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SUPREME COURT OF THE STATE OF WASHINGTON

86711-9

IN THE MATTER OF THE PERSONAL RESTRAINT PETITION OF
MARIBEL GOMEZ

PETITIONER'S MOTION FOR DISCRETIONARY REVIEW

INNOCENCE PROJECT NW CLINIC
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A. IDENTITY OF PETITIONER

Petitioner, Maribel Gomez, asks this Court to accept review of the decision designated in Part B of this motion and to grant her personal restraint petition, or remand the case for a reference hearing.

B. DECISION BELOW

The Court of Appeals, Division III, filed its opinion denying Ms. Gomez's personal restraint petition on October 13, 2011. See Exh. 1.

C. ISSUES PRESENTED FOR REVIEW

1. Did the Court of Appeals misapply the law and facts in concluding that Ms. Gomez's defense counsel was effective?
2. Did the Court of Appeals misapply the law and facts in concluding that Ms. Gomez's defense counsel was not operating under an actual conflict of interest?
3. Did the Court of Appeals err by not ordering a reference hearing?

D. STATEMENT OF CASE

1. Statement of Facts

This case has two narratives. The first comes from evidence presented during a bench trial, after which Maribel Gomez was convicted of Homicide by Abuse for the death of her 25-month-old son, Rafael. The second comes from evidence gathered during the postconviction investigation. It consists of numerous declarations from expert and lay witnesses, business records and other competent and admissible evidence. See generally PRP Brief App. 1-58; PRP amended Brief Supp. App. 59-

64; Reply Brief App. 1-4. The postconviction evidence refutes medical evidence presented by the State at trial. Id. Further, it supports Ms. Gomez's innocence and corroborates her trial testimony that (1) Rafael was not abused and (2) Ms. Gomez did not cause Rafael's death. Id.

At trial, the court repeatedly questioned whether Rafael's head injuries, which it found were the cause of death, could have been accidentally inflicted. RP: 527-547;¹ see infra p. 10. The State's medical witnesses testified the injuries were non-accidental. Id. The defense expert testified the injuries were indicative of abuse. RP: 2242. With no evidence to the contrary, the trial court held that Rafael's head injuries resulted from an assault by Ms. Gomez. Exh. 1 at 2.65; 3.4.

Postconviction evidence from several experts answer the judge's questions by establishing that Rafael's head injuries were accidentally inflicted and could have resulted from a short fall or multiple falls. PRP App. 11, 22; PRP Supp. App. 59; see infra. p. 11. Research continues to "contradict[] the prevalent belief of many physicians dealing with suspected child abuse that low-height falls by young children are without exception benign occurrences and cannot cause fatal intracranial injuries and severe retinal hemorrhages." Exh. 3 at 1.

¹ The trial Report of Proceedings is designated as RP. The Report of Proceedings from other hearings are designated by date.

The case's social history shaped the trial witness's opinions on whether Rafael's injuries were intentionally inflicted. RP: 496; PRP App. 58 at 4. At trial, only Ms. Gomez, her husband and daughter testified that Rafael exhibited self-injurious behaviors. RP: 316, 1935-36, 2095-98, 2630. The trial court did not find their testimony credible, because no other witnesses observed the behaviors. PRP App. 1 at 2.37; 2.70; 2.72.

Prior to trial, Ms. Gomez asked her lawyer, Robert Moser, to speak with many of the friends, family members and government employees who were interviewed postconviction. PRP App. 3. Moser did not do so. PRP App. 4. Postconviction declarations and business records from numerous lay and government witnesses support Ms. Gomez's testimony that Rafael was not abused and that he exhibited self-injurious behaviors. See generally Appendices; see infra pp. 6-12. Postconviction investigation also revealed that the defense expert's testimony was based upon her belief that the defense was conceding abuse. PRP App. 55.

Ultimately, the trial court held the State did not prove a substantial number of its allegations of abuse against Ms. Gomez. Specifically, the court ruled the State failed to prove Rafael's broken femur and occipital skull fracture, broken tibia, burns to his hand, and wound to the back of

his head were caused by Ms. Gomez.² However the Court of Appeals, in denying Ms. Gomez's PRP, erroneously treats the State's unproven accusations of abuse against Ms. Gomez as verities.³ Exh. 1 at 2.⁴

Certain of the State's allegations of abuse were accepted by the trial court. It found that the State proved Rafael's shoulder fractures, bruised/gouged ear injuries and lacerated nipples, and the occipital fracture and epidural hemorrhage preceding his death were the result of assaults by Ms. Gomez. PRP App. 1 at 3.3-3.6. Evidence developed postconviction refutes the medical testimony offered by the State at trial on each of the injuries the trial court attributed to Ms. Gomez.

The trial court sought alternate explanations to the State's allegations that Ms. Gomez caused Rafael's injuries. See infra, p. 10.

² 03/28/07 RP: 31 ("There is insufficient evidence to conclude beyond a reasonable doubt that the broken tibia is a result of any action of the Defendant, much less an assault."; "I could not conclude beyond a reasonable doubt that the femur fracture or occipital fracture were caused by the Defendant assaulting the dependent."); Id. at 32, 34 (There was a wound that was at the back of the head, but somewhat to the side. . . I could not conclude beyond a reasonable doubt that this injury was as a result of an assault by Maribel Gomez on Rafael Gomez."); Id. at 35 ("The Defendant claims the burns on Rafael's hands were caused when Rafael reached for some hot soup and spilled it on his hand. The State conjectures that this was caused by a cigarette burn. But there was not any evidence to conclude or at least evidence beyond a reasonable doubt to conclude that it occurred in such a way.").

³ The Court of Appeals also used the unproven accusations as proof of a pattern or practice of abuse in its appellate decision. State v. Gomez, 147 Wash. App. 1003, No. 26090-9-III (Oct. 14, 2008).

⁴ Moser's deficiencies in failing to make the trial court's rulings clear in the written Findings of Facts and Conclusions of Law violated Ms. Gomez's state and federal right to effective assistance of counsel.

When presented with alternative evidence, the trial court ruled against the State. The following summarizes evidence presented at trial against facts presented postconviction on critical issues considered by the trial court. A more in-depth summary is attached as Exh. 5 (Chart).

A. The State's only fact witness was found not credible and multiple witnesses found postconviction refute the State's abuse allegations

The State did not present any credible fact witnesses to support its allegations that Ms. Gomez abused Rafael. State witness Alicia Estrada, who claimed to have witnessed acts of abuse, was found not credible:

COURT: . . . [D]id we write in there [findings of fact] that **I did not find her [Estrada] credible?**

...

I want a specific finding that says Ms. – Estrada's testimony was often - I made myself a note here; was often contradictory, **you might want to take some notes here then Mr. Moser.**

MR. MOSER: Okay.

COURT: . . . **I want to be real clear about this.** It often made no sense, **it was not credible...**⁵

11/08/07 RP: 13 (emphasis added).

Although the trial court ruled that Alicia Estrada was not credible, the Court of Appeals discusses her testimony as proof of abuse in its decision denying Ms. Gomez's PRP. Exh. 1 at 17.⁶

⁵ Moser's failure to heed the court's admonition and ensure the written findings specified Estrada was not credible further demonstrates his deficient performance.

Postconviction, declarations and business records from numerous lay and government witnesses were presented in support of Ms. Gomez's testimony that she did not abuse Rafael. See generally PRP Appendices. Although Moser called DSHS worker Murray Twelves as a witness, he did not elicit Twelves' observations that Rafael showed no fear of his mother. PRP App. 6. Although Moser called CPS worker Celia DeLuna to the stand, he did not elicit her testimony that she was "impressed w[ith] the quality of parenting in the [Gomez] home." PRP App. 43.

Other witnesses found postconviction did not testify at trial and were not interviewed by Moser. PRP App. 4. The witnesses who were available to testify about Ms. Gomez's nurturing parenting included: certified mental health professional Jorge Chacon; CPS Workers Linda Turcotte and Gracie Alvarado;⁷ family friends Jennifer Peña, Sergio Peña and Alicia Garces; Columbia Ridge Elementary School teacher Rosibel Dávila, SCAN employees Esperanza Pando and Audra Turner; and Father Jesus Ramirez. PRP App. 9, 10, 12, 13, 16, 39, 41, 42, 56, 57.

⁶ The Court of Appeals also references Estrada's testimony in its appellate decision. State v. Gomez, 147 Wash. App. 1003, No. 26090-9-III (Oct. 14, 2008).

⁷ Moser subpoenaed Alvarado, but she did not honor her subpoena. PRP App. 5 at 7. He did not compel her testimony.

B. Multiple witnesses found postconviction refute the State's medical witnesses' trial testimony

As the State did not present credible fact witnesses, Ms. Gomez's conviction was based upon the opinion of medical witnesses. Evidence developed postconviction refutes the trial testimony offered on each of Rafael's injuries that the trial court held were caused by Ms. Gomez.

i. Shoulder injuries

The trial court based its decision that Rafael's shoulder injuries were caused by Ms. Gomez on the State's witnesses' medical testimony that Rafael had acute and chronic proximal humeral fractures and a glenoid fracture. PRP App. 1 at 2.34. Dr. Feldman and Dr. Ross testified that the injuries were non-accidental and were due to severe force, but they provided conflicting testimony on the date of the injuries. RP 444, 1017. Dr. Feldman further testified that a child with this injury would develop "pseudoparalysis" in his arms. RP: 448.

The State's medical witnesses' testimony regarding the shoulder injuries was not refuted by Moser through either fact or expert witnesses. See Amended Brief at 18, 49-50. Despite the careful monitoring of Rafael's life, no one described seeing him with pseudoparalysis. See id. Moreover, declarations from expert witnesses presented during the PRP proceedings revealed that the shoulder injuries could have been caused by non-abusive actions. See id. Dr. Stephens, a certified forensic pathologist

with over thirty years of experience, concluded that the injuries could have been caused by vigorous swinging of the child and/or congenital abnormalities. PRP App. 22. Dr. Ayoub, a board certified radiologist, concluded that the injuries were growth plate injuries that could also have been caused by “forces ranging from normal parental handling or play activities to seizure and/or accidental or nonaccidental trauma.” PRP Reply App. 1. Both experts refute the State’s witnesses’ testimony that abuse was the only explanation for the shoulder injuries.

ii. Bruising/gouging and nipple lacerations

Ms. Gomez, Mr. Arechiga, and Maria Gomez testified at trial that Rafael exhibited self-injurious behaviors. RP: 316, 1935-36, 2095-98, 2630. The trial court did not find their testimony credible, because no other witnesses observed Rafael pinching or biting himself or throwing himself backwards. PRP App. 1 at 2.37; 2.70; 2.72. Moser did not interview or present testimony from the numerous non-relative witnesses who observed Rafael display these behaviors. Instead, he called Murray Twelves and Olga Gaxiola to testify that neither had witnessed Rafael’s self-injurious behaviors. RP: 1802, 2021.

As detailed in the PRP appendices, certified mental health professional Jorge Chacon, CPS Worker Gracie Alvarado, family friend Jennifer Peña, Columbia Ridge Elementary School teacher Rosibel Dávila,

SCAN employee Esperanza Pando, and family friend Alicia Garces were available to testify regarding Rafael's head-banging, food-related problems and biting and pinching at himself. PRP App. 9, 10, 16, 39, 57.

iii. Occipital fracture and epidural hemorrhage

The only witnesses to the event precipitating Rafael's death were Ms. Gomez and her children. Maria Gomez, who was eleven years old, made a statement to police shortly after the event which was generally consistent with Ms. Gomez's testimony. PRP App. 21. On the evening of September 9, 2003, Ms. Gomez was in her kitchen feeding noodle soup to Rafael and her youngest son, Edgar. RP: 295, 2110-11. When the soup was almost gone, Rafael started crying, threw himself backwards onto the floor, and banged the back of his head on the floor multiple times. *Id.*; PRP App. 21. Ms. Gomez fed him more soup to appease him. RP: 2112; PRP App.21. Rafael again threw himself backwards, once more hitting his head on the floor, which was made of linoleum over concrete. RP: 1362, 2113. This time, his eyes rolled back and he went unconscious. *Id.* at 2352. Ms. Gomez began sucking noodles out of his mouth to try to revive him. *Id.* at 1431. She rushed Rafael to her neighbor's house and then to the hospital. *Id.* at 1321, 2353. When Rafael arrived at the hospital, he was not breathing, was without a pulse, and had vomit in his mouth and cheeks and food in his airway. *Id.* at 603-04. He died the next day.

The State did not present any fact witnesses to contradict Maria and Ms. Gomez's description of the events leading to Rafael's death. Instead, it offered testimony from medical witnesses who testified that Rafael died as a result of blunt force injuries to the head. PRP App. 1 at 2.33; 2.38; Amended Brief at 10-11. Those witnesses opined that the head injuries were intentionally inflicted. *Id.* During trial, the trial court repeatedly questioned the State witnesses on whether the head injuries could have been caused by an accident:

COURT: Is it conceivable that the trauma that caused Rafael Gomez's death have been caused by an accident? You've described it as being severe. Another question is could it have been caused by an accident of some kind?

THE WITNESS: There's no history of an adequate accident to explain it. And we've got a kid who is dependent.

...

COURT: Well, you have indicated that this trauma couldn't be caused, for instance, from a fall from a two-foot high couch; is that correct?

THE WITNESS: That's correct.

...

COURT: And then again in the realm of common human experience there's no accidental kind of situation where this could happen that you can think of?

THE WITNESS: It's really hard to come up with accident scenarios that match this. And again, the motor vehicle, some of the things that happen in there are probably the closest to it.

RP: 527-47 (emphasis added).

Postconviction evidence refutes the State's claim that Rafael's head injuries were non-accidental. Dr. Stephens concluded that there is no evidence to support that the occipital skull fractures were inflicted. PRP App. 22 Biomechanical evidence, presented by Phil Lock and Dr. Chris Van Ee, supports that Rafael's head injuries could have been the result of his multiple falls. PRP App. 11; PRP Supp. App. 59. Dr. John Plunkett, a forensic pathologist with over thirty years of experience, concluded the head injuries could have occurred during any of Rafael's reported falls. PRP Supp. App. 62.

Testimony from Dr. Stephens also would have refuted the State's theory that the epidural hemorrhage resulted from inflicted trauma. Dr. Stephens described the hemorrhage as "a very old well-organized hemorrhage that may date back to the December 2002 skull fracture." PRP App. 22. Moreover, Moser could have turned to research, including Dr. Feldman's, to establish that "only 6% of children with epidural hemorrhages were abused." See Frasier, et. al., Abusive Head Trauma in Infants and Children: A Medical, Legal and Forensic Reference (G.W. Medical Publishing 2006), Ch. 2 at 14, citing Shugarman, Grossman, Feldman and Grady, "Epidural hemorrhage: is it abuse?" Pediatrics 1996; 97: 664-668; id. at 119-120 (epidural hemorrhage more often feature of accidental head injury; often associated with skull fracture).

C. The State did not dispute any of the material facts presented during the PRP proceedings; the Court of Appeals' decision did not accurately state or discuss the facts

The State did not dispute any of the material facts presented in the PRP proceedings or challenge the admissibility of the facts. Response. The Chief Judge of the Court of Appeals did not set the case for a reference hearing. Exh. 2 (Order). The Court of Appeals' decision treats the PRP like an appeal, holding that "the [trial] court's findings are easily supported by the evidence and ultimately, the court's conclusion that Ms. Gomez killed her son is easily supported by the findings." Exh. 1 at p. 2. It did not analyze whether the trial court's findings would have been impacted by the postconviction evidence refuting the State medical expert's opinions. Id. It did not address the facts presented by numerous expert and lay witnesses who supported Ms. Gomez's testimony that Rafael was not abused and that she did not cause his death. Id.

2. Procedural History.

Ms. Gomez was found guilty of first degree Manslaughter and Homicide by Abuse on March 28, 2007. She filed a direct appeal. On October 14, 2008, the Court of Appeals vacated her Manslaughter conviction and affirmed her Homicide by Abuse conviction. On May 4, 2009, this Court denied her Petition for Review. On May 14, 2009, the mandate issued. Ms. Gomez filed a PRP on May 13, 2010, in the Court of

Appeals on the grounds that she was denied her Sixth Amendment right to conflict-free and effective assistance of counsel. The Court of Appeals ordered the matter be heard without oral argument. Exh. 2. It then heard oral argument on September 13, 2011. In an unpublished opinion filed on October 13, 2011, the Court of Appeals denied the PRP. Exh. 1.

E. ARGUMENT WHY REVIEW SHOULD BE ACCEPTED

This Court should accept review because the Court of Appeals' decision denying Ms. Gomez's personal restraint petition misapplies long-standing precedent on ineffective assistance of counsel claims, is contrary to established precedent on conflict of interest claims and misstates, or ignores, undisputed facts that entitle Ms. Gomez to relief. The rush to judgment that occurs when a child suffers a fatal injury can, as recent events confirm, result in innocent people being convicted of horrific crimes. See, e.g., Exh. 3 at 5. The cultural context of Ms. Gomez's case can also not be ignored. Injuries suffered by Rafael while in his white foster parents' care went unnoticed or were dismissed as local doctors were influenced by the foster mother and were "biased by her interpretations of Rafael's injuries when treating and diagnosing Rafael." PRP App. 6. Ms. Gomez's trial counsel failed to undertake minimal steps of investigation and advocacy which would have provided the trial court

with a complete narrative of Rafael's life and supported Ms. Gomez's testimony that Rafael was not abused and that she did not cause his death.

The Court of Appeals ignores the substantial record developed postconviction supporting Ms. Gomez's defense. The Court of Appeals cites to Moser's statement that he believed no one saw Rafael's behaviors other than Ms. Gomez. Exh. 1 at 16. That belief was patently false. And yet, the Court uses this false premise to excuse Moser for not conducting an investigation. *Id.* at 4, 13, 16-17. Moreover, the Court of Appeals fails to explain how it could possibly be reasonable for Moser to forgo interviewing or calling witnesses who had exculpatory evidence, but call witnesses to contradict Ms. Gomez's testimony. No rational defense attorney would pursue such a strategy. PRP App. 5, 15.⁸

1. The Court of Appeals Erred In Concluding That Moser Rendered Effective Assistance

The record confirms that Moser failed to conduct a reasonable investigation in Ms. Gomez's case. Though he undeniably had a duty to investigate each element of the charges against Ms. Gomez, he conducted absolutely no independent investigation into Ms. Gomez's most important defense – that Rafael was not abused.⁹ This is especially egregious

⁸ Moser was recently disciplined for his misconduct in a contemporaneous case. Exh. 4.

⁹ The Court of Appeals mischaracterizes Ms. Gomez's defense in stating: "Ms. Gomez's proposed theory at trial was that this child abused himself to death." Exh. 1 at 20. This

considering a proper investigation would have revealed substantial evidence to support the defense. In re Pers. Restraint of Davis, 152 Wn.2d 647, 721, 101 P.3d 1 (2004) (“the failure to conduct a reasonable investigation is considered especially egregious when the evidence that would have been uncovered is exculpatory”); see also Lord v. Wood, 184 F.3d 1083, 1093 (9th Cir.1999).

Evidence gathered during the postconviction proceedings would have impacted the trial court’s ruling on the allegations of abuse it attributed to Ms. Gomez. The trial court sought out testimony on whether certain injuries were accidental. When the trial court was presented with alternate explanations for the injuries, it found that the State did not prove its allegations. The Court of Appeals erred when it failed to consider the evidence which was readily available to Moser at the time of trial, and instead condoned his unreasonable and false belief that critical witnesses would not have added anything to the case. The Court of Appeals also erred by focusing on the sufficiency of the evidence rather than considering whether there is a reasonable probability that the outcome of the trial would have been different had defense counsel conducted a reasonable investigation. See Exh. 1 at 2.

error further demonstrates that the Court did not thoroughly review the PRP evidence. The evidence not only confirms that Rafael exhibited troubling behaviors, but also refutes the State’s testimony that Rafael’s other injuries were not accidental. See Exh. 5 (Chart).

a. The Court of Appeals erred by concluding that Moser made strategic decisions to not call certain witnesses

The Court of Appeals' conclusion that Moser made strategic decisions is unfounded, given that he had not conducted the reasonable investigation that is a precursor to strategic decision-making. State v. Weber, 137 Wn. App 852, 858, 155 P.3d 947 (2007); See also United States v. DeCoster, 487 F.2d 1197 (D.C. Cir.1973). The evidence Ms. Gomez submitted in support of her PRP demonstrates that Moser did not conduct a reasonable investigation into Ms. Gomez's claim that Rafael was not abused. In Brett, this Court found that defense counsel "knew or should have known" of his client's medical and mental conditions and that he was ineffective for failing to conduct a reasonable investigation which would have revealed available evidence to support a defense. 142 Wn.2d at 871. At a reference hearing, medical experts testified about the considerable medical and psychiatric evidence was available at the time of trial to support the defense. Id. at 874. Since the State did not dispute the evidence, this Court held that it established "what defense counsel would have known had it conducted a reasonable investigation." Id. at 876.

In support of her PRP, Ms. Gomez submitted evidence, including declarations from numerous lay witnesses and experts, demonstrating that a substantial amount of evidence was available at the time of trial to

support the defense that Rafael was not abused. The State did not dispute this evidence or argue it was not available before trial. As in Brett, it establishes what Moser would have known through conducting a reasonable investigation.

Rather than consider the evidence that was available to defense counsel at the time of trial, the Court of Appeals disregarded that evidence and concluded that defense counsel “chose not to pursue claims that Rafael harmed himself for good reason – there was little or nothing to support the claim.” Exh. 1 at 13. Had the Court of Appeals reviewed the evidence, it would have known this to be false. The voluminous record includes declarations from numerous people, including Ms. Gomez’s caseworker, who had witnessed Rafael’s behaviors.¹⁰ The record also includes extensive medical evidence refuting the State’s allegations that Rafael’s injuries were inflicted.

¹⁰ The Court of Appeals noted specifically that “no in-home service workers had ever witnessed [Rafael] doing anything to himself.” Exh. 1 at 4. This is refuted by the declaration of Jorge Chacon, a mental health therapist with 40 years of experience, who served as caseworker to the family for 6 months leading up until Rafael’s death. Chacon witnessed Rafael throw several tantrums, jerk his body back and hit himself against a wall, fall backwards onto the floor, throw tantrums when Ms. Gomez stopped feeding him, jerk his arms out to the side suddenly, and hit other children. PRP App. 9.

b. Moser's deficiencies resulted in individual and cumulative instances of ineffectiveness that prejudiced her defense

Moser's other numerous deficiencies, too extensive for discussion, are detailed in Ms. Gomez's Amended Brief and Reply and are included in her request that this Court grant relief. Courts should view prejudice as cumulative and consider the totality of trial counsel's failures. Strickland v. Washington, 466 U.S. 668, 695, 104 S. Ct. 2052, 80 L. Ed.2d 674 (1984); see also Brett, 142 Wn.2d at 882. Because the Court of Appeals concluded Moser was effective, it did not reach the prejudice prong. However, the extent to which Moser's deficient performance prejudiced Ms. Gomez's defense is evident from the trial record. During trial, the court repeatedly sought explanations for Rafael's injuries, searching for evidence to support a defense that he was not abused. See supra, p. 10. Had Moser presented evidence that numerous people witnessed Rafael exhibit self-injurious behaviors, that his head injuries were explained by accidental short falls, that Rafael displayed no signs of pseudo paralysis, and that the shoulder injuries were not intentionally inflicted, there is a reasonable probability that the outcome of the trial would be different.

2. The Court Of Appeals Erred In Concluding Moser Was Not Operating Under An Actual Conflict

In order to show a violation of the Sixth Amendment right to conflict-free counsel, a defendant "need only show that a conflict

adversely affected the attorney's performance..." State v. Dhaliwal, 150 Wn.2d 559, 571, 79 P.3d 432 (2003) (citing Mickens v. Taylor, 535 U.S. 162, 122 S. Ct. 1237, 152 L. Ed. 2d 291 (2002)). A petitioner has established actual conflict if she demonstrates that "some plausible alternative defense strategy or tactic might have been pursued but was not and that the alternative defense was inherently in conflict with or not undertaken due to the attorney's other loyalties or interests." State v. Regan, 143 Wn. App. 419, 428, 177 P.3d 783 (2008), rev. denied 65 Wn.2d 1012, 198 P.3d 512 (2008) (internal citations omitted). It is well-established that a defendant need not demonstrate prejudice. Id. at 427.

The Court of Appeals misapplied the conflict standard by requiring Ms. Gomez to demonstrate prejudice. First, the Court mischaracterized Ms. Gomez's claim by construing it to be that "conflict-free counsel "would have showed Mr. Arechiga to be the culprit." Exh. 1 at 9. Having thus mischaracterized Ms. Gomez's claim, the Court then held that, because Ms. Gomez made "no showing that Mr. Arechiga abused Rafael to death or even that he had the opportunity to," she had not established an actual conflict. Id. at 8. This is an erroneous application of the conflict standard. Ms. Gomez does not need to establish that conflict-free counsel would have uncovered evidence of abuse by Mr. Arechiga. She need only demonstrate, as she has, that defense counsel's conflict prevented him

from pursuing the plausible defense strategy of investigating her claims of innocence and contesting the “pattern or practice” of abuse element.

3. Factual Issues Should Be Resolved By A Reference Hearing

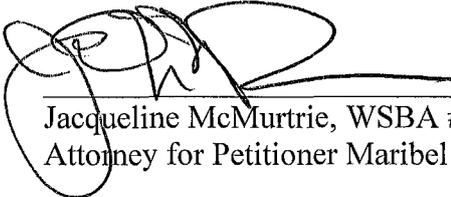
At minimum, Ms. Gomez presented sufficient facts through competent, admissible evidence, to establish a prima facie case that her right to effective assistance of counsel and conflict-free counsel under the state and federal constitutions was violated. Matter of Pirtle, 136 Wn.2d 467, 473, 965 P.2d 593 (1998). The State did not dispute any of the material facts presented during the PRP proceedings. The Court of Appeals did not question the credibility of evidence, but disregarded it in an opinion that misstates the facts. If this Court has questions of fact, it is entitled to refer the matter to Superior Court for a reference hearing.

F. CONCLUSION

For the foregoing reasons, Ms. Gomez respectfully requests that the Court grant her PRP, or in the alternative remand the case for a reference hearing in Superior Court.

Dated this 10th day of November, 2011.

INNOCENCE PROJECT NORTHWEST CLINIC


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Attorney for Petitioner Maribel Gomez


Dylan Tessier
Rule 9 Intern

CERTIFICATE OF SERVICE

I declare, under penalty of perjury, that on the 11th day of November, 2011, a true and correct copy of the foregoing Petitioner's Motion for Discretionary Review was served upon the following, by depositing same with Federal Express, overnight:

Attorney for Respondent
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November 11, 2011 at Seattle, WA
DATE and PLACE



Jacqueline McMurtrie

EXHIBIT 1

FILED

OCT 13 2011

In the Office of the Clerk of Court
WA State Court of Appeals, Division III

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON

In the Matter of the Personal Restraint)	No. 29030-1-III
Petition of)	
)	
MARIBEL GOMEZ,)	Division Three
)	
Petitioner.)	
)	UNPUBLISHED OPINION
)	

SWEENEY, J. — It would be very difficult for any lawyer to try a factually complicated and emotionally charged case such as this. It is, however, easy to second guess decisions that a lawyer made and the strategies he employed many years after the fact, six years to be exact. It is for that reason that we are deferential to the decisions of counsel. *Strickland v. Washington*, 466 U.S. 668, 689, 104 S. Ct. 2052, 80 L. Ed. 2d 674 (1984). Here, Maribel Gomez’s suggestion in her personal restraint petition (PRP) that other approaches might have brought a different result clearly ignores the overwhelming evidence.

A Grant County Superior Court Judge concluded that Ms. Gomez killed her two-year-old son, Rafael:

No. 29030-1-III
In re Pers. Restraint of Gomez

[T]he defendant was virtually the sole caretaker of Rafael when she had custody of him. During those periods of time when he lived with the Defendant, from age 10 to 16 months and again from age 19 months to 25 months, Rafael suffered three skull fractures prior to the incident which caused his death, a broken femur, a broken tibia, two shoulder fractures, a wound to the back of his head, a gouge or bruise to his right ear, burns to his hand, and lacerated nipples.

2.50 No similar injuries were sustained while he was in foster care from birth to 10 months and from 16 to 19 months.

Br. of Pet'r, App. 1 (Findings of Fact and Conclusions of Law on Non-Jury Trial, Findings (FF) 2.49, 2.50) (emphasis added).

Ms. Gomez now contends, by way of this PRP, that she may not have been convicted of the crime had her lawyer done a better job. We have carefully reviewed this record and it is clear that the court's findings are easily supported by the evidence and, ultimately, the court's conclusion that Ms. Gomez killed her son is easily supported by the findings.

FACTS

Ms. Gomez appealed her convictions of homicide by abuse and first-degree manslaughter that followed for the September 2003 death of her two-year-old son, Rafael. *State v. Gomez*, noted at 147 Wn. App. 1003 (No. 26090-9-III, filed Oct. 14, 2008). The factual backdrop for the convictions is set out in our earlier opinion and need not be repeated here other than to note that we affirmed the homicide by abuse conviction

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and vacated the manslaughter conviction. Ms. Gomez now complains that she was not well served by her trial counsel.

In January 2004, the court appointed Robert Moser to represent José Arechiga, Rafael's biological father and now Ms. Gomez's husband, in dependency proceedings regarding Edgar, his other biological child with Ms. Gomez. The Department of Social and Health Services removed the other children from the home and placed them in foster care after the death of Rafael. The court appointed Douglas G. Anderson to represent Ms. Gomez in the proceedings. Both parents argued that there was no abuse in the home. The court ultimately found Edgar a dependent child. Mr. Moser continued to represent Mr. Arechiga on appeal and through the final termination of his parental rights. Mr. Moser also represented Mr. Arechiga in the dependency proceedings of Jacqueline, his biological daughter with Ms. Gomez; she was born after Rafael's death.

The State charged Ms. Gomez with manslaughter following Rafael's death in May 2004. The State later added the homicide by abuse charge. Ms. Gomez asked Mr. Moser to represent her. Mr. Moser agreed to take her case. He was already very familiar with the facts of the case because of his efforts in the dependency proceedings. Mr. Moser was a former deputy prosecutor who went into private practice in June 2003. He spent up to 500 hours on Ms. Gomez's case over the three years prior to trial. Ms. Gomez paid Mr. Moser a few hundred dollars for his appearance at her arraignment.

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Mr. Moser and Ms. Gomez discussed whether to try her case to a jury. Ms. Gomez did not want a jury because of the press the case received in the local news. The two then decided to try the case to the judge sitting without a jury. Mr. Moser selected 13 witnesses, including Ms. Gomez, to testify. He chose many of the witnesses based on what he had heard during the dependency hearing. Mr. Moser declined to call several of Ms. Gomez's friends as character witnesses because he knew, again from the dependency hearing, that they could not testify to specific facts surrounding Rafael's death. Mr. Moser also did not think that Ms. Gomez's claims that Rafael caused these horrific injuries to himself provided much of a basis for a successful defense because no in-home service workers had ever witnessed him doing anything to himself.

Mr. Moser talked to a number of experts about testifying on Ms. Gomez's behalf. He ultimately hired Dr. Janice Ophoven to testify as his primary medical expert on the cause of death. She is a pediatric forensic pathologist. Mr. Moser continued to look for other experts without success. Mr. Moser sent Dr. Ophoven Rafael's complete medical history a year before trial. Dr. Ophoven reviewed the history along with over 100 other documents. She found that Rafael had been abused but concluded he died of asphyxiation rather than head trauma.

The State called five medical experts as witnesses. Dr. Marco Ross, the Spokane County Medical Examiner and a forensic pathologist, concluded that Rafael "died as a

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result of blunt force injuries to the head.” Br. of Pet’r, App. 1 (FF 2.33). And he concluded that “the manner of death was homicide.” Br. of Pet’r, App. 1 (FF 2.33). Dr. Kenneth Feldman and Dr. Gina Fino agreed. Dr. Feldman concluded that “the constellation of findings at his death are specific for abuse.” Br. of Pet’r, App. 1 (FF 2.34). Dr. Ross, Dr. Feldman, and Dr. Fino agreed that subdural hemorrhaging is not a by-product of asphyxiation or disseminated intravascular coagulation (DIC). Br. of Pet’r, App. 1 (FF 2.41). Dr. Ophoven opined that the cause of death was asphyxiation or DIC and that the manner of death was “undetermined.” Report of Proceedings (RP) (No. 26090-9-III) at 2069.

The court concluded that Ms. Gomez caused the death of Rafael and found her guilty of homicide by abuse and first-degree manslaughter. Ms. Gomez appealed the convictions. She did not argue ineffective assistance of counsel. She also did not complain that she could not communicate with her lawyer. We affirmed her conviction of homicide by abuse and vacated her first-degree manslaughter conviction. *State v. Gomez*, noted at 147 Wn. App. 1003 (No. 26090-9-III, filed Oct. 14, 2008). Ms. Gomez now files this PRP.

DISCUSSION

SIXTH AMENDMENT RIGHT TO COUNSEL—CONFLICT OF INTEREST

Ms. Gomez contends that her lawyer had a conflict of interest because he represented her husband in dependency proceedings for their other children at the same time he represented her in this criminal proceeding. This contention presents a question of law that we will review de novo. *State v. Vicuna*, 119 Wn. App. 26, 30, 79 P.3d 1 (2003).

The Sixth Amendment to the United States Constitution guarantees a criminal defendant the assistance of counsel, free from conflict of interest. *State v. Dhaliwal*, 150 Wn.2d 559, 566, 79 P.3d 432 (2003). But the concurrent representation of two defendants does not automatically give rise to a conflict. *See Holloway v. Arkansas*, 435 U.S. 475, 482, 98 S. Ct. 1173, 55 L. Ed. 2d 426 (1978). A conflict of interest exists when a defense attorney owes duties to a party (or other client) whose interests are adverse to those of the defendant. *State v. White*, 80 Wn. App. 406, 411-12, 907 P.2d 310 (1995). The Washington Rules of Professional Conduct (RPC) also prohibit an attorney from representing a client if the attorney's duties will be directly adverse to another client or materially limit the attorney's representation. RPC 1.7. But the RPCs do not represent the constitutional standard for effective assistance of counsel. *White*, 80 Wn. App. at 412-13.

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Ms. Gomez must show that an actual conflict of interest adversely affected her attorney's performance. *Dhaliwal*, 150 Wn.2d at 571. Simply showing a theoretical division of loyalties is not enough. *Mickens v. Taylor*, 535 U.S. 162, 171, 122 S. Ct. 1237, 152 L. Ed. 2d 291 (2002). A conflict adversely affects counsel's performance if "some plausible alternative defense strategy or tactic might have been pursued but was not and that the alternative defense was inherently in conflict with or not undertaken due to the attorney's other loyalties or interests.'" *State v. Regan*, 143 Wn. App. 419, 428, 177 P.3d 783 (2008) (internal quotation marks omitted) (quoting *United States v. Stantini*, 85 F.3d 9, 16 (2d Cir. 1996)).

Mr. Moser represented Ms. Gomez and Mr. Arechiga during separate but related proceedings. The State started dependency proceedings after Rafael's death out of concerns over the abuse that caused his death. Ms. Gomez had separate counsel during those proceedings. The State charged her with first degree manslaughter and she asked Mr. Moser to represent her. Mr. Moser agreed apparently because of his familiarity with the case. The State later added the homicide by abuse charge. Mr. Moser continued to represent Mr. Arechiga in the dependency matter. Both Ms. Gomez and Mr. Arechiga consistently argued that there was no abuse in the home and Rafael died as a result of his medical problems caused by his related behavioral problems.

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Ms. Gomez now contends that Mr. Moser could not investigate Mr. Arechiga for potential abuse of Rafael. She argues that Mr. Moser improperly relied on the dependency proceedings instead of conducting an independent investigation of Mr. Arechiga on her behalf. Ms. Gomez believes that Mr. Moser would have interviewed key witnesses to bolster her case if he did not represent Mr. Arechiga at the same time. She offers the declarations of two attorneys to support her theory.

Mr. Moser agreed to represent Ms. Gomez because he was familiar with the case following the dependency proceedings. This is not a division of loyalty. *Id.* And she makes no showing of adverse interests. Both she and Mr. Arechiga advanced the same theory of the case; they insisted there was no abuse in the home. And Ms. Gomez makes no showing that Mr. Arechiga abused Rafael to death or even that he had the opportunity to. Indeed, Mr. Arechiga was not present during the time of Rafael's death. Maria, Ms. Gomez's daughter, testified that Mr. Arechiga never even disciplined the children. Mr. Arechiga also testified favorably for Ms. Gomez at trial.

There is simply no showing here of abuse by Mr. Arechiga. Indeed, there has never been any suggestion of abuse by him until this petition some six years after the fact. Br. of Pet'r, App. 1 (FF 2.53). Several witnesses were questioned at trial regarding Mr. Arechiga's conduct and none suggested abuse. Ms. Gomez, then, presents a theoretical division of loyalties and not an actual conflict that adversely affected her

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attorney's performance. The suggestion that further "conflict-free" inquiry would have showed Mr. Arechiga to be the culprit is pure speculation.

Far from presenting a conflict of interest, Mr. Moser's participation in the dependency proceeding clearly helped him prepare Ms. Gomez's defense. No rational reader of this record can walk away with anything other than the abiding conviction that Ms. Gomez abused her son to death.

INEFFECTIVE ASSISTANCE OF COUNSEL

Ms. Gomez next says that she was denied her right to effective assistance of counsel because her lawyer did not have enough experience, did not always consult with her through an interpreter, did not prepare her to testify, and did not investigate all available lay and expert witnesses. In support of her arguments, she presents her own declaration; the declaration of her attorney, Mr. Moser; and the declarations of a number of lay and expert witnesses. We review claims of ineffective assistance of counsel de novo. *State v. McFarland*, 127 Wn.2d 322, 334-35, 899 P.2d 1251 (1995).

To establish an ineffective assistance of counsel claim, a defendant must prove that (1) counsel's performance was deficient, and (2) the deficient performance prejudiced the defendant such that there is a reasonable probability that the proceedings would have turned out differently without counsel's errors. *Strickland*, 466 U.S. at 687-95. We strongly presume that counsel's conduct was reasonable, and so the defendant

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bears the burden of proving that the challenged action was not a legitimate trial strategy. *Id.* at 689; *State v. Reichenbach*, 153 Wn.2d 126, 130, 101 P.3d 80 (2004). “A fair assessment of attorney performance requires that every effort be made to eliminate the distorting effects of hindsight.” *Strickland*, 466 U.S. at 689.

Ms. Gomez contends that Mr. Moser lacked experience. She argues that he did not have the knowledge necessary to analyze causation issues or medical expert opinions on child abuse. We begin with the obvious:

“A defendant is not entitled to perfect counsel, to error-free representation, or to a defense of which no lawyer would doubt the wisdom. Lawyers make mistakes; the practice of law is not a science, and it is easy to second guess lawyers’ decisions with the benefit of hindsight.”

State v. Adams, 91 Wn.2d 86, 91, 586 P.2d 1168 (1978) (quoting Finer, *Ineffective Assistance of Counsel*, 58 Cornell L. Rev. 1077, 1080 (1973)). Ultimately, there are many different ways to approach the same case and so a lawyer is not ineffective because he or she chooses one over another. *State v. Grier*, 171 Wn.2d 17, 43, 246 P.3d 1260 (2011). And the fact that the court found Ms. Gomez responsible for her son’s death does not mean counsel was ineffective. *Id.*

Mr. Moser “had never defended a felony case with substantial medical records before Ms. Gomez’s case.” Br. of Pet’r, App. 4 (Declaration of Robert Moser (Moser) at 4). But Mr. Moser did graduate from law school some six years before Ms. Gomez’s case. He had worked for the Grant County Prosecutor’s Office and later went into private

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practice. He had tried criminal, commercial, and tort cases. He had also tried numerous driving under the influence cases in which a breath alcohol concentration technician and a toxicologist appeared as experts. He had represented parents in a number of dependency trials that frequently involved medical experts.

Ms. Gomez must prove that Mr. Moser's performance fell below an objective standard of reasonableness and she was prejudiced as a result. She must point out his specific mistakes. Mr. Moser's defense of this difficult and emotionally charged case appears, from this record, to be highly competent, spirited and, for us, in the finest tradition of trial lawyers.

Ms. Gomez contends that Mr. Moser failed to consult with her through an interpreter and that this hurt her defense. Specifically, she argues that Mr. Moser never informed her of the right to a jury trial or the right not to testify. She further argues that she was not afforded the opportunity to fully explain Rafael's injuries to Mr. Moser.

The right to an interpreter at trial stems from the Sixth Amendment. *State v. Gonzales-Morales*, 138 Wn.2d 374, 379, 979 P.2d 826 (1999). The appointment of an interpreter is a matter within the discretion of the trial court "to be disturbed only upon a showing of abuse." *State v. Trevino*, 10 Wn. App. 89, 94-95, 516 P.2d 779 (1973). But a defendant's right to an interpreter during communications with counsel, which occur

outside the courtroom, is a different matter. That right stems from counsel's duty to consult with the defendant on important decisions. *See Strickland*, 466 U.S. at 688.

Ms. Gomez's native language is Spanish. Mr. Moser does not speak Spanish. Ms. Gomez first used her niece to contact Mr. Moser about taking her case. She recalls only one time prior to trial that Mr. Moser hired an interpreter to go to the hospital and get medical records. She also recalls Mr. Moser using a bilingual friend of hers to explain the added homicide by abuse charge. She remembers numerous times during trial that Mr. Moser used a court interpreter to speak with her, but now claims that the conversations were of little substance.

Mr. Moser's declaration indicates that, for the most part, he cannot remember whether he was using an interpreter while discussing specific issues with Ms. Gomez. He does remember using friends of Ms. Gomez to interpret during several of their meetings outside of the courtroom. He also remembers using the courtroom interpreter during trial. Nonetheless, Ms. Gomez points to three specific issues on which she was not properly consulted: (1) right to jury trial, (2) right not to testify, and (3) opportunity to explain the abuse.

First, the trial judge discussed Ms. Gomez's decision not to pursue a jury trial. Both Mr. Moser and Ms. Gomez told the court that they had reviewed the decision and agreed not to pursue a jury trial. The court questioned Ms. Gomez directly, and she

responded that she had discussed the decision with Mr. Moser and was confident in her decision. Ms. Gomez decided “it was better for one person to make the decision instead of twelve.” Br. of Pet’r, App. 3 (Declaration of Maribel Gomez (Gomez) at 12).

Second, Ms. Gomez offers no evidence, other than her self-serving declaration, to show that Mr. Moser failed to inform her of her Fifth Amendment right not to testify. She testified without objection. Mr. Moser stated that he informed Ms. Gomez of her right not to testify but, again, could not remember with certainty whether he used an interpreter. He stated that he generally always has his clients testify in criminal trials as a matter of strategy: “the trier of fact needs to hear some things from the defendant and has difficulty acquitting unless they have those issues resolved.” Br. of Pet’r, App. 4 (Moser at 5). It appears from the declarations that Ms. Gomez actually wanted to take the stand in order to bolster her defense that this two-year-old boy killed himself. Br. of Pet’r, App. 3 (Gomez at 4-8).

Third, Ms. Gomez had ample opportunity to discuss Rafael’s injuries with Mr. Moser. Interpreters were present both before and during the trial. Mr. Moser chose not to pursue claims that Rafael harmed himself for good reason—there was little or nothing to support the claim. Mr. Moser had listened to lengthy testimony from friends and treatment providers on the supposed causes of Rafael’s injuries during the dependency proceedings and “[f]rom the dependency hearing, it did not appear that any [Child

Protective Services] worker actually saw him doing anything to himself.” Br. of Pet’r, App. 4 (Moser at 7).

Ms. Gomez fails to show that Mr. Moser’s communications resulted in deficient performance and that she was prejudiced. Mr. Moser engaged with Ms. Gomez throughout the process and made some legitimate strategy decisions along the way. His performance was reasonable and competent.

Ms. Gomez next contends that Mr. Moser failed to prepare her to testify: “Mr. Moser didn’t prepare me for the prosecutor’s questions or the way that he asked me the questions. . . . I was never able to express to the court how much I loved Rafita, and how much it hurt me to lose him.” Br. of Pet’r, App. 3 (Gomez at 16-17). Of course, Ms. Gomez’s inability to say what she wanted on the stand does not establish that Mr. Moser failed to prepare her for trial.

Counsel must “bring to bear such skill and knowledge as will render the trial a reliable adversarial testing process.” *Strickland*, 466 U.S. at 688. Mr. Moser could not remember the specific preparation of Ms. Gomez for her testimony, but he remembered discussing the matter several times:

I am not able to say if Ms. Gomez’s testimony helped her case or not. To some extent, it hurt her case, because that judge found she was not credible. After about three hours of testimony, when she was being cross-examined by the prosecutor, she broke down screaming and crying. The judge did not find fault with the prosecutor’s questioning at this point. Ms. Gomez’s reaction at this point seemed to figure into his opinion as to her credibility.

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Br. of Pet'r, App. 4 (Moser at 5-6).

Mr. Moser knew Ms. Gomez and was familiar with what she would testify to. He knew that she intended to say that Rafael inflicted injuries to himself sufficient to cause his death. He discussed her testimony with her several times. Mr. Moser was certainly not required, and ultimately may well have been unable, to emotionally prepare Ms. Gomez for the aggressive cross-examination by the State. Ms. Gomez, then, fails to show that Mr. Moser's performance in preparing her for testimony was deficient in any way or how she was prejudiced by the performance in any event.

Ms. Gomez contends that Mr. Moser failed to investigate numerous lay and expert witnesses. She contends that Mr. Moser should have interviewed Department of Social and Health Services' workers, friends, and family members who she now claims had valuable information about Rafael's daily behaviors that might well have resulted in his death. She further contends that Mr. Moser should have better prepared Dr. Ophoven, his sole expert witness. She also believes that Mr. Moser should have investigated and hired other expert witnesses to refute the State's allegations of abuse. To support her claims, Ms. Gomez submitted declarations from each named lay and expert witness, including Dr. Ophoven. Br. of Pet'r, Apps. 3-17, 56-59.

Generally, an attorney's decision to call a witness to testify is a "matter of legitimate trial tactics," which "will not support a claim of ineffective assistance of

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counsel.” *State v. Byrd*, 30 Wn. App. 794, 799, 638 P.2d 601 (1981). But a petitioner can overcome this presumption by showing that his or her counsel failed to adequately investigate or prepare for trial. *Id.* Counsel has a duty to conduct a reasonable investigation. *Strickland*, 466 U.S. at 691. A decision not to investigate must be directly assessed for reasonableness, with again great deference given to counsel’s judgments. *Id.*

First, Ms. Gomez asserts that Mr. Moser was ineffective because he failed to interview eight government-employed witnesses. Br. of Pet’r at 32 (Jorge Chacón, Linda Turcotte, Cecilia DeLuna, Gracie Alvarado, Sandra Flores, Audra Turner, Esperanza Pando, and Rosibel Dávila). She believes that each of those witnesses would have testified to her excellent parenting skills and Rafael’s propensity to hurt himself.

About 40 witnesses testified at trial. The defense called some 13 of those witnesses. Mr. Moser chose many of his witnesses based on information gathered during the dependency proceedings. Mr. Moser concluded that he could not make a compelling case that Rafael caused these horrific injuries to himself: “I did not think that anyone ever saw Rafael’s behaviors other than Ms. Gomez.” Br. of Pet’r, App. 4 (Moser at 6).

Nonetheless, Mr. Moser called Ms. Gomez, Maria Gomez, and Mr. Arechiga to testify about Rafael’s behavior. Mr. Moser also called Department of Social and Health Services workers Olga Gaxiola and Murray Twelves. Both testified that they did not observe any of the behaviors claimed by Ms. Gomez. Mr. Moser also attempted to

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contact Child Protective Services worker Gracie Alvarado. He delivered a subpoena for her appearance but the subpoena apparently was not honored. The State called Alicia Estrada, a friend who lived with the Gomez family, to testify that Ms. Gomez once “choked Rafael until he turned blue and on another occasion, [Ms. Gomez] kicked Rafael off the front porch.” Br. of Pet’r, App. 1 (FF 2.6).

Again, we make every effort to remove the effects of hindsight when assessing attorney performance. *Strickland*, 466 U.S. at 689. Ms. Gomez would have us do otherwise. She wants us to conclude that the case could have been tried better based on her postconviction investigation. But that is not the standard. She must show that Mr. Moser’s performance fell below an objective standard of reasonableness and that she was prejudiced as a result. Mr. Moser’s decision not to call certain government witnesses was reasonable.

Ms. Gomez claims that Mr. Moser was ineffective because he failed to interview four fact witnesses. Br. of Pet’r at 32 (Father Jesus Ramirez, Jennifer Peña, Sergio Peña, and Alicia Garces). She believes that each of those witnesses would have testified to her loving relationship with her children.

Mr. Moser, again, did not think they had much to add based on what he heard during the dependency hearing: “As far as I could tell, these suggestions were all character witnesses and could not testify to specific facts surrounding any of Rafael’s

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injuries or death.” Br. of Pet’r, App. 4 (Moser at 6). Mr. Moser’s decision not to call certain lay witnesses was appropriate and reasonable.

Ms. Gomez asserts that Mr. Moser was ineffective because he failed to adequately prepare Dr. Ophoven and failed to call other available expert witnesses. She argues that Mr. Moser was essentially required to search the country for those witnesses. “[T]here is no absolute requirement that defense counsel interview witnesses before trial.” *In re Pers. Restraint of Pirtle*, 136 Wn.2d 467, 488, 965 P.2d 593 (1998).

Mr. Moser made a strategic and tactical decision to call an expert medical witness to explain the cause of Rafael’s death. He eventually selected Dr. Ophoven and sent her a group of documents (including the coroner’s report and the police report) for her review. He apparently did not give Dr. Ophoven the neuropathology report until after the trial began. As a result, her opinion as to the cause of death initially matched the State’s—blunt force trauma to the head. She later discovered from the neuropathology report that there was no nerve damage in Rafael’s brain and the cause of death was actually choking. Dr. Ophoven conceded abuse and opined that the manner of death was “undetermined.” RP (No. 26090-9-III) at 2069.

In *In re Personal Restraint of Stenson*, our Supreme Court declined to hold the petitioner’s trial counsel ineffective for not personally interviewing the medical examiner before trial, but instead, relied on the investigator’s pretrial interview of the witness. 142

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Wn.2d 710, 754, 16 P.3d 1 (2001). Similar to what Ms. Gomez points to here, at Mr. Stenson's trial, the medical examiner offered unexpected, damaging testimony. The court stated that Mr. Stenson's attorney's "cross-examination of Brady did not go well because Brady was a difficult witness, not because of deficient preparation." *Id.* at 755.

Dr. Ophoven certainly was a troublesome witness for Ms. Gomez because she conceded abuse and opined that the cause of death was asphyxiation or DIC and that the manner of death was "undetermined." RP (No. 26090-9-III) at 2069. Dr. Ophoven now declares, some six years later, that she would have reviewed the cause of the prior incidences of abuse if she had been told they were a part of the charges. She declares she did not review them initially because they did not affect the cause of manner of death.

This change of perspective hardly shows ineffective assistance. Dr. Ophoven reviewed over 100 documents in forming her preliminary opinion on the cause of Rafael's death. Br. of Pet'r, App. 19. She reviewed medical records outlining Rafael's history of injuries and the autopsy report following his death. Mr. Moser provided many of those records. In concluding her 10-page report, Dr. Ophoven stated: "It is my opinion that the details of what happened to Rafael cannot be pieced together just from the postmortem examination. There is a history of possible aspiration during feeding. There is evidence of prior abusive injuries to the boy that dates back to 2001." Br. of Pet'r, App. 19. She herself opined that there was evidence of prior abusive injuries to

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Rafael dated back to 2001. From the record before us, Mr. Moser's preparation of Dr. Ophoven did not fall below the standard discussed in *Stenson*. Ms. Gomez has not met her burden of establishing that trial counsel's performance was deficient based on inadequate witness preparation because Mr. Moser made a strategic tactical decision to call an expert to rebut the State's expert testimony, sent that expert discovery before and during trial, and then the expert volunteered a less-than-perfect opinion from the witness stand.

In addition to Dr. Ophoven, Mr. Moser contacted multiple experts. He sent medical records and other discovery to those experts for their review. He contacted two experts specifically on the issue of Rafael's potential epilepsy. Both experts returned the discovery and declined the invitation to testify. He is not required to search the entire country for all available expert witnesses. Such a standard would not be reasonable tactically or financially. Mr. Moser's investigation of potential experts was reasonable.

HOLDING

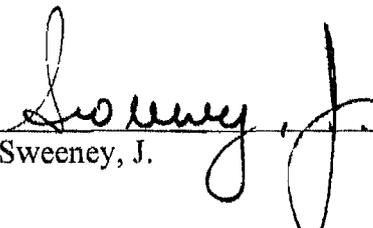
In sum, this is not a case where defense counsel spent only a few hours preparing for trial or made little effort to research the facts or the law. Counsel conducted the appropriate investigations to determine what defenses were available. Ms. Gomez's proposed theory at trial was that this child abused himself to death. There was little to no evidence to support that notion. Her proposed theory here on appeal is now that someone

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else, maybe Mr. Arechiga, abused this child to death. There is no support for that theory either. On the contrary, the evidence here is that Ms. Gomez abused this child to death. Again, Mr. Moser's defense of this difficult and emotionally charged case appears from this record to be highly competent.

We deny the personal restraint petition.

A majority of the panel has determined that this opinion will not be printed in the Washington Appellate Reports but it will be filed for public record pursuant to RCW 2.06.040.


Sweeney, J.

WE CONCUR:


Korsmo, A.C.J.

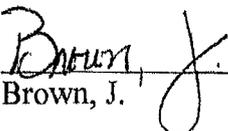

Brown, J.

EXHIBIT 2

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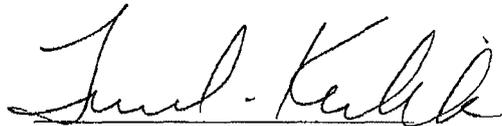
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proceedings for their other children brought as a result of Rafael's death, and (2) she was denied her constitutional right to effective assistance of counsel because several claimed instances of deficient performance by counsel prejudiced her defense.

The Court has reviewed the reviewed the record and file, and is of the opinion that the claims raised in Ms. Gomez's petition are not frivolous. RAP 16.11(b).

Accordingly, the Court orders that the Clerk set this petition before a panel of judges for determination on the merits on the next available docket without oral argument. RAP 16.11(c).

DATED: April 1, 2011



TERESA C. KULIK
CHIEF JUDGE

EXHIBIT 3

CASE REPORT

PATHOLOGY/BIOLOGY

Patrick E. Lantz,¹ M.D. and Daniel E. Couture,² M.D.

Fatal Acute Intracranial Injury, Subdural Hematoma, and Retinal Hemorrhages Caused by Stairway Fall*

ABSTRACT: We describe an infant with an acute subdural hematoma, a fatal head injury, and severe hemorrhagic retinopathy caused by a stairway fall. His cerebral and ocular findings are considered diagnostic of abusive head trauma by many authors. Our literature search of serious injuries or fatalities from stairway or low-height falls involving young children yielded 19 articles of primary data. These articles are discrepant, making the classification of a young child's death following a reported short fall problematic. This case report contradicts the prevalent belief of many physicians dealing with suspected child abuse that low-height falls by young children are without exception benign occurrences and cannot cause fatal intracranial injuries and severe retinal hemorrhages. The irreparable harm to a caregiver facing an erroneous allegation of child abuse requires physicians to thoroughly investigate and correctly classify pediatric accidental head injuries.

KEYWORDS: forensic science, retinal hemorrhages, subdural hematoma, shaken baby syndrome, child abuse, accidental fall, abusive head trauma, stairway fall, short fall

Extensive multilayered retinal hemorrhages (RHs), an acute subdural hematoma (SDH), and brain injury—recognized manifestations of abusive head trauma (shaken baby syndrome)—reportedly do not occur from an accidental head injury when an infant falls downstairs or from a low height (1–31). If a young child dies from a stated short fall, a few authors assert that the caregiver(s) falsified the history (32–35). We present an infant with a fatal traumatic brain injury, acute SDH, and severe hemorrhagic retinopathy. A thorough investigation corroborated witness accounts that the injuries resulted from an accidental fall (<1.5 m) down carpeted steps, which has important medico-legal implications.

Case Report

Transported in extremis by ambulance, a 7¼-month-old male infant had a modified Glasgow Coma Scale of 3 and a rectal temperature of 35°C on arrival at our medical center's emergency department. Resuscitative measures restored a labile heart rate and blood pressure after he experienced pulseless electrical activity (PEA). Axial cranial computed tomography (CT) revealed a left acute SDH of mixed low attenuation suggestive of active bleeding (Fig. 1). Associated findings included a left to right midline shift with early subfalcine and uncal herniation, mild edema of the left cerebral hemisphere, plus blood layering along the tentorium and

falx cerebri. The cranial, cervical, thoraco-abdominal, and pelvic CT images revealed no other injuries. He had an initial hemoglobin of 76 g/L, a hematocrit of 0.228, a prothrombin time of 17.6 sec,

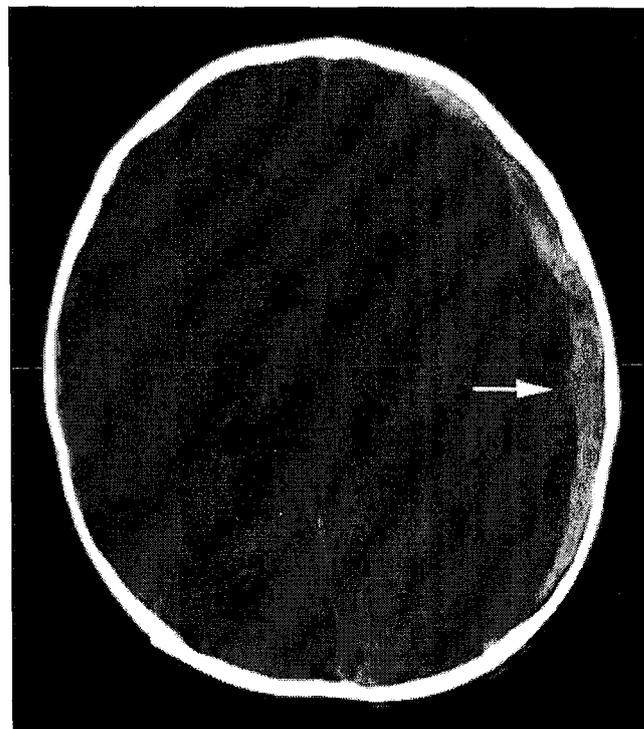


FIG. 1—An axial cranial computed tomography image shows an acute mixed low attenuation subdural hematoma (arrow) compressing the left cerebral hemisphere with a resultant 0.7–0.8 cm left to right midline shift.

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a partial thromboplastin time of >200 sec, a platelet count of $247 \times 10^9/L$, an arterial blood pH of 6.884, and a lactic acid of 12.5 mmol/L. In the operating room, progressive bradycardia and hypotension preceded a final episode of PEA. Resuscitative efforts continued for 20 min during exploration for a bleeding source and evacuation of the compressive subdural blood that had increased to about 2 cm in thickness. At 9:27 PM, he was pronounced dead.

Separate interviews with the mother and maternal grandparents revealed that immediately before the incident, he was active, playful, and crawling on the floor. In adjacent rooms, the mother and grandmother heard a loud thud. Finding him supine on the basement steps' landing (the stairway door had inadvertently been left open), the grandmother comforted him but did not move him while the mother called emergency medical services (dispatch time: 6:45 PM). He cried for about 2 min, started to gasp, and then became unresponsive. Paramedics arrived at 6:52 PM, immediately began resuscitative measures and transported him to the hospital (arrival time: 7:15 PM).

Delivered vaginally at term following an uncomplicated pregnancy, he weighed 4.0 kg and had Apgar scores of 8 and 9 at 1 and 5 min, respectively. Physical examination in the nursery noted cranial molding, a caput succedaneum, and a head circumference of 38.1 cm. He received vitamin K, and no hemostatic complications occurred following circumcision. He attended all scheduled well-child checkups (WCCs) and received all of his routine immunizations. His head circumference was at the 75th percentile when he was 5 weeks old and was at the 90th percentile at his 6-month WCC. According to the mother, grandparents, and family friends, he had been crawling since he was about 6½ months old.

His autopsy weight and length were at the 70th and 97th percentile, respectively, for his age. External injuries included a superficial 1.5-cm pale tan abrasion on the right shoulder and two small pale blue nonpatterned bruises on his lower extremities. Indirect

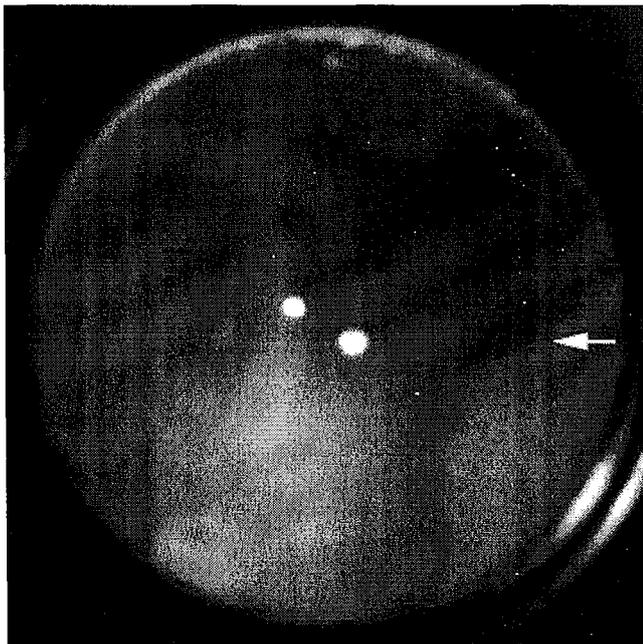


FIG. 2—The indirect ophthalmoscopic projected aerial image reveals a subinternal limiting membrane hemorrhagic cyst (arrow) covering most of the left macula plus thin wisps of vitreal extravasated blood characteristic of Terson syndrome.

ophthalmoscopy revealed bilateral RHs (left > right). A large preretinal hemorrhagic cyst and vitreal blood obscured most of the left macula (Fig. 2). Ocular examination disclosed bilateral acute perineural soft tissue extravasated blood, optic nerve sheath hemorrhages, and multilayered RHs (left > right). Peripheral RHs were focally <0.1 cm from the right ora serrata, whereas the left globe contained vitreal blood and extensive multilayered RHs extending 360° to the ora serrata (Fig. 3). Blood had extravasated within the subcutaneous tissue near the surgical incision, but a definite impact site on the scalp or underlying soft tissue was not evident. No bony, ligamentous, or soft tissue injury involved the cervical spine, and his osseous survey revealed no acute or healing fractures. Neuropathological examination of the brain and spinal cord verified the radiological findings of an acute intracranial injury with compressive effects from a left acute SDH. A focal microscopic contusion of the right inferior cerebellar hemisphere had overlying acute subarachnoid hemorrhage (SAH). Immunohistochemical staining of the brain for β -amyloid precursor protein exhibited a vascular axonal injury pattern except for focal axonal staining of the midline pons and lateral upper cervical spinal cord.

The upper half of the stairway (hallway to the landing) consisted of a carpeted flight of six oak steps and landing (total units of rise = 7). The riser height measured 0.2 m, contributing to a total

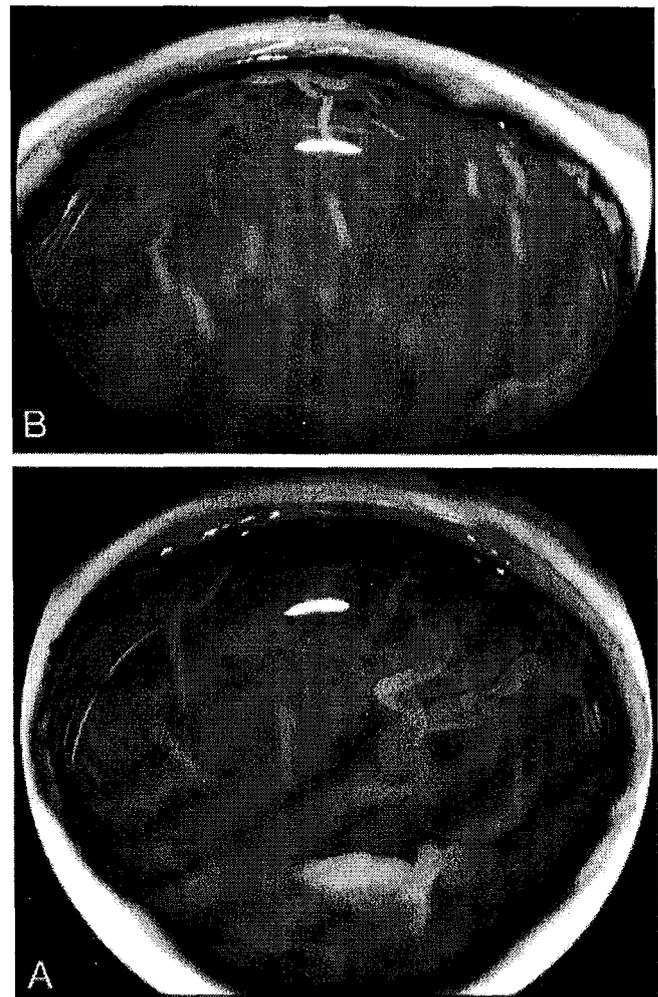


FIG. 3—The left globe exhibits extensive hemorrhagic retinopathy with vitreal blood (A) and has peripheral retinal hemorrhages abutting the ora serrata (B). The retinal folds are postmortem artifacts.

vertical height from the landing to upstairs floor of 1.42 m and a stairway pitch of 37°. The treads and landing measured 2.7 cm thick, and the synthetic carpet and pad had a combined thickness of 1.9 cm.

The mother and grandparents provided detailed, credible, and repeated unchanging accounts of the incident to the emergency medical services dispatcher, paramedics, emergency department personnel, neurosurgeon, detectives, and medical examiner. Medical professionals, law enforcement personnel, and the multidisciplinary child fatality prevention team found no contradictory evidence or risk factors after their evaluation of the medical and investigative findings.

Discussion

The missed diagnosis of an abusive head injury in an infant or toddler can have catastrophic consequences (36). Conversely, the mistaken diagnosis of abusive head trauma can cause irreparable harm with devastating medical, social, and legal ramifications (37). To systematically find the reports of original data about serious injuries or fatalities from stairway or low-height falls involving young children, we searched the National Library of Medicine through September 2010. The terms and medical subject headings (MeSHs) included:

- accidents/mortality [MeSH] OR child abuse/diagnosis [MeSH] OR craniocerebral trauma/etiology [MeSH] OR retinal hemorrhage [MeSH] OR intracranial hemorrhages [MeSH]
- accidental falls [MeSH] OR fall OR falls OR stair*
- #1 and #2.

Setting the English language search strategy to “Limit to All Child (0–18 years)” recovered 906 articles. We reviewed pertinent abstracts and articles on serious childhood injuries or fatalities related to stairway and low-height falls, plus cited references and correspondence to identify related reports. We also examined citations from two recent review articles discussing short-fall deaths in young children (35,38). After excluding review articles, commentaries, position papers, technical reports, and consensus guidelines, we identified 19 articles of original data. The authors of nine of these studies did not discuss RHs.

Falls Downstairs

In a retrospective review encompassing April 1985 to October 1985, Joffe and Ludwig (39) found no evidence of intracranial hemorrhage in 363 children, 1 month to 18.7 years of age (mean and median age: 55 and 38 months, respectively), with a history of a fall downstairs. Concussions occurred in three children and six sustained skull fractures; however, the percentage of children having radiographic imaging was not stated. The authors maintained that falls downstairs seldom result in serious injury and are much less severe than free falls of the same total vertical distance.

In contrast, Chiaviello et al. (40) reported on 69 children <5 years of age (median age: 2 years) who had fallen downstairs and presented to their pediatric emergency department from November 1990 through October 1992. The majority of children (84%) were injured at home while unsupervised (71%). Significant injuries occurred in 22% of the children including 11 concussions, five skull fractures, two cerebral contusions, one SDH (the child fell while being carried), and one cervical fracture. Of the eight children hospitalized, two were admitted to the intensive care unit. The authors concluded that stairway-related injuries in young children are most often superficial but that severe head injury can occur.

In a retrospective review of extensive cerebral hemispheric hypodensities on CT imaging, <5 h after traumatic events, Steinbok et al. (41) identified five infants and children (ages: 4 months–14 years) with well-documented accidental head injuries that caused death within 48 h. A 7-month-old infant had an acute SDH, mild intraventricular hemorrhage, and parenchymal hypodensities associated with bilateral preretinal hemorrhages and RHs, considered consistent with nonaccidental trauma. However, on the basis of corroborating eyewitness accounts, the child protection team concluded that the fatal injury was the result of a fall downstairs as described by the family. The child protection team also determined that a 2-year-old child with tentorial and convexity SDHs, parenchymal hypodensities, and normal funduscopy died after falling from a stool.

A retrospective analysis of medical records for 24 months (2005–2007) by Docherty et al. (9) revealed 239 children <15 years of age (median age: <1 year) with a history of having fallen downstairs. Injuries occurred in 90% of the patients with 69% (165 of 239) sustaining minor head and facial injuries. The authors reported that 2% (five of 239) had skull fractures; however, only 18 children had skull radiographs (one child had a skull fracture diagnosed on a cranial CT without having skull radiography). All the skull fractures occurred when children were dropped while being carried on stairs. The authors concluded that children who fall downstairs are typically toddlers and generally only sustain minor injuries (mainly minor head injuries) and infants who fall downstairs with a caregiver or are dropped while being carried downstairs require an especially careful evaluation.

Low-Height Falls

In the pre-CT era, Gutierrez and Raimondi (42) described 27 neonates, infants, and toddlers they treated from 1968 to 1972 with posttraumatic acute SDHs. The authors stated that falls and child abuse caused 33.3% and 29.6% of the injuries, respectively. RHs occurred in 40% of the newborns, 63.1% of the infants, and 33.3% of the toddlers. Of the five children who died, three were ≤3 months of age, while the other two were 3 and 4 years of age. The authors did not characterize the circumstances associated with the RHs or deaths.

From medical examiner’s files from January 1983 through December 1986, Hall et al. (43–45) identified 18 children (mean age: 2.4 years) who died from accidental falls of <0.9 m (eight witnessed by two or more people in public places). Intracranial injuries included 15 SDHs (five with linear skull fractures), one epidural hematoma (EDH), one cerebral edema, and one cerebral laceration. Fall circumstances consisted of two dropped on ice, five while playing, eight off an object, and three down steps. Two fatal SDHs occurred in medical facilities. Delays in recognition and treatment of head injuries were identified as contributing factors in these deaths. According to the authors, investigations by law enforcement and the medical examiner’s office ruled out child abuse.

During a 2-year period from a children’s hospital emergency department, Williams (30) prospectively studied the fall height necessary to cause severe injury or death in infants and young children. Inclusion criteria included children <3 years of age, a description of injuries and outcome, and a free unobstructed fall from stationary object witnessed by two or more people or by a nonrelated person uninvolved in care of the child. The fall height was estimated to the nearest foot. Of the 106 children in the witnessed group, no injuries occurred in 15 including seven who fell <3.05 m. Mild injuries (bruises, abrasions, lacerations, and simple fractures) occurred in 77 children including 43 who fell >3.05 m.

Severe injuries including intracranial hemorrhages, cerebral edema, depressed skull fractures, and compound or comminuted fractures occurred in 14 children falling between 1.52 and 12.19 m. Three children who fell between 1.22 and 1.52 m onto edged surfaces had small, depressed skull fractures, and one infant died after falling 21.34 m. A comparison group consisted of 53 children <3 years of age who had a free fall that was not witnessed or was witnessed by a single caretaker only. In this latter group, 18 had severe injuries and two died after falling <1.52 m. The author did not describe the fall circumstances or surfaces fallen onto and conceded that falls of >1.83 m generally occurred outside accounting for the frequency that independent observers corroborated higher falls. Because severe injuries and deaths from falls ≤1.52 m occurred only in the uncorroborated group, the author assumed that many if not all of the severe injuries attributed to low-height falls represented child abuse.

Chadwick et al. (33) retrospectively classified 317 children presenting to a trauma center between August 1984 and March 1988 with a history of a fall. Seven of 100 children died from short falls (0.3–1.22 m). No deaths occurred in the 65 children who fell 1.52–2.74 m, and one death occurred in 118 children who fell 3.05–13.72 m. Fatal short-fall histories included two from standing height, two from bed/table, one downstairs, and two from arms of an adult. Head injuries in these seven consisted of one skull fracture, seven SDHs, and five SAHs, and all had cerebral edema. Five had RHs (severity and location not specified). The authors inferred that if the histories of short falls were accepted as correct, this would mean that the risk of death is, counterintuitively, eight times greater for children who fall from <1.22 m than for those who fall from 3.05 to 13.72 m. They therefore surmised that when children incur fatal injuries from falls of <1.22 m, the history was incorrect; however, they did not validate their assumption with the medical examiner's certification.

Duhaime et al. (10) prospectively studied 100 consecutively admitted head-injured children ≤24 months of age (mean age: 9 months). All had an ophthalmological examination within 36 h of admission. The authors developed an algorithm that incorporated the specific injury type, best history available, and associated physical and radiological findings, so that their determination of inflicted injury was purportedly independent of the ophthalmological examination. Their algorithm indicated presumptive or suspicious inflicted injury if a history of forces was considered by the authors to be mechanically insufficient to cause a particular injury, designating falls of <0.91 m as "trivial." For the 73 children with a history of a fall, the reported height or mechanisms for those falls were 34 <1.22 m, 21 >1.22 m, 10 downstairs, and eight downstairs in a walker. Three EDHs occurred in accidental falls <4 feet. Of the 24 children meeting criteria for presumed inflicted injury, eight had a history of a fall of <1.22 m. Ten children in the study had RHs (all with SDHs); nine of 10 had inflicted injuries (two with a history of a trivial fall). The authors concluded that RHs can occur in severe accidental head trauma but were never seen in trivial accidental head injuries. After their study was completed, the authors identified three children with accidental head injuries who had RHs—a nonfatal traffic accident, a fall downstairs in a walker, and a fatal three-story fall.

Reiber (46) evaluated coroner's records from 1983 to 1991 and identified 19 pediatric fatal head injuries (age: <5 years) with fall histories of <1.83 m. Manner of death determinations were 14 homicides, three undetermined, and two accidents. Six children, including two of the three children in his undetermined category, had RHs or axonal injury that the author considered indicative of accelerative injury. Accidental deaths included a 21-month-old

child who fell 1.52–1.83 m from a top bunk, sustaining an SDH plus cerebral edema, and a 17-month-old toddler who fell backward 0.61–0.91 m from a rocking chair, causing an SDH, an SAH, and a cerebral contusion. The author determined that while children on occasion suffer fatal head injuries from short falls, such events are extremely rare.

From an administrative database (Washington State Comprehensive Hospital Abstract Reporting System), Rivara et al. (47) reported the incidence and characteristics of fall-related injuries in children and adolescents (≤19 years of age) occurring in 1989 and 1990. Data on fatalities came from the state of Washington vital statistics tapes for the same years. Fall-related injuries accounted for 2658 hospital admissions. Head injuries including concussions, skull fractures, and intracranial bleeding occurred in 586 (22%) of the children. Head trauma was more common in preschool children (42.1%) compared with 14.4% of adolescents (15–19 years of age). The circumstances of the 11 fall-related deaths were not characterized; however, eight were because of head injuries. Only one child <10 years of age died.

From medical records of 287 children with head injuries that occurred from January 1986 through December 1991, Reece and Sege (25) categorized 54 as definite abuse and 233 as accidents. The authors conceded that funduscopic examinations were not recorded in all 287 children, even though they reported the presence of RHs in 18 of 54 definite abuse cases and in five of 233 accidents. The abuse and accident groups had mean and median ages of 0.7 and 0.3 versus 2.5 and 2.3 years, respectively. Of those children with a history of a short fall (<1.22 m), the authors classified 62 cases as accident and eight as abuse. The short-fall accident group had five complex skull fractures, 12 concussions, two brain contusions, five SDHs, one SAH, and no RHs, whereas in short-fall histories characterized as abuse, there were three SDHs, three SAHs, one complex skull fracture, and two RHs. They commented that short falls seldom cause SDHs and SAHs, while RHs are virtually never seen.

Reviewing more than 75,000 reports of playground-related head/neck injuries in the United States Consumer Product Safety Commission National Injury Information Clearinghouse databases from January 1988 through June 1999, Plunkett (48) found 18 fatal fall-related traumatic brain injuries. Ages ranged from 12 months to 13 years (mean and median ages: 5.2 and 4.5 years, respectively) with fall heights estimated between 0.6 and 3 m. Five children were 12–24 months of age, but none in the study were <1 year old. Noncaregivers witnessed 11 incidents, and one was videotaped. In the six fundal examinations by nonophthalmologists, four children had bilateral RHs. Cerebral findings included one EDH, two cerebral infarcts, 10 SDHs, and 12 with cerebral edema. The author reasoned that an infant or young child might sustain a fatal head injury and RHs from a fall of <3 m.

Wang et al. (49) retrospectively examined 729 charts of pediatric patients (<15 years of age) treated for accidental fall-related trauma from 1992 through 1998. Twelve children died, eight from heights ≥4.57 m and four from <4.57 m. The four children who died of falls <4.57 m did not have stigmata of abuse according to the Suspected Child Abuse and Neglect team. A 3-year-old girl died after tripping, sustaining an orbital fracture, ocular injury, and SDH. The authors concluded that children suffering low-level falls (<4.57 m) had a similar risk for intracranial injuries compared with those who fell from greater heights (>4.57 m), although triage may have overrepresented low-level falls with significant clinical signs.

Denton and Mileusnic (50) described a 9-month-old infant who had a witnessed fall off a bed and then was reportedly asymptomatic for 72 h before being found dead. Autopsy findings included a

linear nondisplaced parietal skull fracture, occipital sutural diastasis, subgaleal hemorrhage, a small posterior SDH, marked cerebral edema, and a small tear in the corpus callosum but no diffuse axonal injury or RHs.

From a retrospective 6-year medical record review (1994–1999), Park et al. (51) described fall-related head injuries and outcomes in children <7 years of age at a pediatric trauma center. Child abuse and motor vehicle accidents were excluded from the study. The authors identified 52 children <3 years of age and 16 children who were 4–6 years old; all had cranial CTs. Falls were classified as low (<1 m) or high (>1 m) level based on witness or paramedic narratives. Typical low-level falls were from a chair, bed, table, or sofa, while high-level falls usually occurred from a window, balcony, or stairs. Of the 68 children, five (four <3 years of age) died because of intracranial injuries (three SDHs and two severe contusions). Of the 38 low-level falls, 19 children had a skull fracture without an intracranial injury, seven had an intracranial injury, six had an extracranial injury (extremity fracture or viscus injury), and one (2.6%) died. The authors did not characterize the fall circumstances but concluded that children sustaining low-level falls are at risk of intracranial injury and death.

In a prospective study, Trenchs et al. (28) reported no SDHs or deaths in 154 children, 15 days to 2 years of age (mean age: 10.1 months), hospitalized from May 2004 to May 2006 with head injuries from vertical falls. Eighty-three percent of the falls were from heights ≤ 1.2 m. Seven children fell downstairs from a standing position. One hundred twenty-two children had skull fractures, and 16 (10.4%) had intracranial injuries including 14 EDHs, one SAH with parenchymal contusion, and one cerebral contusion. Unilateral RHs (confined to the posterior pole) occurred in three children with an EDH and midline shift, but RHs were not evident in children who had no intracranial injuries. The authors contended that diffuse, bilateral RHs indicated trauma other than a fall.

Falls from household furniture and staircases accounted for 21.3% and 6.9%, respectively, of the 174 fatal accidental falls in infants and children analyzed by Behera et al. (52). Their retrospective study of medical records and autopsy reports covered a 10-year period (January 1998–December 2007). Ages ranged from 4 months to 14 years (mean age: 4.87 years) with 7.5% ≤ 1 year old. Intracranial injury was the most common cause of death with SDHs documented in 60 of 147 of the fatal head injuries. The average fall distance was 5.38 m, and the lowest fall height occurred with a 6-month-old infant who fell from a bed. The authors did not correlate fall circumstances with intracranial injuries.

Stray-Pedersen et al. (53) characterized the clinical findings of an 11-month-old infant, who according to her parents, was standing, fell backward, and struck her head on a carpeted wooden floor. Shortly thereafter, she stiffened and became less responsive. On admission to the hospital, she had a decreased level of consciousness and a dilated left pupil. Following emergency surgery to evacuate a compressive left SDH, an ophthalmological examination disclosed numerous bilateral, multilayered RHs. Because of the putative inconsistency between the history and the severity of the SDH and RHs, the case was reported to law enforcement and the parents were charged with child abuse. Initial coagulation testing was normal; however, subsequent analyses uncovered mild von Willebrand disease Type I. As such, the medical conclusions were modified and the allegation of child abuse was withdrawn. The authors indicated that repeat laboratory testing might be necessary to reveal minor coagulation disorders and emphasized that coagulopathies are extremely difficult to diagnosis in fatalities.

Conclusions

These published reports of original data are discordant and controversial, making the correct classification of a young child's death following a reported short fall a diagnostic challenge. Most childhood stairway and low-level falls do not cause serious head injuries. Nevertheless, not all seemingly minor falls are minor. This case report refutes a pervasive belief that childhood low-height falls are invariably trivial events and cannot cause subdural bleeding, fatal intracranial injuries, and extensive multilayered RHs. The harmful and potentially devastating consequences for a caregiver or family facing a false allegation of child abuse obligate physicians to thoroughly investigate and accurately classify pediatric accidental head injuries.

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EXHIBIT 4



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Discipline Notice - Robert A Moser

WSBA Bar#: 32253 **Member Name:** Robert A Moser
Action: Reprimand **Effective Date:** 02/02/2011
RPC: 1.3 - Diligence
 1.14 - (prior to 9/1/2006) Preserving Identity of Funds and Property of a Client
 3.2 - Expediting Litigation
 8.4 (d) - Conduct Prejudicial to the Administration of Justice
 1.15A - Safeguarding Property

Discipline Notice: Robert A. Moser (WSBA No. 32253, admitted 2002), of Moses Lake, was reprimanded following approval of a stipulation on February 2, 2011. This discipline was based on conduct involving failure to act with reasonable diligence, trust account irregularities, failure to expedite litigation, and conduct prejudicial to the administration of justice.

In 2004, Mr. Moser took over as attorney for a probate from a disbarred lawyer, who continued to serve as personal representative. As part of the transfer of duties, Mr. Moser received funds from the estate, including \$100,000 in proceeds from an accidental-death insurance policy for which the decedent had declared no beneficiary. Mr. Moser placed these funds into his IOLTA rather than a separate, interest-bearing trust account where the funds would earn interest for the estate or the ultimate payee. Although he determined that the insurance proceeds should pass to the deceased's children, Mr. Moser did not inform the children that he had placed the funds into his IOLTA. After losing track of the personal representative in 2005, Mr. Moser took no action to close the estate until July 2010, after the children hired separate counsel and the court removed Mr. Moser as attorney for the estate.

Mr. Moser's conduct violated RPC 1.3, requiring a lawyer to act with reasonable diligence and promptness in representing a client; RPC 1.15A(e), requiring a lawyer to promptly provide a written accounting to a client or third person after distribution of property or upon request; former RPC 1.14(c)(2)-(3) and current RPC 1.15A(i)(2), requiring a lawyer to place client or third-person funds that will produce a positive net return in a separate interest-bearing trust account for the particular client or third person with earned interest paid to the client or third person, or in a pooled interest-bearing trust account with sub-accounting that allows for computation of interest earned by each client or third person's funds with the interest paid to the appropriate client or third person; RPC 3.2, requiring a lawyer to make reasonable efforts to expedite litigation consistent with the interests of the client; and RPC 8.4(d), prohibiting a lawyer from engaging in conduct that is prejudicial to the administration of justice.

Joanne S. Abelson represented the Bar Association. Mr. Moser represented himself.

The discipline search function may or may not reveal all disciplinary action relating to a lawyer. The discipline information accessed is a summary and not the official decision in the case. For more complete information, call 206-727-8207.

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EXHIBIT 5

INCIDENT/ INJURY	TRIAL COURT FINDINGS & CONCLUSIONS	READILY AVAILABLE EVIDENCE NOT PRESENTED BY DEFENSE
<p>Nipple lacerations & ear bruises</p>	<p>The Trial Court did not accept the family’s testimony about Rafael’s behaviors and found that no other witnesses had observed Rafael “engage in such destructive behavior.” PRP App. 1 at 2.37.</p> <p>The Trial Court found that: “the defendant’s and Mr. Arechiga’s testimony concerning the nipple lacerations” was not credible, that the wound to Rafael’s nipple was not self-inflicted, and that Ms. Gomez intentionally inflicted the lacerations. PRP App. 1 at 2.72.</p> <p>The Trial Court found that it was not reasonable to conclude that Rafael’s ear bruise was self-inflicted and that the ear injuries were results of assaults by Ms. Gomez. PRP App. 1 at 2.69; 3.5.</p>	<p>CPS worker Linda Turcotte could have testified that she had previously investigated the nipple lacerations and determined that they were not the result of abuse. PRP App. 29 at 25-35; PRP App. 41, 42.</p> <p>Defense counsel could have established (in the defense’s case or through cross-examination of the State’s witnesses) that the nipple lacerations were not present when Rafael left Ms. Gomez’s care, but were discovered after he had been with this foster parents. The emergency nurse, who testified for the State, did a thorough search of Rafael’s body, particularly his abdomen, where she misidentified Mongolian spots for bruises. RP: 879. She did not observe nipple lacerations. <i>Id.</i> Yet, after Rafael spent two days with his foster family and returned to the hospital for a cast, the nipple lacerations that “appeared as pinch marks” were detected on his abdomen by a physician’s assistant who testified for the State at trial. RP: 575-76.</p> <p>In addition, numerous civilian and government-employed witnesses were readily available to corroborate Ms. Gomez’s testimony regarding Rafael’s physical behavior, including pinching himself. These witnesses include: Jorge Chacon (PRP App. 9); Gracie Alvarado (PRP App. 52); Jennifer Peña (PRP App. 10); Alicia Garces (PRP App. 57); Rosibel Davila (PRP App. 16); Esperanza Pando (PRP App. 39).</p> <p>Dr. Stephens, in reviewing the Trial Court’s findings in regard to the ear and nipple injuries, notes that “the bruised ear and pinched nipples are consistent with the self-injurious behavior reported by family members and others.” PRP App. 22 at 14. In making this statement, Dr. Stephens relied in part on a police interview of Maria where she described Rafael’s behavior of pinching his ear until it bled. PRP App. 21 at 7. Maria explained, “He was pinching [his ear] a lot all the time, he was pinching it, my mom said told [sic] him to stop but he wouldn’t and at night I think he would like pinch it all the time, and when he woke up my mom looked at</p>

		<p>him and he had like blood so my mom just used a little bit of alcohol.” <u>Id.</u></p> <p>In his preliminary review of the case, Forensic pathologist Dr. John Plunkett found that “...the Medical Examiner at the time of his investigation and autopsy should have rigorously investigated and taken into account Rafael’s history of self-injurious behaviors. These behaviors were a critical piece of his medical history, and therefore were critical to understanding the origin of the skull fracture and other injuries. The investigation should have included, at a minimum, a complete evaluation by a pediatric geneticist and pediatric neurologist.” PRP Supp. App. 62 at 2.</p>
<p>Basilar/ Occipital skull fracture</p>	<p>The trial court found that several days before his death, Rafael sustained a basilar skull fracture, also referred to as an occipital fracture. PRP App. 1 at 2.57.</p> <p>The Trial Court cited Dr. Feldman’s testimony at trial that the occipital fracture was serious and indicative of serious or severe blunt force trauma to the head. PRP App. 1 at 2.62.</p> <p>The trial court cited Dr. Ophoven’s testimony that the skull fractures found during the autopsy predated the fatal injury and were the result of inflicted trauma</p>	<p>Had Dr. Stephens been called to testify, he would have refuted the Trial Court’s finding that the “occipital [skull] fracture and accompanying epidural hemorrhages sustained by Rafael Gomez in the days immediately prior to his death were the result of an assault by the defendant.” PRP App. 1 at 3.4. Dr. Stephens would have testified that the timing of the fracture cannot be dated with certainty to the days immediately prior to Rafael’s death. PRP App. 22 at 9. Dr. Stephens notes that slides taken at the autopsy “show an old fracture or fractures, with no acute (recent) findings. The findings are at minimum weeks old and could be as old as December 2002.” Therefore, Dr. Stephens concludes it is not possible to determine the cause of these skull fractures based on presently available information. Furthermore, he concludes, “it is very unlikely that these are new fractures since it would be extraordinarily coincidental to have new fractures appear in the same place as healed fractures.” <u>Id.</u> at 10. Dr. Stephens further explains that skull fractures are “not uncommon with children and can be asymptomatic.” PRP App. 22 at 6.</p> <p>Regardless of the timing of the occipital fractures, expert opinion regarding the biomechanics of Rafael’s fall establishes that the force of a backwards fall experienced by Rafael is enough to have caused his injuries. Phil Locke is an engineer with more than 40 years of experience. PRP App. 11 at 1. If Mr. Locke had been called to testify at trial, he would have shown that the velocity at impact of Rafael Gomez falling backwards would have been equivalent to the velocity of</p>

	<p>and the result of a terrible blow. PRP App. 1 at 2.64.</p> <p>The trial court found that in December 2002, Rafael was diagnosed with a skull fracture and a femur fracture. PRP App. 1 at 2.16. The trial court found that it could not conclude beyond a reasonable doubt that the December 2002 femur fracture or occipital fracture were caused by the Defendant assaulting the dependent. 03/08/07 RP: 31.</p> <p>The Trial Court found that even if it accepted the testimony that Rafael fell from the bed days before his death, that such a fall would not have caused the skull fracture. PRP App. 1 at 2.65.</p> <p>The Trial Court found that the occipital fracture and epidural hemorrhage were the result of assault by Ms. Gomez. PRP App. 1 at 2.66; 3.5.</p>	<p>the impact of falling from a second story building (11 feet). <u>Id.</u> at 3. In addition, Mr. Locke would have testified regarding the differences between impacting concrete and impacting other surfaces: “[T]here is absolutely no “give” to the concrete surface. Consequently, concrete results in, by far, the highest peak acceleration (deceleration) in the event of an impact.” <u>Id.</u> at 3-4. In reaching these conclusions, Mr. Locke took into account biomechanical considerations “in addition to any medical susceptibilities or causations.” <u>Id.</u> at 1.</p> <p>Other experts in biomechanical engineering corroborate Mr. Locke’s opinion. Dr. Chris Van Ee holds a PhD in Biomechanical Engineering from Duke University and has specific expertise “in the analysis and risk assessment of head injury in the infant and adult populations.” PRP Supp. App. 59 at 1. Had he been called at trial, Dr. Van Ee would have testified that Rafael’s head injuries could have been the result of his multiple falls. <u>Id.</u> at 11. Dr. Van Ee’s and Mr. Lock’s testimony both would have directly refuted the State’s allegations that the skull fracture was a few days old and that it was the result of inflicted trauma.</p> <p>Testimony from Dr. Stephens also would have refuted the State’s theory that the epidural hemorrhage resulted from inflicted trauma. Dr. Stephens described the hemorrhage as “a very old well-organized hemorrhage that may date back to the December 2002 skull fracture.” PRP App. 22 at 10. Like the occipital fracture, the epidural hemorrhage was “at minimum weeks old and possibly dated back to December 2002.” <u>Id.</u> at 13. Furthermore, Dr. Stephens would have testified that “[e]pidural hemorrhages are rarely associated with non-accidental trauma.” <u>Id.</u> at 10. Indeed, in a 2006 study, Dr. Feldman and others found that “only 6% of children with epidural hemorrhages were abused.” <u>See Amended Brief</u> at 49.</p>
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<p>Shoulders (periosteal and epiphyseal-metaphyseal injuries of the proximal humeri)</p>	<p>The Trial Court found that the shoulder injuries were an “unusual injury” that are “commonly seen in children who are abused.” PRP App. 1 at 2.54.</p> <p>Quoting Dr. Feldman, the Trial Court found that a child with this injury will usually develop “pseudo paralysis” and hold the arm close to the body, which would be readily noticeable to caregivers. <u>Id.</u> The Court further found that the “upper arm injury was not accidental; that it was intentionally inflicted by the defendant.” <u>Id.</u> at 2.56.</p>	<p>Numerous social workers and other individuals who observed Rafael in that time period could have testified that they had not noticed any such “pseudo paralysis” in Rafael’s arms.</p> <p>Had defense counsel consulted with Ms. Gomez about the cause of Rafael’s injuries, he would have found out that some weeks before Rafael’s death, when Ms. Gomez went to the park with her children, Rafael’s uncle Gregorio was playing with the children by swinging them around by their arms. PRP App. 3. Rafael liked this, and kept asking Gregorio to do it again. <u>Id.</u> All three adults took turns swinging Rafael around by his arms. <u>Id.</u></p> <p>Dr. Stephens would have testified that possible explanations for Rafael’s shoulder injuries include “vigorous swinging of the child, and/or with congenital abnormalities (e.g. vitamin deficiency, congenital malformation).” PRP App. 22 at 10. However, Dr. Stephens also opines that the evidence on the proximal humeri findings is “conflicting and the x-rays should be re-read by an experienced radiologist with expertise in bone radiology.” <u>Id.</u> at 10. Of particular relevance is the serious inconsistency among the State’s experts regarding whether the injuries were a “fracture” or a “tear.” <u>Id.</u></p>
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