be hyperacute (<3 h) or chronic (>10 d) (see **Figs. 3 and 11**). The low density may also represent pre-existing, wide, CSF-containing subarachnoid spaces (eg, BECC) or SDHG (ie, CSF-containing) that may be acute or chronic (see **Figs. 3, 12 and 15**).^{4,103,104,175,181} Blood levels are unusual in the acute stage unless there is coagulopathy.^{4,104,181,188} CT cannot distinguish acute hemorrhage from rehemorrhage on existing chronic collections (BECC or chronic SDHG) (see **Figs. 3 and 15**).^{4,66,72,92–104,173,178,181} Traditionally, the interhemispheric SDH as well as mixed-density SDH were considered characteristic, if not pathognomonic, of SBS/NAI.^{1,2,4,168,171–173} This has been proved unreliable. Interhemispheric SDH may be seen with AI or with nontraumatic conditions (eg, HIE, venous thrombosis, venous hypertension, or dysphagic choking ALTE) (see **Figs. 2, 6–10**).¹⁷⁸ Mixed-density SDH also occurs in AI as well as in other conditions (see **Figs. 3, 9, and 11**).¹⁷⁸ Furthermore, SDH may occur in BECC

spontaneously or result from minor trauma (ie, AI), and rehemorrhage within SDH may occur spontaneously or with minor AI (see **Figs. 1, 4, 15, and 17**).^{4,12,38,40,72,90,104,178,181}

Only MR imaging may provide more precise information than CT regarding pattern of injury and timing, particularly with regard to (1) hemorrhage versus thromboses (**Table 1**) and (2) brain injury.^{104,181–190} As a result, MR imaging has become the standard and should be done as soon as possible. Mixed-intensity collections, however, are problematic regarding timing.¹⁸¹ Matching the MR imaging findings with the CT findings may help along with follow-up MR imaging. Blood levels may indicate subacute hemorrhage versus coagulopathy. The timing guidelines are better applied to the sediment than to the supernatant. With mixed-intensity collections, MR imaging cannot reliably differentiate BECC with acute SDH from acute SDHG/SDH, from hyperacute SDH, or from chronic SDH or chronic SDHG with rehemorrhage (see **Figs. 1, 4, and 13–17**).^{4,104,181} T2* hypointensities are iron sensitive but may not differentiate hemorrhages from venous thromboses that are not detected by MRV (eg, cortical, medullary, or subependymal).

BRAIN INJURY

Edema or swelling in pediatric head trauma may represent primary injury or secondary injury and be acute-hyperacute (eg, minutes to a few hours) or delayed (eg, several hours to a few days),

including association with short-distance falls and lucid intervals.^{4,53–62} The edema or swelling may be further subtyped as traumatic, malignant, hypoxic-ischemic, or related to (or combined with) other factors. Traumatic edema is related to areas of primary brain trauma (ie, contusion or shear) or to traumatic vascular injury with infarction (eg, dissection, herniation, or spasm) (see **Figs. 3, 6, 9, and 11**). Traumatic edema is usually focal or multifocal, whether or not hemorrhagic. CT, however, may not distinguish focal or multifocal cerebral high densities as hemorrhagic contusion, hemorrhagic shear, or hemorrhagic infarction.⁴ Focal or multifocal low density edema may also be seen with infarction (eg, arterial or venous occlusive), encephalitis, demyelination (eg, ADEM), or seizure edema.^{4,89,146–154} Also, MR imaging often shows shear and contusional injury as focal/multifocal restricted diffusion, GRE hypointensities, and/or T2/FLAIR high intensities.⁴ Focal/multifocal ischemic findings may also be due to traumatic arterial injury (eg, dissection) or venous injury (eg, tear or thrombosis), arterial spasm (as with any cause of hemorrhage), herniation, or edema with secondary perfusion deficit or seizures (eg, status epilepticus) (see **Figs. 2, 6, and 11**).^{4,64,154,189,192} These may not be reliably differentiated, however, from focal/multifocal ischemic or hemorrhagic infarction from nontraumatic causation (eg, dissection, vasculitis, venous, or embolic) even without supportive MRA, CTA, MRV, or angiography. Also, similar cortical or subcortical intensity abnormalities (including restricted diffusion) may also be observed with

Table 1
MR imaging of intracranial hemorrhage and thrombosis^a

Stage	Biochemical Form	Site	T1–MR Imaging	T2–MR Imaging
Hyperacute (+ edema) (<12 hours)	Fe II oxyHb	Intact RBCs	Iso-low I	High I
Acute (+ edema) (1–3 days)	Fe II deoxy Hb	Intact RBCs	Iso-low I	Low I
Early subacute (+ edema) (3–7 days)	Fe III metHb	Intact RBCs	High I	Low I
Late subacute (–edema) (1–2 weeks)	Fe III metHb	Lysed RBCs (extracellular)	High I	High I
Early chronic (–edema) (>2 weeks)	Fe III transferrin	Extracellular	High I	High I
Chronic (cavity)	Fe III ferritin and hemosiderin	Phagocytosis	Iso-low I	Low I

^a Fe II, ferrous; Fe III, ferric; Hb, hemoglobin; I, signal intensity; Iso, isointense; RBCs, red blood cells; +, present; –, absent. Data from Refs. ^{4,188,189}

encephalitis, seizures, and metabolic disorders. Therefore, a differential diagnosis is always required.^{4,154,189,192}

Malignant brain edema, a term used for severe cerebral swelling after head trauma, may lead to rapid deterioration.^{1,4,54,55,62} The edema is usually bilateral and may be related to cerebrovascular congestion (ie, hyperemia) as a vasoreactive rather than an autoregulatory phenomenon and associated with global ischemia. A unilateral form may also occur in association with an ipsilateral SDH that progresses to bilateral edema (see **Figs. 3** and **6**).⁶⁴ There may be rapid or delayed onset (ie, lucid interval). Predisposing factors are not well established but likely include a genetic basis. Hyperemic edema may appear early as accentuated gray-white matter differentiation on CT, then progresses to loss of differentiation.

Global hypoxia (eg, apnea or respiratory failure) or ischemia (eg, cardiovascular failure or hypoperfusion) is likely a major cause of or contributor to brain edema in a child with head trauma (eg, malignant edema).^{4,38,40,54,55,62} HIE, depending on its severity and duration, may have a diffuse appearance acutely (ie, diffuse or vascular axonal injury) with decreased gray-white differentiation throughout the cerebrum on CT (eg, white cerebellum sign) and then evolve to a more specific pattern on CT or MR imaging (eg, border zone or watershed, basal ganglia/thalamic, cerebral white matter necrosis, reversal sign) (see **Figs. 2, 6, 7, 10, and 18**).^{4,189} It is typically bilateral but may not be symmetric. This more diffuse pattern may distinguish HIE from the multifocal pattern of primary traumatic injury, although they may coexist. Hypoxia-ischemic brain injury due to apnea/respiratory arrest may occur with head trauma or with neck/cervical spine/cord injuries (eg, SCIWORA) whether or not AI or NAI (see **Fig. 7**).^{4,35,54,55,62} It may also occur with any non-traumatic cause (choking, paroxysmal coughing, aspiration, and so forth) (see **Figs. 2** and **18**).^{4,25,160–166} In addition to the diffuse brain injury, there may be associated subarachnoid and SDH without mass effect (see **Figs. 2, 7, 10, and 18**).^{4,38,40,54,55,62} MR imaging shows hypoxic-ischemic injury, depending on timing, as diffuse-restricted diffusion on DWI/ADC plus matching T1/T2 abnormalities as the injury evolves (see **Figs. 2, 6** and **11**).^{4,189} Other important contributors to edema or swelling include such complicating factors as seizures (eg, status epilepticus [see **Fig. 2**], fluid-electrolyte imbalance, other systemic or metabolic derangements (eg, hypoglycemia, hyperglycemia, hyperthermia), or hydrocephalus.⁴ It is well known that many of these may also be associated with restricted diffusion along

with other nontraumatic processes (encephalitis, seizures, and metabolic disorders).^{4,154,186,187,189} Again, a differential diagnosis is required.

SUMMARY

An extensive review of the literature to date fails to establish an evidence base for reliably distinguishing NAI from AI or from the medical mimics. The medical and imaging findings alone cannot diagnose intentional injury. Only a child protection investigation may provide the basis for inflicted injury in the context of supportive medical, imaging, or pathologic data. The duty of a radiologist is to give a detailed description of the imaging findings, provide a differential diagnosis, and communicate the concern for NAI, directly to the primary care team in a timely manner. Radiologists should be prepared to consult with child protection services; other medical and surgical consultants, including a pathologist or biomechanical specialist; law enforcement investigators; and attorneys for all parties as appropriate. Radiologists must also be aware of certain conditions that are known to have clinical and imaging features that may mimic abuse. These should be properly evaluated, and the possibility of combined or multifactorial mechanisms with synergistic effects should also be considered. Furthermore, a negative medical evaluation does not make NAI the default diagnosis. A timely and thorough multidisciplinary evaluation may be the difference between appropriate child protection versus an improper breakup of a family or a wrongful indictment and conviction.

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IN THE COURT OF APPEALS
OF THE STATE OF WASHINGTON
DIVISION II

STATE OF WASHINGTON,

Respondent,

v.

LEON REYES

Appellant.

NO. 52449-0-II

DECLARATION OF MARK VON
WAHLDE

I, Mark von Wahlde, declare under penalty of perjury under the laws of the State of Washington, the following is true and correct:

1. That I am a Pierce County Deputy Prosecuting Attorney assigned to respond to the personal restraint petition filed in the instant cause.
2. I prepared the Appendix to respondent's brief in this matter.
3. The judgment and sentence, pre sentence investigation report, court's instruction to the jury, and defense witness list are documents which I downloaded from the Pierce County Superior Court's LINX website. I did not alter them, other than to provide a Bates stamp on the bottom of the document for reference purposes. In all other respects those documents are duplicates of the documents on file with the Court.

4. I sent a copy of the presentence investigation report included in the Appendix to Ms. Nunez, the person who wrote that report in 2007. She emailed me and also mailed me back her signed declaration and I included it in the appendix.

5. I received the Narang and Barnes articles included in the Appendix from either Dr. Carole Jenny or Dr. Elizabeth Wood (I am not sure which one).

6. I received the Declaration of Dr. Elizabeth Woods included in the Appendix from Dr. Woods.

Dated: August 22, 2019

Signed at Tacoma, WA.



Mark von Wahlde

Certificate of Service:

The undersigned certifies that on this day she delivered by U.S. mail and or ABC-LMI delivery to the attorney of record for the appellant and appellant c/o his attorney true and correct copies of the document to which this certificate is attached. This statement is certified to be true and correct under penalty of perjury of the laws of the State of Washington. Signed at Tacoma, Washington, on the date below.

Date

Signature

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IN THE COURT OF APPEALS
OF THE STATE OF WASHINGTON
DIVISION II

IN RE THE PERSONAL RESTRAINT
PETITION OF:

LEON REYES,

Petitioner.

NO. 52449-0-II

DECLARATION OF ELIZABETH
WOODS.

I, Elizabeth Woods, declare under penalty of perjury under the laws of the State of Washington, the following is true and correct:

1. I am a pediatric physician licensed in the State of Washington and currently employed as the medical director and staff pediatrician at the Child Abuse Intervention Department of Mary Bridge Children’s Hospital.

2. I have been board certified by the American Board of Pediatrics in General Pediatrics since 2011. I am a member in the following organizations: Helper Society Member, Honorary Society for Physicians working in Child Abuse (2018 – Present); Committee On Child Abuse and Neglect, American Academy of Pediatrics (2018 – Present); and the American Academy of Pediatrics – Fellow member (2007 – Present).

1 3. Some of my education and experience regarding child abuse and neglect is
2 addressed below:

3 **Relevant Education for Child Abuse**

- 4 1. Training Institute on Strangulation Prevention, Pediatric Strangulation Part 1
5 2. 2019 5th Annual Child Maltreatment Conference: Joint conference Madigan Army Medical Center
6 3. 2019 Western Regional Children’s Advocacy Center WRCAC training, Court Preparation for the
7 4. 2019 San Diego International Conference on Child & Family Maltreatment
8 5. 2019 Ray E. Helfer Society’s Institute on Abusive Head Trauma
9 6. 2019 Chadwick Rady Children’s Institute on Sexual Abuse
10 7. 2019 2018 Joint conference Madigan Army Medical Center CHAT Team and Mary Bridge
11 8. 2018 Stand Up to Sex Trafficking,: Awareness, Implementation, Networking (SUSTAIN) Series,
12 9. 2018 Fourth Annual CSEC Task Force Conference (Commercial Sexual Exploitation of Children)
13 10. 2018 “It’s All in the Eyes: Eye Examination in the Evaluation of Child Abuse” COCAN Training
14 11. 2018 Darkness to Light “Stewards of Children” Movement to End Child Sexual Abuse Certification
15 12. 2018 San Diego International Conference on Child & Family Maltreatment
16 13. 2018 Ray E. Helfer Society’s Institute on Abusive Head Trauma
17 14. 2018 Chadwick Rady Children’s Institute on Sexual Abuse
18 15. 2018 Ray E Helfer Society Child Abuse Conference
19 16. 2017 Midwest Regional Children’s Advocacy Center Medical Training Academy, Identification and
20 17. 2017 Child Abuse Conference, Madigan Army Medical Center, Conference Chair
21 18. 2017 San Diego International Conference on Child & Family Maltreatment
22 19. 2015-2017 Coordinator for Community Pediatrics and Child Abuse Training for Pediatric Residents
23 20. 2007-2010 Residency Training, Nancy Kellogg, ChildSafe (Formerly the Alamo Children’s
24 21. 2010 Child Abuse Training Course-2 day course, San Antonio Texas
25 Advocacy Center) -in addition to standard curriculum for all residents participated in additional
 elective training

18 **Past Child Abuse Experience**

- 19 1. Case Review Committee (CRC)- 2007-2017
20 a. The CRC is a multidisciplinary team appointed on order by the installation commander and
21 supervised by the military treatment facility Commander. The committee exists to
22 coordinate medical, legal, law enforcement and social work assessment, identification,
23 command intervention and investigation and treatment functions from the initial report of
24 spouse or child abuse to closure.
25 b. Served as physician representative for the CRC at the following installations:
 i. Brooke Army Medical Center, Ft. Sam Houston, Texas (resident-training)
 ii. Darnall Army Medical Center, Ft. Hood, Texas (physician representative)
 iii. Schofield Army Barracks Health Clinic, Hawaii (physician representative)
 iv. Tripler Army Medical Center, Hawaii (physician representative)
 v. Madigan Army Medical Center, JBLM, Washington (physician representative)
2. Sexual Abuse Resource Coordinator Team (SARC) -2013-2015
 a. Served as the Pediatric Physician representative to the hospital wide team

- b. Assisted in implementation of planning of the response for our hospital and department for sexual abuse cases in the Pediatric age group
- c. Facilitated the follow-up protocol for Pediatric age patients for hospital protocol.
- d. Established hospital Standard Operating Policy

3. C.H.A.T. (2016-2018) Child Health Advocacy Team

- a. Served as military officer/liaison for all child abuse cases for Joint Base Lewis McChord
- b. Developed a team of Child Abuse Consultants to serve Madigan Army Medical Center consisting of inpatient and outpatient Pediatricians and hospitalists with child abuse experience beyond that of the typical Pediatrician.
- c. Provide inpatient/outpatient consultative services to all of primary care, inpatient teams and emergency services.
- d. Provide physician resources and expertise to all of Madigan Army Medical Center, surrounding outlying military clinics
- e. Engage with investigations, Police, CID & military police, provide testimony and cover CRC.
- f. Serve as a supervisory team to the outpatient Pediatric clinic and monitor all cases from initiation to closure
- g. Facilitate training of the individual team members in Child Abuse education. Promote the attendance of conferences and educational opportunities.
- h. Educate outlying clinic and primary care clinics on our Advocacy team and it's role
- i. Promote the education of residents in child abuse by providing one on one child abuse education, establishing community education at Providence and engaging residents with incoming cases.

4. My profession requires me to be familiar and current with the literature relating to the science of abusive head trauma. This includes material relating to head and brain injuries occurring due to injuries sustained by children caused by shaking, falling blunt force, impact injuries (both inflicted and accidental). I am currently familiar with that literature.

5. The treatment of injured children is a large part of my practice and includes children injured from abusive head trauma, falls and from accidental injuries including window falls.

6. I have testified as an expert witness in Washington criminal trials of people charged with assaulting children as well as dependency trials determining custody of children who have been abused. I have also testified in other states in child physical and sexual assault cases.

1 7. I am a member of the Northwest Child Abuse Medical Consultation Peer
2 review committee for Washington State and attend bimonthly peer review meetings.

3 8. I serve as a consultant to Seattle Children’s Hospital on Child Physical and
4 Sexual Assault cases.

5 9. I have read the medical records of Haydon Kostelecky as well as the report
6 of the medical examiner, Dr. Ramoso, regarding Haydon Kostelecky’s death. I have also
7 read the March 20, 2007 Pre-Sentence Investigation Risk Assessment Report containing
8 the post-trial statements of Leon Reyes.

9 10. I have read the testimony of Dr. Yolanda Duralde in Pierce County Superior
10 Court Case Number 06-1-00890-3, State v. Leon Reyes. Dr. Duralde’s 2007 opinion
11 testimony is medically valid and its substance generally accepted within the pediatric
12 medicine community of today.

13 11. I have read the testimony of Dr. John Paschall in Pierce County Superior
14 Court Case Number 06-1-00890-3, State v. Leon Reyes. Dr. Paschall’s 2007 opinion
15 testimony is medically valid and its substance is generally accepted within the pediatric
16 medicine community of today.

17 12. I have read the declaration of Dr. Janice Ophoven filed in *In re Reyes*,
18 Washington Court of Appeals cause number 52449-0-II. Dr. Ophoven states that “much of
19 the medical testimony presented during Mr. Reyes’s trial is “not scientifically valid in light
20 of recent advances” in the medical community’s understanding. That statement may be
21 representative of the opinion of some forensic pathologists today, but it does not represent
22 a significant section of the pediatric medical community and is not generally accepted by
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1 the pediatric medical community. Dr. Ophoven's opinions are also not accepted by the
2 child abuse medical community on an international or national level.

3 13. Dr. Ophoven's declaration presents no scientific advances generally
4 accepted by the pediatric medical community occurring since January 1, 2007 which
5 would call the testimony of Dr. Duralde or Dr. Paschall into question.

6 14. Dr. Ophoven's declaration presents no scientific advances generally
7 accepted by the child abuse medical community occurring since January 1, 2007 which
8 would call the testimony of Dr. Duralde or Dr. Paschall into question.

9 15. Dr. Ophoven's argument that "It is now generally accepted that a child can
10 be lucid, and appear essentially symptom-free (at least to a layperson) for up to 72 hours
11 after suffering injuries that manifest as cerebral edema, subdural hematoma and retinal
12 hemorrhages" is false. In fact, it is the opposite: Symptoms of inflicted head trauma are
13 immediate. Vomiting, seizures and unresponsiveness are typical immediate symptoms in
14 abusive head trauma cases and Haydon demonstrated all of these based on statements
15 made by Mr. Reyes. The marked swelling of the brain (edema) causing increased
16 intracranial pressure, irritation of blood to the brain tissue, release of toxins which irritate
17 the brain and the lack of oxygen to injured parts of the brain all contribute to the resulting
18 symptomatology of vomiting and seizures. Haydon's symptoms leading up to the event in
19 the weeks prior was likely due to abusive abdominal trauma.

20 21 16. Dr. Ophoven states "...it is now generally accepted that encephalopathy
22 virtually always reflects hypoxia-ischemia (lack of oxygen) rather than the traumatic
23 tearing of axons." This opinion is likely based on research of Cohen and Ramsay which
24 focuses on the etiology of subdural bleeding, basing their assertion that such hemorrhages
25

1 are consequent to hypoxia-ischemia (H-I) on a study that Cohen and colleagues published
2 in 2013. A critique of this paper noted serious flaws in design, statistics and interpretation
3 of data, thereby questioning claims of a relationship between HI and subdural hemorrhage.
4 Squire's contribution is merely a replay of many of her previous papers that repeatedly
5 attempt to discredit the enormous body of literature documenting the clinical and
6 pathological characteristics of abusive head trauma. There is no generally accepted
7 literature in the medical community of Pediatrics and/or Child Abuse to support these
8 etiologies. The hemorrhages as Haydon experienced were a result of shaking and blunt
9 force trauma which resulted in shearing of blood vessels as the acceleration/deceleration
10 events occurred to his brain.
11

12 17. This case presented more than just the symptoms of what Dr. Ophoven calls
13 "shaken baby syndrome." Other findings support Dr. Duralde's and Dr. Paschall's
14 conclusion that Haydon Kostecky died as a result of non-accidental trauma.

15 Haydon Kostecky presented with the following medical injuries

- 16 1) Acute subdural hemorrhage overlying the right hemisphere of the brain;
- 17 2) Subdural hemorrhage along the tentorium;
- 18 3) Brain edema;
- 19 4) Subarachnoid hemorrhage;
- 20 5) Soft tissue swelling and bruising over the left frontal region (forehead) *
evaluation by the medical examiner was a chronic (or older) subgaleal
hematoma with concern for impact injury;
- 21 6) Liver laceration (right lobe) with adjacent hemorrhage
- 22 7) Splenic laceration with evident healing;
- 23 8) Injury to the duodenum, hemorrhage and separation of the wall of the
duodenum;
- 24 9) Hemorrhage in the wall of the duodenum;
- 25 10) Free fluid in the abdomen resulting from hemorrhaging organs;

- 1 11) Adhesions in the bowel area indicative of older injuries (blunt force trauma to
2 the abdominal wall);
- 3 12) Adhesions of the small intestine indicative of older injuries (blunt force trauma
4 to the abdominal wall)
- 5 13) Adhesions of the stomach indicative of older injuries (blunt force trauma to the
6 abdominal wall)
- 7 14) Adhesions of the transverse colon indicative of older injuries (blunt force
8 trauma to the abdominal wall);
- 9 15) Adhesions of the pancreas indicative of older injuries (blunt force trauma to the
10 abdominal wall);
- 11 16) Adhesions of the duodenal wall indicative of older injuries (blunt force trauma
12 to the abdominal wall)
- 13 17) Adhesions of the liver indicative of older injuries (blunt force trauma to the
14 abdominal wall)
- 15 18) Bilateral retinal hemorrhages
- 16 19) Optic nerve sheath hemorrhage
- 17 20) Posterior rib fracture of the 9th rib with acute hemorrhage, new injury
- 18 21) Old and new marks to legs-linear red marks, erythematous loop marks, bruises
19 and petechiae which were consistent with being beaten with either a cord or a
20 belt
- 21 22) Prior medical history of concerning injuries, facial bruising, fracture
- 22 23) Prior family history provided of multiple injuries all with provided story of
23 injury mechanism
- 24
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Haydon Kostelecky was a victim of non-accidental trauma over a period of time. He
suffered significant abusive injuries to his head, abdomen and skin. The culmination of
records including medical records, EMS records and medical examiner records show
findings that are consistent with

- 1) Acute Abusive Head Trauma involving shaking
- 2) Acute Abusive head trauma resulting from blunt force trauma
- 3) Acute and Chronic Abdominal Trauma
- 4) Trauma induced to legs resulting in linear pattern injury
- 5) Acute Squeezing or Shaking trauma which resulted in Rib fracture

1 His injuries from the abusive head trauma caused trauma to his brain which resulted in his
2 death. In addition he had severe acute and chronic abdominal injuries that support a
3 history of chronic violent abuse and easily could have also resulted in his death.

4 18. There is no hypothetical cause for the injuries Haydon Kostelecky which
5 could rule out either abusive head trauma or the fact that he was a victim of significant
6 chronic abuse.

7 19. There has not been a paradigm shift in the medical community's
8 understanding of head trauma as Dr. Ophoven suggests. It may be noted that Dr.
9 Ophoven's statements suggesting or asserting otherwise are in direct contradiction of the
10 AAP (American Academy of Pediatrics) Consensus on Abusive Head trauma which was
11 published in November 2017 and is supported by multiple Pediatric and Radiology
12 Medicine groups nationally and internationally to include the Society for Pediatric
13 Radiology, European Society of Pediatric Radiology, American Society of Pediatric
14 Neuroradiology, American Professional Society on the Abuse of Children, Swedish
15 Pediatric Society, Norwegian Pediatric Association and Japanese Pediatric Society and the
16 American Academy of Pediatrics.

17
18 20. As stated in the consensus statement on Abusive head trauma in infants and
19 young children "there is no controversy concerning the medical validity of the existence of
20 Abusive Head Trauma, with multiple components including subdural hematoma,
21 intracranial and spinal changes, complex retinal hemorrhages and rib and other fractures
22 that are inconsistent with the provided mechanism of trauma. The mechanism of trauma as
23 described, a fall from a bunkbed, would not result in the injuries that Haydon suffered nor
24 his resulting death.
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Dated: August 21, 2019

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Signed at Tacoma, WA.

Elizabeth Woods
ELIZABETH WOODS

Certificate of Service:

The undersigned certifies that on this day she delivered by U.S. mail and or ABC-LMI delivery to the attorney of record for the appellant and appellant c/o his attorney true and correct copies of the document to which this certificate is attached. This statement is certified to be true and correct under penalty of perjury of the laws of the State of Washington. Signed at Tacoma, Washington, on the date below.

Date Signature

PIERCE COUNTY PROSECUTING ATTORNEY

August 23, 2019 - 11:39 AM

Transmittal Information

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Appellate Court Case Title: In re the Personal Restraint Petition of Leon Lee Reyes
Superior Court Case Number: 06-1-00890-3

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